Audit and Assurance

Tue 05 April 2022, 09:00 - 13:00

Agenda

09:00 - 09:00
0 min

1. Welcome and Introductions

John Union

09:00 - 09:00
0 min

2. Apologies for Absence

John Union

09:00 - 09:00
0 min

3. Declarations of Interest

John Union

09:00 - 09:00
0 min

4. Minutes of the Committee meeting held on 8th February 2022

John Union

04 Draft Public Audit Minutes - 080222MD (DG Comments).pdf (16 pages)

09:00 - 09:00
0 min

5. Action log following meeting held on 8th February 2022

John Union

05 Public Action Log - 05.04.22MD.NF.pdf (1 pages)

09:00 - 09:00
0 min

6. Any other urgent business

09:00 - 09:00
0 min

7. Items for Review and Assurance

7.1. Internal Audit Progress Reports

Ian Virgil

7.1 Internal Audit Progress Report Cover.pdf (3 pages)
7.1a Internal Audit Progress Report.pdf (18 pages)

7.2. Audit Wales Update

Audit Wales

7.2 Audit Wales Update.pdf (8 pages)

7.3. Review changes to Standing Financial Instructions and Accounting Policies (work plan)

Catherine Phillips/Nicola Foreman

7.3 Review of Standing Financial Instructions and Accounting Policies Report.pdf (3 pages)

7.4. Review System of Assurance (workplan)

Nicola Foreman

7.4 Systems of Assurance Report.pdf (3 pages)

7.5. Review Draft UHB Annual Report (workplan)

Nicola Foreman

7.5 Draft UHB Annual ReportMD.pdf (3 pages)
7.5a Annual Report paper for Audit Committee_Appendix 1.pdf (2 pages)

7.6. Self-assessment of effectiveness (workplan) – Verbal

Nicola Foreman

7.7. Counter Fraud Progress Report

Catherine Phillips/Nigel Price

7.7 Counter Fraud Progress Report Cover.pdf (2 pages)
7.7a Counter Fraud Progress Report.pdf (17 pages)

7.8. Procurement Compliance Report

Catherine Phillips/Claire Salisbury

7.9. Losses and Special Payments Panel Report

Catherine Phillips

7.9 Losses and Special Payments Panel Report.pdf (2 pages)
7.9a Appendix 1 - Minutes of the November 2021 Losses Special Payments Panel.pdf (7 pages)

09:00 - 09:00
0 min

8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

8.1 Declarations of Interest Gifts and Hospitality Tracking Report.NF.pdf (4 pages)
8.1a Declarations of Interest Apr 20 to Present - Full Register.pdf (3 pages)

8.2. Regulatory Compliance Tracking Report

Nicola Foreman

8.2 - Regulatory Compliance Tracking Report.NF.pdf (4 pages)
8.2(a) Regulatory Tracker - April 2022.NF.pdf (3 pages)

8.3. Audit Wales Recommendation Report

Nicola Foreman

8.3 - Audit Wales Recommendation Report April 2022.NF.pdf (3 pages)
8.3(a) - Audit Wales Recommendation Tracker .pdf (4 pages)
8.3(b) - Audit Wales Recommendation Summary Table April 2022.NF.pdf (1 pages)

8.4. Internal Audit Tracking Report

Nicola Foreman

- 8.4 - Internal Audit Tracking Report.NF.pdf (3 pages)
- 8.4(a) Internal Audit Tracker April 2022.NF.pdf (13 pages)
- 8.4(b) Internal Audit Summary Tables - April 2022.NF.pdf (3 pages)

8.5. Internal Audit Annual Plan 22/23 (workplan)

Ian Virgil

- 8.5 Internal Audit Plan Cover.pdf (2 pages)
- 8.5a Draft Internal Audit Plan.pdf (31 pages)

8.6. Audit Wales Annual Plan (workplan)

Audit Wales

- 8.6 Audit Wales Annual Plan.pdf (16 pages)

8.7. Audit Enquiries to those charged with governance and management

Catherine Phillips/Nicola Foreman

- 8.7 Audit Enqiries and Responses Letter Cover.pdf (2 pages)
- 8.7b Audit Wales Audit Enquiries and Responses Letter.pdf (17 pages)

09:00 - 09:00
0 min

9. Items for Information and Noting

9.1. Internal Audit reports for information

Ian Virgil

9.1.1. Verification of Dialysis Sessions Final Report (Substantial Assurance)

- 9.1 Verification of Dialysis Sessions Final Report.pdf (14 pages)

9.1.2. Raising Staff Concerns Final Report (Reasonable Assurance)

- 9.2 Raising Staff Concerns Final Report.pdf (16 pages)

9.1.3. IT Service Management Final Report (Limited Assurance)

- 9.3 IT Service Management Final Report.pdf (21 pages)

9.1.4. Arrangements to Support the Delivery of Mental Health Services (Advisory)

- 9.4 Arrangements to Support the Delivery of Mental Health Services.pdf (17 pages)

09:00 - 09:00
0 min

10. Agenda for Private Audit and Assurance Committee

John Union

10.1. Procurement Compliance Report

10.2. Workforce and Organisational Development Compliance Report

09:00 - 09:00
0 min

11. Any Other Business

John Union

09:00 - 09:00
0 min

12. Review and Final Closure

12.1. Items to be deferred to Board / Committee

John Union

12.2. Date, time and venue of the next Committee meeting:

Thursday 12 May 2022 at 9am

Unconfirmed Minutes of the Public Audit & Assurance Meeting
Held on 8th February 2022 at 09:00
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Catherine Phillips	CP	Executive Director of Finance
Timothy Davies	TD	Risk & Regulation Officer
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Darren Griffiths	DG	Audit Wales
Claire Whiles	CW	Assistant Director of Organisational Development
Nigel Price	NP	Local Counter Fraud Specialist
Observers:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Charles Janczewski	CJ	UHB Chair
Aaron Fowler	AF	Head of Risk & Regulation
Anthony Veale	AV	Audit Wales
Mark Jones	MJ	Audit Wales

Item No	Agenda Item	Action
AAC 22/02/08/001	**Welcome and Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 22/02/08/002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 22/02/08/003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	

AAC 22/02/08/004	**Minutes of the Committee meeting held on 9th November 2021** Darren Griffiths (DG) noted that there were amendments to be made regarding page 2 and page 3. The Director of Corporate Governance (DCG) stated that the changes had been received and would be incorporated. **The Committee resolved that:** a) Subject to the above amendments being made to the draft minutes of the meeting held on the 9th November 2021, the draft minutes were held as a true and accurate record of the meeting.	
AAC 22/02/08/005	**Action log following meeting held on 9th November 2021** The Executive Director of Finance (EDF) confirmed that AAC 21/11/09/010 on the Action Log had been completed. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 22/02/08/006	**Any other urgent business:** To agree any additional items of urgent business that may need to be considered during the meeting The Committee resolved that: a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 22/02/08/007	**Internal Audit Progress Reports** Ian Virgil (IV) presented the Internal Audit Progress Report (the Report) and highlighted the following – • Eight audits were scheduled to be finalised for the February meeting but had not been completed to meet that deadline. • Two of the audits had reached draft report stage. • The IT service management system draft report was with Management for review and comments. • Section 3 of the Report confirmed that the outcome from the four audits had been finalised. • The graph on section 4 of the Report highlighted 34 reviews in the plan. The current progress was that 10 audits had been finalised to date and a further 2 were	

	at the draft stage. A further 11 were a “work in progress” and 9 were in the planning stages. • Page 4 of the Report detailed that following the Management Executive meeting in November, it was agreed that 4 audits would be deferred from the plan due to ongoing pressures in the Health Board. • Two audits would also be combined into one audit due to the overlap. • With the adjustments made and the 34 audits remaining, there was enough coverage across the Health Board to be able to give a formal opinion to the Health Board for the year. • Under section 5 of the Report good progress had been made in developing the plan for 22/23. Meetings had taken place with the Executives and a draft plan would be created to go back to the Management Executive meeting and then submitted to the April Audit Committee meeting for formal approval. The Committee Chair (CC) queried whether the 9 reports in the planning stage and 2 in other stages could be completed within the timescale. IV responded that although the formal audit year ran from April to March, the audits would continue through May to be submitted to the June Committee. IV commented that he was confident that the reports could be completed within time. Wendy Wright (WW) presented the following reports and highlighted the following: 1. The Core Financial Systems Final Report - The General Ledger and Accounts Receivable had been looked at. - They made two low priority recommendations. Firstly, regarding the best practice point and secondly regarding the timeliness in actioning leavers in the Oracle system. - In comparison to the previous audit completed it was noted that the position had improved. 2. Theatre Utilisation (Surgery Clinical Board) - The audit was undertaken on behalf of the Surgery Clinical Boards and objectives focused on governance arrangements, policy and procedures. - One high priority recommendation was made which related to policy and procedure. - Two recommendations were made in relation to the Theatreman System.	

	- The third medium priority recommendation related to opportunities to maximise Theatre resource. - The report provided reasonable assurance. 3. Retention of Staff Report - The objectives focused on strategies, plans, policies and initiatives to support staff retention. In addition to the Leavers process and data collected for staff turnover. - 5 medium priority recommendations were made. - It was found that the People and Culture Plan was fundamental for taking that area forward. - A recommendation was also made regarding the Nurse Retention Action Plan. - In terms of looking ahead, the People and Culture Plan was strong on determining what evaluation arrangements had been put in place to determine if the plan and objectives had been affected. - Any retention initiatives taken forward should have evaluation mechanisms in place. - The Leavers' Checklist was a helpful guidance document for managers and should become more formalised within the Health Board procedure. - The report provided reasonable assurance. 4. Welsh Language Standards - Provided medium priority across the six recommendations that had been raised. - The first recommendation related to having greater cascade of actions around Clinical Boards and departments. - Another point raised was in relation to rolling out Welsh Language champions across the Health Board. - Given the lapse of time that had passed since the Welsh Language Standards had come into being, there was opportunity to give greater consideration to the resource arrangement and governance arrangement around the Standards. - The last point was in relation to the publication of Welsh Language Policy which was under review. The Chair queried the number of reds for response times on Appendix B. The Chair queried if that was due to the pressures the teams had faced. IV responded that delays had been due to pressures within the organisation.	

	The Committee resolved that: a) The Internal Audit Progress Report, which included the findings and conclusions from the finalised individual audit reports, was considered. b) The removal of the four identified audits from the Internal Audit Plan for 2021/22 was approved. c) The proposal to combine the two audits on Recovery of Services and Delivery of the 21/22 Plan was approved.	
AAC 22/02/08/008	**Audit Wales Update** Darren Griffiths (DG) presented the Audit Wales Update report and highlighted the following: • Two pieces of work had been completed. That was, (1) the Phase 2 Structured Assessment which had looked at the Corporate Governance and Financial Management Arrangements of the Health Board, and (2) the follow up of the 2017 Review of Radiology Services. • Audit Wales were in the process of drafting the report on the review of the Health Board's Quality Governance Arrangements. There had been a slight delay due to staffing constraints in the team. However, the emerging findings and conclusions had been presented to colleagues on the Executive Team and Members of the Quality, Safety and Experience Committee. • A national report on joint working between Emergency Services had been published. The key messages were summarised in Appendix 1 of the Update. **The Committee resolved that:** a) The Audit Wales Update was noted and discussed.	
AAC 22/02/08/009	**Audit Wales Report: Taking Care of the Carers? – Management Response** DG stated the report had been shared with the Committee at the last meeting. However, due to publication of timescales it had not been possible for the Health Board to put together a response. The management response had now been received. The response was very detailed and thorough. The Health Board could take a great deal of assurance regarding the actions the Health Board was taking in that important area.	

	The Assistant Director of Organisational Development (ADOD) presented the report and highlighted the following: • The Audit Wales Taking Care of Carers? publication was produced in October 2021. • The audit had enabled the Health Board to provide assurance on the 6 recommendations resulting from the report. • The People and Culture Plan provided additional alignment and pathway for supporting staff in every step of their career journey. • The monitoring and reporting element within the People and Culture Plan would also provide assurance to the Audit Committee. The Independent Member for Trade Union (IMU) highlighted that the focus on staff wellbeing was a very high priority. DG commented that a lot of the actions were listed as "ongoing". For the purpose of tracking the recommendations, it was noted that the Committee might want to consider when to take the recommendations off the Tracker when they feel the appropriate action had been undertaken. The Director of Corporate Governance (DCG) responded that she would agree timescales with the EDPC and ADOD offline to confirm sensible dates. **The Committee resolved that:** a) The management response and actions identified, including reporting requirements and utilisation of the Board Checklist, were supported.	
AAC 22/02/08/010	**Radiology Services - Update on Progress** DG presented the Radiology Services Report and highlighted the following: • An initial review of Radiology Services was completed in 2017. • The review looked at the Health Board's progress against the recommendations made in 2017. • Overall, the Health Board had improved in the way it planned and delivered Radiology Services through strong management of the Service. • Good progress had also been made to address the majority of 2017 recommendations. • No new recommendations were made. However, the recommendation relating to increasing the appraisal	

	rates of non-clinical staff should be reinstated on the Audit Tracker due to the limited progress to date. The Chair queried why limited action had been taken in relation to the recommendation to increasing the appraisal rates of non-clinical staff, which could cause concern. DG responded that the Service had been grappling with this issue for some time. There was evidence that management has started to address the recommendation, but because the response rate had not increased it was considered important for the recommendation to remain on the Tracker because non-Clinical staff were just as important as Clinical staff. The EDPC commented that it was an area that was low already and the Covid-19 pandemic had made it worse. Appraisals were very low at 30%. The EDPC would request the Head of Workforce in each Clinical Board to focus upon that area. DG highlighted the risk in relation to Diagnostic Services caused by the pent-up demand for services during the pandemic. It was important to draw that risk to the attention of the Committee and Health Board so that the risk could be considered as part of recovery planning. The Chair queried if that would be looked at again in the future. DG responded that it was the second time that Service Area had been reviewed and Audit Wales wanted to make sure their work covered other service areas over the years. However, Audit Wales would keep an eye on the outstanding recommendation as part of their own arrangements for tracking progress. **The Committee resolved that:** a) The Radiology Services Update on Progress was discussed and noted.	
AAC 22/02/08/011	**Structured Assessment (Phase 2) Report and Management Response** DG updated the Committee on the following: • The Phase 2 report had reviewed the Corporate Governance and Financial Management arrangements of the Health Board. • Overall, it was a positive report.	

	• Audit Wales had found that the Health Board had effective Committee and Board arrangements in place which were underpinned by maturing assurance systems. • Opportunities to strengthen transparency remained. • There were clear plans in place to support the recovery of services but arrangements for monitoring and reporting overall plan delivery should be strengthened. • The Health Board had maintained a robust oversight of its finances. However, the pandemic continues to pose a risk to the Health Board to remain even. • Two recommendations were raised. That was (1) to enhance public transparency of Board business, and (2) to strengthen arrangements for monitoring and reporting on the overall delivery of the Annual Plan and future IMTPs. Both recommendations had been accepted by the Health Board. The DGC commented that the recommendations related mostly to the timeliness of the information on the Health Board's website and making sure there was publication of Board and Committee papers and recordings of those meetings. These areas had now been built into standard operating procedures and should happen automatically. The only one outstanding was making sure that the public and other interested parties were being signposted to future Board and Committee meetings via social media. **The Committee resolved that:** a) The Structured Assessment (Phase 2) Report and Management Response was noted.	
AAC 22/02/08/012	**Risk Management System** The DCG highlighted the following: • An Audit was completed in March 2021. • The report highlighted the 5 recommendations that were picked up by Internal Audit at the time. • The recommendations have been implemented. • An internal audit was due out at the end of the year. • The Appendix set out the plans in terms of training and development to ensure officers understood what the risk appetite was. • The next step was to make decisions in line with the risk appetite. **The Committee resolved that:**	

	a) The update on the Health Board's Risk Management Systems and ongoing developments in that area was noted.	
AAC 22/02/08/013	**Review of Standing Orders** It was noted that the Standing Orders were up to date and in line with the Model Standing Orders issued by WG. **The Committee resolved that:** a) The update, as set out in the body of the report, with regards to the Health Board's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, was noted.	
AAC 22/02/08/014	**Refreshed Governance Arrangements for Covid 19** The DCG highlighted the following: • During the first wave of Covid 19 some Committees of the Board were "stood down". • Committees were not stood down during the current wave, although the Chair had requested that Committee agendas were more refined. • Executives were stood down from all Committees except for those where they were the Executive Lead. • The Covid 19 Governance Group had met twice. The Chair of the Board had considered whether that Group should continue to meet given that Covid was slowing down. • The arrangements would stay in place until they were stood down. The Vice Chair commented that the diagram did not include the Mental Health committee. The DCG responded that Mental Health sat under the site leadership for UHL and would make sure to include it. **The Committee resolved that:** a) The governance arrangements and update as at 21st December 2021(Appendix 1) was noted. b) The Board Governance Group Terms of Reference (Appendix 2) was noted. c) The Systems Resilience Template (Appendix 3) covering the key areas of Quality and Safety, Workforce, Governance, Operations, Governance and Public Health was noted.	

	d) The current Governance Structure in place (Appendix 4) was noted.	
AAC 22/02/08/015	**Audit Wales Report - Committee Governance Arrangements at WHSSC** The DCG stated that the Committee had previously seen the report by Audit Wales which had made recommendations for WHSSC and WG. The report included in the Committee meeting papers had been prepared by WHSCC and gave their response to the recommendations and updates on where they were. **The Committee resolved that:** a) The progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, was noted. b) The progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, was noted.	
	Items for Approval / Ratification	
AAC 22/02/08/016	**Declarations of Interest and Gifts and Hospitality Tracking Report** The Regulation and Risk Officer (RRO) presented the report and highlighted the following: • In November 2021 there was an agreement to modify the process for Declarations of Interest to ensure it was not a single Declaration of Interest rather than an annual requirement. The view was that the previous arrangement was too confusing. • From November 2021 the communication plan had focused upon ensuring that staff should submit a Declaration of Interest once during their employment. • Declaration of Interests could now be completed on ESR which was more user-friendly. • Corporate communications had now suggested that a trial “power hour” was tested. Members from the Risk and Regulation team, along with the ESR and the corporate Communications team would be available at a certain time to provide assistance on the process. • The current Register covered the period from 1st of April 2020 – 1st April 2022. • 1418 Declarations of Interest, gifts and hospitality forms had been recorded on the Register.	

	• The Register reflected current employees. • 70% of band 8a and above staff had now received active and correct Declaration forms. • 94% of Declarations were green i.e. no cause of concern • 2.6% were a medium risk conflict. • 0.03% were a high conflict risk. • Due to the success of recent advertising campaigns, it had been agreed that the Communications team would initiate a communication plan throughout 2022. That would be delivered through the Staff Connect app, Staff Weekly update, screen savers and the power hour. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The Declarations of Interest, Gifts, Hospitality & Sponsorship Register was noted.	
AAC 22/02/08/017	**Regulatory Compliance Tracking Report** The RRO presented the report and highlighted the following: • The purpose of the report was to provide Members with assurance of the implementation of recommendations made by external Regulatory Bodies. • An internal audit into the Corporate Governance Regulatory Compliance Tracker was undertaken in July and August 2021. • As a result of the audit undertaken, the Health Board was given a reasonable assurance rating. • There was one recommendation from the audit that remains on the internal Tracker. That related to the management of Welsh Health Circulars. • Patient safety solutions were monitored and managed by the Patient Safety and Organisational Learning Manager who maintained a tracker of PSNs received. • The Regulatory Tracker attached to the report was up to date as at 21st January 2022. • The team's assessment of the review/ongoing review of the Tracker should reduce the risk that key regulatory requirements are missed. **The Committee resolved that:** a) The approach taken by the Risk and Regulation team to the tracking and reporting of compliance with regulatory inspections and recommendations, was approved.	

	b) The assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations, was approved. c) The continuing development of the Legislative and Regulatory Compliance Tracker was noted.	
AAC 22/02/08/018	**Audit Wales Tracking Report** The RRO presented the report and highlighted the following: • Appendix 1 showed a summary of the external audits undertaken in previous years. • 15 external audits were noted on the Tracker and brought forward from the last Committee meeting. • Since the last meeting, 4 recommendations had been completed and 11 were partially complete. • A review of all outstanding recommendations had been undertaken with Executives Leads. • The report would be presented at each Audit Committee meeting to provide Regulatory updates. The reports had also been discussed at ME meetings. The Chair commented that the two overdue items remained on the Tracker until completed. The RRO responded that it was to do with the complexity and did not reflect a lack of focus by the lead officers. **The Committee resolved to:** a) the progress which had been made in relation to the completion of the Audit Wales recommendations, was noted and assurance was received. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	
AAC 22/02/08/019	**Internal Audit Tracking Report** The RRO presented the report and highlighted the following: • The Tracker attached to the report demonstrated that progress had been made against the recommendations made in years 2019-2020, 2020-2021, 2021-2022. • Overall the outstanding recommendations had reduced from 86 to 85. That could be contributed to the removal of entries. Since that date a further 16 entries had been added to the Tracker. • A review of the outstanding recommendations had been undertaken since the last Audit Committee	

	meeting and each Executive Lead had been sent the recommendation which fell within their remit. • Assurance was provided by the fact the Tracker was in place and actively managed. IV commented that Audit Wales had the chance to check what was on the draft version of the Tracker. It had been a helpful way to engage in the process and they were planning to carry that on with the team. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit was noted. b) The progress which had been made since the previous Audit and Assurance Committee Meeting in November 2021 was noted. c) The approach taken towards the management and monitoring of Internal Audit Recommendations was noted.	
AAC 22/02/08/020	**Timetable for the Production of the 2021-2022 Annual Report** The DCG presented the report and highlighted the following: • The report highlighted the timetable for the year. • The Health Board was working with Audit Wales and Internal Audit on the end of year arrangements. The remuneration of staff was the part which was audited. • The Appendix set out the key dates. The final submission to WG was on 15th of June 2022 and a Special Audit Committee meeting and a Board meeting had been scheduled for 14 June 2022. The Chair queried if the proposed timetable followed last year's timetable. The DCG responded that the dates did not change and generally the timetable was the same. IV queried part 1 in the April section of the report. There was a deadline there for Internal Audit to receive and comment on the Sustainability element. That was removed and it would not feed into a formal report from Internal Audit. The DCG responded that they were aware that there was not a formal requirement for it. Last year it was agreed that, as a Board, the sustainable element was still needed. **The Committee resolved that:**	

	a) The proposed timetable and approach, as set out in the report, for the Annual report 2022-22 prior to the same being presented to full Board for formal approval, was ratified.	
AAC 22/02/08/021	**Audit Wales Annual Audit Report** The DCG stated the report provided a summary of the work completed in 2021. The individual pieces had been brought to the Audit Committee meetings previously. **The Committee resolved that:** a) The Audit Wales Annual Audit Report was noted	
AAC 22/02/08/022	**Committee Annual Work Plan - 2022/23** The DCG stated that the workplan was there to ensure that the Health Board was delivering its Terms of Reference. They were broadly the same as in previous years. The Forward Plan sat alongside the Annual Work Plan and captured anything that was not covered on the Annual Work Plan. The Committee's Annual Work Plan would be submitted to the Board for formal approval at the end of March 2022. DG commented that the Audit Wales Annual Audit Plan would be presented at the next meeting. **The Committee resolved that:** a) The Work Plan 2022/23 was reviewed. b) The Work Plan 2022/23 was ratified. c) Approval to the Board on 31st March 2022 was recommended.	
AAC 22/02/08/023	**Committee Terms of Reference - 2022/23** The DCG stated that since the Terms of Reference were reviewed annually and there were no significant changes. DG commented that he was conscious Audit Wales had not had an opportunity to meet with Members of the Audit Committee without Officers being present. The Chair responded that they previously met with Internal Audit virtually and were happy to meet with Audit Wales in the same way. The DCG commented that a meeting would be organised. **The Committee resolved that:**	**NF**

	a) The changes to the Terms of Reference for the Audit and Assurance Committee were reviewed. b) The changes to the Terms of Reference for the Audit and Assurance Committee were ratified. c) The changes to the Terms of Reference were recommended to the Board for approval on 31st March 2022.	
AAC 22/02/08/024	**Committee Annual Report – 20221/2022** The DCG stated that the report was a backwards look at the work of the Committee within the last 12 months. It was presented to give assurance to the Committee and to make sure the Committee was doing what it was supposed to do in line with its Terms of Reference. It was noted that the draft report enclosed required updating to reflect the attendance and matters discussed in the Committee meeting that day before submission to the Board in March 2022. **The Committee resolved that:** a) The draft Annual Report 2021/22 of the Audit and Assurance Committee was reviewed. b) The draft Annual Report was recommended to the Board for approval.	
	Items for Information and Noting	
AAC 22/02/08/025	**Response to Audit Wales Decarbonisation Baseline Review** The DCG stated that the EDSP wanted the Committee to have sight of that review. The Committee resolved that: a) The Response to Audit Wales Decarbonisation Baseline Review (including the survey) was noted.	
AAC 22/02/08/026	**Internal Audit reports for information:** i. Core Financial Systems Final Report (Substantial Assurance) ii. Theatre Utilisation Final Report (Reasonable Assurance) iii. Retention of Staff Final Report (Reasonable Assurance) iv. Welsh Language Standards (Reasonable Assurance) Nothing further was added.	
	Review and Final Closure	

AAC 22/02/08/027	**Items to be deferred to Board / Committee** Nothing further was added.	
AAC 22/02/08/028	To note the date, time and venue of the next Committee meeting: **Tuesday 5th April 2022 at 9.00am**	

Public Action Log
Following Audit & Assurance Committee Meeting
8th February 2022
(For the Meeting 5th April 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
Actions in Progress					
AAC 22/02/08/022	Annual Audit Wales Plan	Audit Wales Annual Plan to be shared at the next Committee meeting.	Audit Wales	05/04/2022	Complete On today's agenda – item 8.6
AAC 22/02/08/023	Meeting with Audit Wales	Independent Members to meet with Audit Wales virtually.	Nicola Foreman	TBC	In progress Meeting to be organised between the Committee IMs and Audit Wales.
AAC 22/02/08/009	Audit Wales Report: Taking Care of the Carers' – Management Response	Nicola Foreman to agree timescales with Rachel Gidman and Claire Whiles regarding when to take the recommendations off the Tracker.	Nicola Foreman	TBC	In progress NF to liaise with RG and CW.
Actions referred to Board / Committees					
AAC 22/02/08/022	Committee Annual Work Plan - 2022/23	The Committee's Annual Work Plan would be submitted to the Board for formal approval at the end of March 2022.	Nicola Foreman	31/03/2022	Complete On the agenda for the Board meeting in March 2022.

Report Title:	**Internal Audit Progress Report**				Agenda Item no.	7.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	05/04/22	
			Private				
Status *(please tick one only):*	Assurance	X	Approval	X	Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report
Background and current situation:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Cardiff and Vale University 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 Audit 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 UHB.

The 2021/22 plan was formally approved by the Audit Committee at its April 21 meeting.

The progress report provides the Audit 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 and proposed amendments to the plan.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including details of proposed postponed / removed audits and commentary as to progress with the delivery of assignments.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The progress report highlights the conclusions and assurance ratings for audits finalised in the current period. The Executive summaries for the finalised reports are also included within the progress report and those given Limited or No Assurance are also included separately on the agenda in full. There is one report that has been given a Limited Assurance rating during the current period.

The progress report includes two further proposed amendments to the agreed 21/22 Internal Audit plan.

The audits remaining within the plan still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed adjustments to the Internal Audit Plan for 2021/22.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee April 2022

NWSSP Audit and Assurance Services

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

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1. Introduction

This progress report provides the Audit & 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 2021/22 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 2021/22 was agreed by the Audit & Assurance Committee in April 2021 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

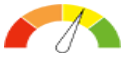
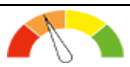
The assignments noted in the table below are those which had been planned to be reported to the April Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Capital Scheme - Genomics	Draft	Reasonable	Significant delays in receiving information from Health Board Management.
Estates Assurance – Waste Management	Draft	Reasonable	Slight delay in completion of fieldwork.
Nurse Bank	Work in Progress		Delay in agreeing audit brief with Management.
Chemocare IT System	Work in Progress		Delay in commencing audit fieldwork due to the availability of Internal Audit staff resource.
Children & Women CB – Nurse Rostering	Work in Progress		Delay in completing fieldwork due to the availability of Ward Managers.
NIS Directive Implementation	Work in Progress		Delay in commencing audit fieldwork due to the availability of Internal Audit staff resource.
Management of Staff Sickness Absence	Planning		Agreed to delay fieldwork until completion of Retention audit, to avoid additional pressure on Management. Subsequent availability of Internal Audit staff resource.

3. Outcomes from Completed Audit Reviews

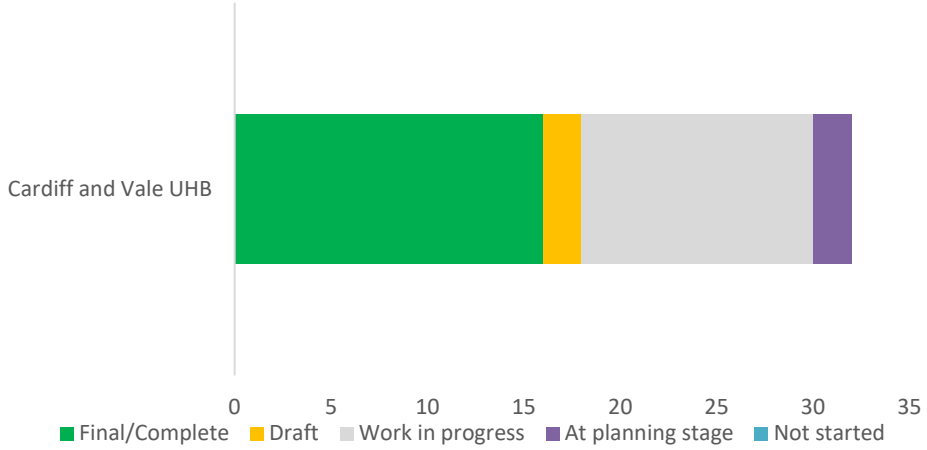
Four assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The Executive Summaries from the finalised assignments are reported in Section six. The full reports are included separately within the Audit Committee agenda for information.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Verification of Dialysis Sessions (Specialist Services Clinical Board)	Substantial	
Raising Staff Concerns (Whistleblowing)	Reasonable	
IT Service Management (ITIL)	Limited	
Arrangements to support the delivery of Mental Health Services (Mental Health Clinical Board)	N/A Advisory	

4. Delivery of the 2021/22 Internal Audit Plan

There are a total of 32 reviews included within the updated 2021/22 Internal Audit Plan (including adjustment for the proposed two changes detailed below), and overall progress is summarised below.



From the illustration above it can be seen that sixteen audit outputs have been finalised/completed so far this year with two further audit reports issued in draft.

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

The delivery of the 2021/22 plan has been impacted by the pressures placed on the Health Board due to the Covid-19 pandemic.

A total of 10 audits had previously been identified for removal / deferral from the plan following discussions with management and agreement from the Executive team. These have been previously approved by the Committee.

A further two audits have also now been proposed for removal / deferral, as follows:

- **PCIC CB – Primary Care Vaccinations**

  This audit is proposed for removal from the 21/22 plan. Elements of the planned scope have been picked up as part of the wider audit of the Covid 19 Vaccination Programme - Phase 3 delivery. This has been agreed with the Chief Operating Officer.

- **Digital Strategy Roadmap**

  This audit has been agreed for deferral to the 22/23 plan by the Director of Digital

and Health Intelligence, due to current pressures on the IT team and the availability of key management. The roadmap will be included in the scope of the 22/23 Digital Strategy audit.

The audits that have been deferred from the 2021/22 plan have been considered for inclusion within the 2022/23 plan, as part of the process for developing the plan detailed within section 5 below.

The adjustments agreed to date and the further two highlighted above, mean that a total of 32 audits remain within the 21/22 plan. This will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year.

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 B highlights the times for responding to Internal Audit reports.

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

5. Development of the 2022/23 Plan

Meetings were held with the Health Board's Executive Directors during January and February to identify and discuss potential areas for inclusion within the 2022/23 Internal Audit Plan.

An outline plan was then developed and discussed with the Chairman and Chief Executive prior to being submitted to the Management Executive for review and comment.

The draft 2022/23 plan was subsequently produced and is included separately on the Committee agenda for formal review and approval.

6. Final Report Summaries

6.1 Verification of Dialysis Sessions (Specialist Services Clinical Board)

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Nephrology and Transplant Directorate for the verification of community dialysis sessions provided by external suppliers.

Overview

Our overall rating of Substantial Assurance reflects the governance, reporting and monitoring arrangements in place for the provision of dialysis sessions.

We identified a key matter requiring management attention, which refers to the accessibility of key documents that support the monthly verification exercise.

Two further low priority recommendations of an advisory nature are within the detail of the report.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate governance arrangements in place for the provision of dialysis sessions.	Substantial
2	Procedural guidance in place	Substantial
3	Effective controls for verification of sessions and payment of invoices	Reasonable
4	Activity provided by external suppliers is monitored and reported	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matter Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2	Lack of visibility and accessibility of verification documents	3	Operation	Medium

6.2 Raising Staff Concerns (Whistleblowing)

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to raising staff concerns and to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the systems objectives were managed appropriately.

Overview

We have issued reasonable assurance on this area.

The matters that require management attention include:

- The Freedom to Speak Up communication campaign cannot be overestimated in value given the low number of staff concerns currently reported. The timeliness of campaigns should be improved.
- Whilst processes are in place to record staff concerns, we make a recommendation to enhance current arrangements to ensure the robustness of recorded concerns.
- The Health Board is yet to determine whether the Board or sub-committee will monitor the use of the All-Wales Procedure for Staff to Raise Concerns.

Other low priority recommendations are within the detail of the report.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Adoption of the All-Wales Procedure for NHS Staff to Raise Concerns	Substantial
2	Staff awareness of the procedure	Reasonable
3	Managers are aware of their responsibilities	Reasonable
4	Processes are in place to record, investigate and address staff concerns	Reasonable
5	Governance arrangements for the review, reporting and escalation of identified concerns and themes	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
3	Timeliness of the Freedom to Speak Up communication campaign	2 & 3	Operation	Medium
4	Greater clarity within the Freedom to Speak Up Staff Concerns Log	4	Operation	Medium
5	Compliance with the governance arrangements of the All-Wales Procedure for NHS Staff to Raise Concerns	5	Design	Medium

6.3 IT Service Management (ITIL)

Purpose

To provide assurance to Cardiff and Vale UHB's Audit Committee that a process is in place for ensuring IT services are provided in an efficient and secure manner and reflect the needs of the organisation.

Overview

Overall, there are poor controls in place over the IT Service Desk function. It is acknowledged that management are planning major improvements by implementing a new call handling system, restructuring the service desk department and introducing new ways of working based on the ITIL Framework. However, based on the present situation we have issued limited assurance on this area. The significant matters which require management attention include:

- Lack of an IL Framework for the delivery of services;
- Lack of documented guidance for call handlers;
- Inaccurate call classification and prioritisation of calls; and
- High levels of 'open' calls with lack of monitoring.

Additional recommendations are also made which can be found within the report.

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives

1	Service Design
2	Service Desk Operation
3	Operation Management
4	Knowledge Management

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Lack of an ITIL Framework	1	Design	High
2	Lack of documented guidance for call handlers	2	Design	High
3	Inaccurate call classification and prioritisation	2	Operation	High
4	High level of open calls and lack of call monitoring	2	Operation	High
5	Lack of Service Catalogue	1	Design	Medium
6	Lack of call resolution and closure targets	3	Design	Medium
7	Lack of defined problem management process	3	Design	Medium
8	Lack of knowledge management process	4	Operation	Medium

6.4 Arrangements to support the delivery of Mental Health Services (Mental Health Clinical Board)

Purpose

The overall objective of this advisory review was to evaluate and support the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges.

Overview

This is an advisory review to support management, rather than an assurance report, we therefore offer no assurance rating.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Clinical Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will enable the Clinical Board to enhance the arrangements to support the delivery of Mental Health Services.

Management within the Clinical Board have a good understanding of the risks and challenges facing mental health services, but now need to look for solutions, at a time when there is a heightened demand on services, which is only likely to increase as the impact of COVID-19 reduces.

Report Classification

Assurance not applicable

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate:

1	The services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them;
2	The means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities; and
3	The potential service delivery risks and challenges which limit the effective operation of mental health services.

Opportunities

		Audit Objective
1	Maintain a 'live' tool of documented Mental Health Services	1
2	Undertake an informed update of the Health Board's Mental Health webpages	1
3	Consider the response to issues which hamper staff efficiency and effectiveness	2
4	Undertake a review of the Clinical Board's Risk Management arrangements	3
5	Explore solutions to address the key risks and challenges identified	3

ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Legislative, Regulatory & Alerts Compliance	06	Corporate Governance	Q1		Final Report Issued August 21	Reasonable	Sept
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	11	Public Health	Q1		Final Report issued August 21	Reasonable	Sept
CD&T CB – Ultrasound Governance	27	COO	Q1		Final Report issued August 21	Limited	Sept
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	29	COO	Q2		Final Report issued August 21	Reasonable	Sept
Clinical Audit	15	Medical	Q2		Final Report issued October 21	Limited	Nov
Five Steps to Safer Surgery	16	Medical	~~Q1~~	Q2	Final Report issued October 21	Limited	Nov
Theatre Utilisation (Surgery Clinical Board)	25	COO	Q1		Final Report issued Jan 22	Reasonable	Feb
Retention of Staff	09	Workforce	Q2		Final Report issued Jan 22	Reasonable	Feb
Core Financial Systems	03	Finance	Q3		Final Report issued Jan 22	Substantial	Feb
Welsh Language Standards	08	Workforce & OD	Q3		Final Report issued Jan 22	Reasonable	Feb
IT Service Management (ITIL)	**19**	**Digital & Health Intelligence**	**Q2**		**Final**	**Limited**	**April**
Raising Staff Concerns (Whistleblowing)	**05**	**Corporate Governance**	**~~Q2~~**	**Q3**	**Final**	**Reasonable**	**April**
Verification of Dialysis Sessions (Specialist Services Clinical Board)	**26**	**COO**	**Q3**		**Final**	**Substantial**	**April**
Arrangements to Support the Delivery of Mental Health Services (Mental Health Clinical Board)	**28**	**COO**	**Q4**		**Final**	**N/A Advisory**	**April**

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Capital Scheme – Genomics	*SSU*	*Strategic Planning*	*Q2*		*Draft*	*Reasonable*	*May*
Estates Assurance – Waste Management	*SSU*	*Finance*	*Q3*		*Draft*	*Reasonable*	*May*
Claims Reimbursement	04	Nursing	Q3		Work in Progress		May
Nurse Bank	13	Nursing	Q3		Work in Progress		May
Chemocare IT System	21	Digital & Health Intelligence	Q3		Work in Progress		May
Security of Network and Information Systems (NIS) Directive Implementation	22	Digital & Health Intelligence	Q3		Work in Progress		May
Children & Women CB – Nurse Rostering	30	COO	~~Q4~~	Q3	Work in Progress		May
Risk Management	01	Corporate Governance	Q4		Work in Progress		June
Covid 19 Vaccination Programme - Phase 3 delivery	10	Public Health	Q4		Work in Progress		May
Health & Safety	18	CEO	~~Q2~~	Q4	Work in Progress		May
Recovery of services and Delivery of the Annual Plan 2020/21	31	COO	Q4		Work in Progress		June
Performance Reporting	32	COO	Q4		Work in Progress		June
Wellbeing Hub at Maelfa	*SSU*	*Strategic Planning*	*Q4*		*Work in Progress*		*May*
Capital Systems Management	*SSU*	*Strategic Planning*	*Q4*		*Work in Progress*		*May*
Management of staff Sickness Absence	07	Workforce	Q2	Q4	Planning		June
Post Contract Audit of DHH Costs	34	Finance	Q1	Q4	Planning		May

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Major Capital Scheme – UHW II	*SSU*	*Strategic Planning*	*Q1-4*		*Complete* *On-going observer role, proactive input, and overview of the progression through the period.*	*n/a*	*n/a*
Development of Integrated Audit Plans	*SSU*	*Strategic Planning*	*Q1-4*		*Complete* *Plans have been developed for inclusion within the respective business case submissions for relevant major projects/ programmes.*	*n/a*	*n/a*
Reviews Deferred / Removed from the plan							
ALNET Act	36		Q2		Director of Therapies and Health Sciences requested Deferral to 22/23 plan as work on-going to embed processes within Health Board. Agreed by June AC.		
Consultant Job Planning Follow-up	17	Medical	Q4		Removed as assurance level increased to Reasonable after 20/21 follow-up – Agreed by June AC		
Clinical Board's QS&E Governance	12	Nursing	~~Q2~~	Q4	Director of Nursing requested deferral to 22/23 plan. QS&E Governance arrangement currently being reviewed by Audit Wales and a new Framework is also being introduced. – Agreed by September AC.		
Estates Assurance - Decarbonisation	*SSU*	*Finance*	*Q3*		*Deferred to 22/23 plan as HB not requirement to publish Action Plan until March 22. Agreed by November AC.*		

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
IM&T Control & Risk Assessment	02	Digital & Health Intelligence	Q3		Deferred to 22/23 as the last assessment was only finalised in May 22 and the agreed actions are being monitored through the Health Board's tracker. – Agreed by November AC.		
Medical & Dental Staff Bank	14	Medical	Q3		Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
Medicine CB – QS&E Governance Framework	23	COO	Q2		Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
Financial Plan / Reporting	33	Finance	Q3		Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
Delivery of 21/22 Annual Plan	37	Strategic Planning	Q3		Combined with audit of Recovery of Non-Covid services due to potential overlap of scope. Agreed by February AC		
Medical Equipment and Devices	35	Therapies & Health Sciences	~~Q2~~	Q4	Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
PCIC CB – Primary Care Vaccinations	24	COO	~~Q2~~	Q4	Combined with the wider audit of the Covid 19 Vaccination Programme - Phase 3 delivery. To be agreed by April AC.		

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Digital Strategy Roadmap	20	Digital & Health Intelligence	Q4		Proposed for Deferral to 22/23 plan and will be included in scope of Digital Strategy audit. Agreed by the Director of Digital. To be agreed by April AC.		

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Legislative, Regulatory & Alerts Compliance	Reasonable	Final	20/08/21	14/09/21	25/08/21	25/08/21	G
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	Reasonable	Final	22/07/21	12/08/21	12/08/21	13/08/21	G
CD&T CB – Ultrasound Governance	Limited	Final	27/07/21	12/08/21	24/08/21	25/08/21	R
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	Reasonable	Final	04/08/21	26/08/21	13/08/21	16/08/21	G
Clinical Audit	Limited	Final	17/09/21	11/10/21	07/10/21	15/10/21	G
Five Steps to Safer Surgery	Limited	Final	22/09/21	15/10/21	26/10/21	27/10/21	R
Theatres Utilisation (Surgery Clinical Board)	Reasonable	Final	04/11/21	25/11/21	20/01/22	21/01/22	R
Retention of Staff	Reasonable	Final	14/01/22	04/02/22	24/01/22	24/01/22	G
Core Financial Systems	Substantial	Final	11/01/22	01/02/22	21/01/22	25/01/22	G
Welsh Language Standards	Reasonable	Final	06/01/22	27/01/22	20/01/22	21/01/22	G
Verification of Dialysis Sessions (Specialist Services CB)	Substantial	Final	25/02/22	21/03/22	16/03/22	17/03/22	G
Raising Staff Concerns 9Whistleblowing)	Reasonable	Final	09/02/22	03/03/22	15/03/22	17/03/22	R
IT Service Management (ITIL)	Limited	Final	10/01/22	01/02/22	16/03/22	17/03/22	R

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22	G	April 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2021/22	R	73% 16 from 22	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 14 from 14	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	62% 8 from 13	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 13 from 13	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Archwilio Cymru
Audit Wales

Audit Committee Update – **Cardiff & Vale University Health Board**

Date issued: March 2022

Document reference: 2875A2022

This document has been prepared for the internal use of Cardiff & Vale University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Financial audit update

2 **Exhibit 1** summarises the status of our current and upcoming financial audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the Health Board's 2021-22 Performance Report, Accountability Report, and Financial Statements.	We are currently undertaking our audit planning and interim testing. The Health Board is required to provide us with the draft financial statements on 29 April 2022 and the draft performance report and accountability report on 6 May 2022. These are the Welsh Government's deadlines.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work completed since we last reported to the Committee in February 2022 (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
2022 Audit Plan	To be considered in April 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic Services: Follow-up Executive Lead – Chief Operating Officer	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	Current status: Date of publication realigned with anticipated publication date of national planned care work Planned date for consideration: July 2022
Quality Governance Executive Leads – Executive Nurse Director and Executive Medical Director	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured	Current status: Report being drafted Planned date for consideration: July 2022

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	assessment work across Wales which has pointed to various challenges with quality governance arrangements.	
Review of Estates: Follow-up of Recommendations Executive Lead – Executive Director of Finance	In 2017, we undertook a review of estates. The work examined the Health Board's strategic approach to estates management, and its approach for delivering an economical, efficient, and effective estates service. We made a number of recommendations to the Health Board. This work will follow-up progress against these recommendations.	Current status: Project Brief issued and approved Planned date for consideration: July 2022

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Current status: Whole system commentary and data analysis currently being completed. Further work not yet started. Date for consideration to be confirmed

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Local Work 2022	The precise focus of this work is still to be determined.	Date for consideration to be confirmed

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design, and good practice research.

5 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee in February 2022. Details of future events are available on the GPX website.

NHS-related national studies and related products

6 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Administration and Public Accounts Committee to support its scrutiny of public expenditure. We have not published any reports since we last reported to the Committee in February 2022.

7 In March 2022, the Auditor General published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through his national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. The closing date for responding to the consultation is 8 April 2022.

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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.

Report Title:	**Review of Standing Financial Instructions and Accounting Policies**				Agenda Item no.	7.3
Meeting:	**Audit and Assurance Committee**		Public	x	Meeting Date:	5 April 2022
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	**Director of Corporate Governance/Director of Finance**					
Report Author (Title):	Head of Corporate Governance					

Main Report
Background and current situation:

NHS Bodies in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They have effect as if incorporated in the Health Board's Standing Orders ("SOs") (incorporated as Schedule 2.1 of the SOs).

The SFIs detail the financial responsibilities, policies and procedures adopted by the Health Board. They are designed to ensure that the Health Board's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency effectiveness and sustainability.

The Health Board's SFIs (and SOs) are based upon the model standing financial instructions and model standing orders issued by Welsh Ministers to Local Health Boards. There is a requirement to keep the SFIs and SOs under review to ensure they remain accurate and current. A review of the SOs was undertaken recently and a report was taken to the Committee in February 2022 to provide an update with regards to the Health Board' SOs. Accordingly, this paper relates to the routine review of the SFIs.

The Model Standing Financial Instructions (along with the Model Standing Orders, Reservations and Delegation of Powers) were last reviewed by Welsh Government in March 2021. On the 7 April 2021 the Welsh Government wrote to the Chair of the Health Board to inform him that the Health Board was required to incorporate and adopt the latest review of the NHS Wales model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions into the Health Board's own SOs. This updated version of the Welsh Government's Model SFIs and SOs is incorporated and set out in the Welsh Health Circular (WHC (2021) 010) which was issued on 16 September 2021.

In line with the letter issued by the Welsh Government in April 2021, and following formal Board approval in May 2021, the Health Board incorporated and adopted the Welsh Government's updated Standing Financial Instructions, Standing Orders, and Reservation and Delegation of Powers.

Since the review undertaken by Welsh Government in March 2021 and the instructions issued to the Health Board in April 2021 to update its SFIs and SOs, the Welsh Government has not carried out any further reviews of the Model Standing Financial Instructions and SOs.

Accordingly, no further amendments to the Health Board's Standing Financial Instructions are required at present.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Pursuant to the Committee's Terms of Reference, and with regard to its role in providing advice to the Board, the Committee is required to comment specifically upon the Health Board's SFIs and accounting policies (amongst other matters).

The Health Board's SFIs were last updated in May 2021 in line with the Welsh Government's instruction letter dated 7 April 2021 and following formal Board approval in May 2021. No further updates and /or amendments to the Health Board's SFIs are required at this moment in time. That said, the Health Board's SFIs (along with its SOs) are kept under regular review and should any further updates and /or amendments be required, a further report detailing the same will be brought back to the Committee for discussion and consideration.

The Health Board's SOs, which incorporate its SFIs, are subject to an annual review by the Health Board in accordance with paragraph xxx) of Section A of the SOs, hence the purpose of this report.

For completeness, it is proposed that an update report (based upon the content of this report) will be presented to full Board in May 2022 for noting.

Recommendation:

The Committee is requested to:

a) **Note** the update, as set out in the body of this report, with regards to the Health Board's Standing Financial Instructions.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No

Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	May 2022

Report Title:	Systems of Assurance – Update Report			Agenda Item no.	7.4
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	5 April 2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Risk and Regulation Officer				

Main Report
Background and current situation:

A Cardiff and Vale University Health Board Assurance Strategy 2021-24 was approved by the Board in September 2021. The purpose of the strategy is to ensure that there is a common understanding throughout the Health Board of what is meant by assurance and its importance in a well-functioning organisation.

The strategy will result in an assurance system which enables the Board, Committees and Senior Management to review the Corporate Governance, Risk Management and Internal Control framework and address any weaknesses identified. Once implemented it will take the Health Boards system of risk control to a higher maturity level. The methodology adopted is based on the principles of assurance defined by the HM Treasury Orange Book (Management of Risk – Principles and Concepts) and these principles have been expanded to cover all areas of Governance.

Key to the effectiveness of the assurance system is the creation of a central register of assurances, drawn from all Clinical Boards and Corporate Directorates, which details the types and value of assurance and where these sit within the Health Board's 'Lines of Defence'. This central register will be maintained and analysed by the Corporate Governance Directorate and will enable the creation of Assurance Maps to illustrate the extent of assurance evidence, the reliability of evidence, any gaps in assurance or areas of over-assurance (e.g. duplication).

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The identification of assurance evidence to be brought forward to the central register represents a significant piece of work for Clinical Boards and Corporate Directorates. This factor, allied to the need to inform stakeholders from these areas of a newly emerging concept, led to the need to commence the process through 'one to one' explanatory briefings delivered by the Corporate Governance Team.

All but four Clinical Boards/Corporate Directorates were captured in the first tranche of briefings (October – November 2021). A further series of briefings will occur through the remainder of March and into April 2022 to which all remaining stakeholders have agreed to attend.

An outline of evidence type and purpose has been agreed with PCIC, Public Health and Specialist Services Clinical Boards and this has set the conditions for these areas to submit their assurance evidence.

Following the initial tranche of briefings and support to Clinical Boards/Corporate Directorates in October/November 2021 it was decided that there should be a temporary suspension in the creation of an assurance register to reduce pressure on Clinical Boards/Corporate Directorates already facing COVID-19 and winter bed pressures.

Whilst recognising the continuing COVID recovery pressures across the organisation it is felt that Spring 2022 is an appropriate time to re-commence the engagement with assurance holders across

the Health Board. This re-engagement has already commenced and it is intended that a first iteration of the Health Board's Assurance Map will be shared at the May 2022 Board Meeting.

Recommendation:

The Committee are requested to:

Note the proposed development of the Systems of Assurance and the progress made towards a higher level of maturity.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
An improved System of Assurance will provide greater evidence of risk control.
Safety: Yes
An improved System of Assurance will provide greater evidence of safety control.
Financial: Yes
An improved System of Assurance will provide greater evidence of financial control.
Workforce: Yes
An improved System of Assurance will provide greater evidence of UHB compliance with the moral and statutory requirements of an employer.
Legal: Yes
An improved System of Assurance will provide greater evidence of UHB statutory compliance.
Reputational: Yes
An improved System of Assurance will provide greater evidence of the control of reputational harm.

Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Review of Draft UHB Annual Report			Agenda Item no.	7.5
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	5 April 2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Goverance				

Main Report
Background and current situation:

The purpose of this report is to provide the Audit and Assurance Committee with an update on the progress being made with the drafting of the 2021-22 Annual Report.

As Committee Members will be aware (see paper considered by the Committee on 8 February 2022), the Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based upon HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts (ARAs).

NHS bodies are required to publish, as a single document, a three part Annual Report and Accounts document, which must include:

Part 1 The Performance Report, which must include:
• An overview

Part 2 The Accountability Report - this is to demonstrate how the Health Board has met key accountability requirements to the Welsh Government and must include:-

• A Corporate Governance Report - this explains the composition and organisation of the Health Board's governance structures and how they support the achievement of the Health Board's objectives.

• A Remuneration and Staff Report - this contains information about the renumeration of senior management, fair pay ratios, sickness absence rates etc.

• A Parliamentary Accountability and Audit Report - this contains a range of disclosures relating to the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long term expenditure trends and the audit certificate and report.

Part 3 The Financial Statements – this includes:-
• The Audited Annual Accounts 2021-22

In recognition of the continuing challenges faced by NHS Wales during 2021-22 due to responding to COVID–19, minimum reporting requirements as per the Financial Reporting Manual (FReM) are in place for a limited time and only relate to non-audited elements of the ARAs.

For 2021-22:-

- There will be no requirement to prepare a separate Annual Quality Statement, or to prepare a separate Annual Putting Things Right report.

.

- Entities apply the FReM are permitted to omit the performance analysis section of the Performance Report.

- The Sustainability Report is not mandatory for inclusion in the Annual Report. However, the Health Board should make a statement in its Annual Report indicating where and when the metrics will be available, and when available, these should be published on the Health Board's website.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The proposed timetable and approach for the production of the 2021-22 Annual Report was considered by the Committee when it met in February 2022. A summary of progress against key deadlines is provided at Appendix 1.

Committee Members will note that the draft Annual report was not considered by Management Executive as planned on 28 March 2022, although it is due to be considered by Management Executive on 4 April 2022. The draft provided does not include the Financial Statements as these will not be available until May 2022, neither does it included the performance data that will be provided by Welsh Government in June 2022.

Committee Members will note further that there are a number of gaps within the draft Annual Report and accordingly the draft Report continues to be a "work in progress". A further draft of the Annual Report is due to be considered by the Committee in May 2022.

Recommendation:

The Committee is requested to:

a) **NOTE** the progress made in relation to the drafting of the 2021-22 Annual Report; and
b) **REVIEW** and provide any comments with regard to the content of the draft report attached as Appendix 2.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes – an Equalities Impact Assessment relating to the publication of the draft Annual Report is due to be undertaken in June 2022.
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Management Executive	4 April 2022

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03/28/2022 16:21:28

Appendix 1

ANNUAL REPORT AND ACCOUNTS TIMETABLE 2021-22: PROGRESS UPDATE

Date	Meeting	Required	Completed
24 January and 14 February	Management Executives	Annual Report Contents and Format List and timetable	
8 February	Audit Committee	Annual Report Contents and Format List and timetable	
4 April	Management Executives	Review Draft Annual Report (including performance Report and Accountability Report) and Financial Statements	Draft Report due to be presented to ME on 4 April Financial Statements not available until May
5 April	Audit Committee	Review Draft Annual Report (including performance Report and Accountability Report) and Financial Statements	Draft report circulated to Committee Members.
29 April	WAO	Submission of Draft Accounts	
6 May	WAO	Submission of Draft Annual Report Review Draft Annual Report (including performance Report and Accountability Report)	
14 June (AM)	Audit Committee	Review Annual Report and Financial	

		Statements and recommend approval to the Board Receive WAO on Financial Statements	
14 June (PM)	Board Meeting	Approve Annual Report and Financial Statement and recommend and consider WAO on Financial Statements	
15 June	Welsh Government	Submission of Whole of Government Accounts Return to Welsh Government	
28 July	AGM	Presentation of Annual Report and Financial Statement and Quality Account.	

Key:

	Deadline met
	Slight delay but no significant impact on overall timeline
	On track to meet deadline

Report Title:	Counter Fraud Progress Report			Agenda Item no.	7.6
Meeting:	Audit Committee	Public	✓	Meeting Date:	5th April 2022
		Private			
Status *(please tick one only):*	Assurance	✓	Approval		Information
Lead Executive:					
Report Author (Title):	Nigel Price				

Main Report

Background and current situation:

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, the purpose of this report is to provide the Committee with details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists, from the 1st February 2022 to the 31st March 2022.

Committee members are asked to note that the detailed Counter Fraud Progress Report, which details the Counter Fraud completed days and a report on investigations and a risk assessment exercise**,** is attached to this covering report.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Please see the content of the attached Counter Fraud Progress Report.

Recommendation:

The Committee is requested to:

a) **Note** the contents of the attached Counter Fraud Progress Report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	✓	Long term	✓	Integration		Collaboration	✓	Involvement	✓

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Loss of public funds which has an effect on patient care
Safety: No
Financial: Yes
Loss of public funds which has an effect on patient care
Workforce: Yes
Reduction of available staff during investigations and sanctions
Legal: Yes
Use of UK legislation to conduct investigations
Reputational: Yes
All negative publicity undermines public confidence
Socio Economic: Yes/No
N/A
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Mohamed,Sarah
03/28/2022 16:21:28

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
AUDIT COMMITTEE 5th April 2022

COUNTER FRAUD PROGRESS REPORT
For the period 1st February 2022 to 31st March 2022

NIGEL PRICE
COUNTER FRAUD

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
BWRDD IECHYD PRIFYSGOL CAERDYDD A'R FR

COUNTER FRAUD PROGRESS REPORT

AUDIT COMMITTEE (Public Session)

1. Introduction

2. Closed Cases Report

3. Progress and General Issues

4. Current Case Updates

Appendix 1 Summary of allocated days

Appendix 2 Recruiting Agency Pre-Employment Risk Assessment

Mission Statement

To provide the Cardiff and Vale University Health Board with a high-quality NHS Counter Fraud Service, which ensures that any report of fraud is investigated in accordance with NHS Secretary of State Directions and all such investigations are carried out in a professional and cost-effective manner.

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
BWRDD IECHYD PRIFYSGOL CAERDYDD A'R FR

1. INTRODUCTION

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists, from the 1st February 2022 to the 31st March 2022

The report's format has been adopted, in consultation with the Finance Director, to update the Audit Committee about counter fraud referrals, investigations, changes and current operational issues.

At 31st March 2022 **440** days of Counter Fraud work have been completed against the agreed **440** days in the Counter Fraud Annual Work-Plan for the 2021/22 financial year as shown in **Appendix 1**.
The days have been used investigating allegations of fraud; interviewing witnesses; preparing, delivering and analysing the feedback from the fraud awareness presentations; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; interviewing suspects; preparing case files for the Crown Prosecution Service and carrying out a risk assessment exercise on pre-employment checks conducted by agencies which supply staff to the organisation.

2. CLOSED CASE REPORTS

During this reporting period one investigation has been closed.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

During this reporting period no presentations have taken place however, departments will be contacted to arrange presentations for the new financial year. The feedback for all the presentations delivered this year shows that 100% of those who attended feel more confident in discussing their concerns about possible frauds.

3.2 Risk Assessment Exercise

Following an incident in a UK health board where an unqualified person was employed through an employment agency, a risk assessment has been carried out. The assessment was focused on the due diligence checks carried out by employment agencies which provide staff to Cardiff & Vale UHB. The report about the exercise is attached at Appendix 2.

4. CURRENT CASE UPDATES

6 investigations are open.

Open Cases:

WARO/20/00050 - Falsifying Prescriptions Investigation - Opened 28/05/2020

A member of staff at a GP Practice had been creating, issuing and then deleting prescriptions from patients' records. Those prescriptions were initially believed to be for one of the subject's family but further enquiries identified 380 separate prescriptions over a four-year period which were for other patients at the GP Practice. The value of the medications is assessed to be over £2,000.00.
The subject has been interviewed and admitted the allegation. A court hearing is listed for April 2022.

INV/21/00124 - Timesheet Investigation - Opened 09/07/2021

Initially recorded as an overpayment investigation now amended to timesheet fraud investigation.

INV/21/00262 - Overpayment of Salary - Opened 30/09/2021

The subject is suspected to have received payments to which they were not entitled and have not contacted the health board to report it. Inquiries continuing.

INV/21/00386 - Working Abroad - Opened 30/11/2021

The allegation is that the subject is living and working abroad but is getting a family member to collect and forward his NHS medication. Inquiries continuing.

INV/22/00037 - Overpayment of Salary - Opened 11/01/2022

Inquiries continuing

INV/22/00038 - Overpayment of Salary - Opened 11/01/2022

Inquiries continuing

Closed Cases:

WARO/21/00041 - Suspected False Information to Obtain Medication Investigation - Opened 08/03/2021 Closed 21/03/2022

The allegation is that the subject has given numerous false names and addresses to obtain medication. The reviewing solicitor's decision is that the threshold for a criminal prosecution has been met but it is not in the public interest to prosecute.

NHS Counter Fraud Service (Wales) Cases

Case 1

This case was referred to NHS CFS (Wales) via the Fraud and Corruption Reporting Line and relates to payments made to Doctors for certifying death prior to cremation.
A Cardiff based Funeral Home had reported that a large number of their cheques had been altered, namely that the payee details had been changed. A 3rd party Bank Authorisation was obtained from the Managing Director of the Funeral Home allowing NHS CFS (Wales) access to their bank account. Financial enquiries established that all of the cheques had been paid into the account of a Specialist Registrar employed at C&V UHB.
On 26th March 2019, with the assistance of South Wales Police, the subject was arrested and interviewed under caution. The subject made full admissions and stated that the theft of the cheques had occurred due to his gambling addiction. The subject was released pending further enquiries.
Further enquiries have established that the losses due to the stolen cheques is in the region of £35,000 and that there are also potential issues in relation to claims for locum shifts at the subject's substantive employer and other Health Boards throughout South Wales which total approximately £40,000.
On the 9th March the subject was sentenced to 2 years imprisonment, suspended for 2 years. The subject was also ordered to undertake 200 hours of unpaid work within the next 12 months (subject to COVD-19 restrictions. The Proceedings of Crime Act 2002 Confiscation investigation is underway and is due to be concluded later in the year
The subject satisfied the POCA 2002 Confiscation Order which issued on 11 May 2021. On 8 June 2021, the subject repaid the full amount of £66,838.47 of which £28,437.66 will has been paid as compensation to Cardiff & Vale UHB.
During the GMC hearing on 08.10.21, the subject was suspended from the Medical Register for a period of 12 months. The outcome of the health board's internal disciplinary investigation will be provided at the end of that investigation.

Case 2

A mandate fraud occurred on 9 March 202. Enquiries have been conducted and a number of suspects have been identified. It is believed that there is Organised Crime Group involvement which hacks emails and arranges for money to be transferred and laundered on an internationally. A significant amount was recovered via the bank into which the money was credited, some remains outstanding. Enquiries are ongoing. Advice/Guidance in respect of Mandate Fraud has been sent to all NHS Wales Health Bodies. NHS CFS Wales have liaised with the National Crime Agency and an arrest alert has been issued for the main subject should they return to the UK. – NHS CFS Wales investigation to be closed with the option to reopen should subject be arrested upon return to UK.

Case 3

Allegation received from health board LCFS. Subject terminated employment in February 2020 due to ill health but continued to receive salary until March 2021.
Enquiries conducted confirmed no contact from subject to Health Board or Payroll.
Enquiries conducted with the subject's bank confirmed that the monies remained in the account.
CFSW contacted the subject directly and arrangements were made to repay the overpaid salary. The full amount of £18,103.29 was repaid in Sept 2021. The investigation is now concluded and will be closed in Q4. - The investigation has been closed.

Case 4

Allegation received from health board LCFS. Subject terminated employment in April 2020 but continued to receive salary until June 2021.
Enquiries conducted confirmed no contact from subject to health board or payroll.
Enquiries conducted with the Subject's bank confirmed that the funds appear to have been spent. Circumstances of subject leaving were verified with Heath Board which confirms net O/P at £10,659.41. Analysis of bank account completed which indicates that the subject has spent funds and now resides overseas.
CFSW now intend to write to subject to arrange interview or conduct written interview if subject is unable to return to the UK.
CFSW have written to subject to confirm if they intend to return to the UK to arrange an interview under caution, subject has not yet responded and a further email has been sent to chase up on this.

Case 5

Allegation was received via the health board LCFS. The subject has allegedly worked for another health board, during scheduled time allocated on their Cardiff and Vale UHB job plan.
Initial enquires have confirmed this person received fees from another health board for carrying out consultations. The claim forms were requested from payroll, so they could be compared with the information on the job plan.
Analysis of the claims identified that the subject had carried out over 100 assessments for another health board during Cardiff and Vale UHB time. The subject has been invited to attend an interview under caution with NHS CFS Wales. Inquiries are continuing.

Case 6

Allegation was received via NWSSP Payroll Services. The subject was employed in December 2020 by Cardiff and Vale UHB via the Workforce hub, as part of the COVID recruitment drive. It was alleged that the subject has not completed any shifts for Cardiff and Vale and has been paid in error. As a result, the subject has received a net overpayment of £15,728.90.
Enquires have established the subject was initially employed by the temporary staffing department on a zero-hour contract. The subject was then offered a six-month fixed term post on one of the wards at UHW. The subject has attended the induction training with the department, but then failed to turn up for any shifts. Inquiries are continuing.

NEW REFERRAL

Allegation was received via the health board LCFS. The subject attended the A&E department several times in one week displaying drug seeking behaviour. The subject has allegedly been seen at other NHS premised in NHS Wales. It is alleged that they use false personal details and false information in order to be provided with Morphine. An alert has been forwarded to all LCFS' in NHS Wales, with instructions to circulate to the relevant emergency departments. Inquiries are ongoing.

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
BWRDD IECHYD PRIFYSGOL CAERDYDD A'R FR

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2021/22

AREA OF WORK	Allocated Days	Days to date
Strategic Requirements		
Attendance at All Wales Meetings	8	6
Meetings/Training Courses	6	6
Preparation of Annual Reports etc	10	10
Audit Committee Meetings/Reports	10	10
Quarterly Statistics Returns	5	5
Annual Activity		
Create an Anti Fraud Culture (inc PPV)	30	30
Awareness Presentations, Newsletters etc	40	40
Other work to deter Fraud	10	10
Prevention		
Review of System Weaknesses etc	20	20
Detection		
Local Pro-Active Work	10	16
NHS CFA Exercise (Procurement)	10	10
National Fraud Initiative (NFI)	20	20
Investigation, Sanctions and Redress		
Investigations/Enquiries	245	241
Court Hearings/Sanctions etc	10	10
Civil Redress/Repayment	6	6
TOTAL DAYS	**440**	**440**

APPENDIX 2

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Risk Assessment Exercise
Pre-Employment Agency Checks

March 2022

Executive Summary

An incident occurred in which a recruiting agency provided a person whose stated qualifications and experiences were false. An investigation by the Local Counter Fraud Services revealed a weakness in the recruiting process. Based on that an exercise to confirm that the agencies apply robust checks on the claims made by potential employees was carried out. Agencies contracted to supply staff to the NHS must comply with requirements to complete pre-employment checks as set out in the NHS Employment Check Standards 2016.

The risks of employing unqualified and appropriately trained staff within an organisation can have a considerable negative impact on;

1. Patient Safety,
2. Staff Safety
3. Health and safety within the workplace.
4. Financial Management.
5. the professional reputation of the organisation.

It should be noted that due to impact of COVID-19, restrictions have changed in the way in which pre-employment checks are being completed. Specifically, in relation to the viewing of original documents.

This exercise has been completed fully across three Health Boards covered by our LCFS service with potential for further exercises. Across all of the Agencies whose practices were reviewed only one agency was found not have completed satisfactory checks. There was a disconnect in understanding between the health board and the agency. The Agency stated they believed the Health Board to be conducting the relevant checks regarding experience where the health board believed them to have been completed by the Agency. Although this finding did not form part of this health boards' check it is still relevant and important as the agency is still part of the framework and could be utilised in the future. Recommendations to mitigate the risk of the organisation have been made as detailed at the end of this report.

Introduction and Background

This exercise, led by Local Counter Fraud Services, has focused on pre-employment checks completed by suppliers which provide agency workers to Cardiff and Vale.

As part of an on-going risk assessment, identified risks to the organisation involved patient safety, staff safety, health and safety in the work place and potential risks to the financial management of the organisation. A proactive approach to reviewing and reducing these identified risks has been developed, with a specific remit looking at the pre-employment checks completed by suppliers and whether these checks are compliant or non-compliant with shared policies already in place.

Under the Crown Commercial Services agreements RM6160 (Non-Clinical Staff) and RM6161 (Clinical Staff) there is a Framework Specification in place for the supply of registered agency personnel to the health boards and trusts in Wales. Both frameworks contain sections regarding pre-employment checks contained within their specifications, the wording is almost identical for both, relevant sections are detailed below:

5. Temporary Worker Compliance Requirements - Pre-Employment Check Standards (RM6160)

5.1. The Supplier shall undertake employment checking which seeks to verify that all Temporary Workers meet the preconditions of the role they are applying for. All Temporary Workers must be fully compliant prior to the commencement of the role.

5.2. The Supplier shall have a dedicated compliance manager who will ensure that all checks have been undertaken correctly prior to the appointment of a Temporary Worker.

5.3. For NHS Contracting Authorities, the Supplier shall ensure that Temporary Workers supplied are compliant with the requirements specified in NHS Employers Check Standards:

5.3.1. Identity checks;

5.3.2. Professional Registration and Qualification checks;

5.3.3. Employment History and Reference checks;

5.3.4. Right to Work checks;

5.3.5. Work health assessments; and

5.3.6. Criminal Record checks.

5.4. For full details of pre-employment check checks for NHS Contracting Authorities, the Supplier shall refer to NHS Employers Check Standards: https://www.nhsemployers.org/your-workforce/recruit/employment-checks

5.8. All Contracting Authorities may specify additional, or tailored employment or security check requirements at Call-Off stage. All additional Employment or security checks shall be conducted by the Supplier at no additional cost to the Contracting Authority. As part of this contract the following requirements are detailed within the Service Specification.

8. Temporary Worker Compliance Requirements - Employment Check Standards (RM6161)

8.1. The Supplier shall undertake employment checking which seeks to verify that all Temporary Workers meet the preconditions of the role they are applying for. All Temporary Workers must be fully compliant prior to the commencement of the role.

8.2. The Supplier shall have a dedicated compliance manager who will ensure that all checks have been undertaken correctly prior to the appointment of a Temporary Worker.

8.3. For NHS Contracting Authorities, the Supplier shall ensure that Temporary Workers supplied are compliant with the requirements specified in NHS Employers Check Standards:

8.3.1. Identity checks;

8.3.2. Professional Registration and Qualification checks;

8.3.3. Employment History and Reference checks;

8.3.4. Right to Work checks;

8.3.5. Work health assessments;

8.3.6. Criminal Record checks; and

8.3.7. Appraisal and Revalidation checks.

8.4. For full details of pre-employment check checks for NHS Contracting Authorities, the Supplier shall refer to NHS Employers Check Standards: https://www.nhsemployers.org/your-workforce/recruit/employment-checks

8.8. All Contracting Authorities may specify additional, or tailored employment or security check requirements at Call-Off stage. All additional Employment or security checks shall be conducted by the Supplier at no additional cost to the Contracting Authority.

Scope of Exercise

The exercise looked at relevant pre-employment data for the financial year 2020/21 relating pre-employment checks carried out by relevant suppliers. For the purposes of this exercise, pre-employments checks data was requested direct from Suppliers (namely Agencies) in relation to registered and unregistered agency nurses, health care assistance and administrative staff.

Method

A random selection approach was chosen by Local Counter Fraud Services in requesting the required data in order to run the exercise.

Agency Supplier Data

A list of agencies that are used by Cardiff and Vale was obtained showing that there were 33 Agencies that are utilised by the health board.

From this list, 11 agencies were chosen at random;

1. 'Agency 1'
2. 'Agency 2'
3. 'Agency 3'
4. 'Agency 4'
5. 'Agency 5'
6. 'Agency 6'
7. 'Agency 7'
8. 'Agency 8'
9. 'Agency 9'
10. 'Agency 10'
11. 'Agency 11'

A Local Counter Fraud Specialist requested lists of all agency staff provided by the companies to Cardiff and Vale in the relevant time period which was 1st April 2020 to 31st March 2021. This shows that a total of 318 agency workers were provided. From this list a random selection of between 20-25% of workers was selected in this case producing 71 workers. The following information was requested from the Agency:

- Proof of Photographic ID (i.e. Passport)
- Birth Certificate (if driving license used instead of passport)
- Evidence of right to work in UK
- DBS check (if required for role)
- Proof of qualifications (if applicable)
- Professional Registration (if applicable)
- Visa Details (if applicable)

As part of the framework, agencies are required to respond to requests for such information of 14 days.

The supplied information was then cross checked against the required standards and recorded in a spreadsheet. Dependant on the role filled or the individuals circumstances not all of the requested information is applicable. Should a required element not be provided or be unsatisfactory the spreadsheet would result in a 'Red' result highlighting the specified worker in red to show the deficiency.

Findings

From the data collated by Local Counter Fraud Services the results are summarised below:

'Agency 1'

- Counter Fraud Services requested data relating to randomly selected 5 Agency Workers (13 Total Workers).
- 'Agency 1' were compliant in returning the data within the specified 14-day time frame.
- There was a mixture of registered nurses and Health Care Assistants included. All had relevant ID and DBS checks. Registered Nurses had qualifications proof and registration.
- 'Agency 1' were fully compliant across all requested information.

'Agency 2'

- Counter Fraud Services requested data relating to randomly selected 3 Agency Workers (6 Total Workers).
- 'Agency 2' were compliant in returning the data within the specified 14-day time frame.
- 'Agency 2' were fully compliant across all requested information including DBS, qualifications and registration.

'Agency 3'

- Counter Fraud Services requested data relating to randomly selected 5 Agency Workers (19 Total Workers).
- 'Agency 3' were compliant in returning the data within the specified 14-day time frame.
- 'Agency 3' were fully compliant across all requested information including DBS, qualifications and registration.

'Agency 4'

- Counter Fraud Services requested data relating to randomly selected 20 Agency Workers (112 Total Workers).
- 'Agency 4' were compliant in returning the data within the specified 14-day time frame.
- There was a mixture of Surgeons, Nurses and Pharmacists, the relevant qualifications registrations and DBS certificates were all provided.
- There were 4 European Passports and 3 Australian Passports provided. For the European workers this Audit falls prior to any requirement to be registered with the Settlement Scheme or Skilled Worker Visa, being an EU citizen gave them the right to work in the UK with no further documentation required. The two Australian workers provided residents permits showing they were permitted to work in the UK.
- 'Agency 4' were fully compliant across all requested information.

'Agency 5'

- The Agency were contacted however they did not supply any workers to the health board during the specified time period, therefore no checks conducted.

'Agency 6'

- Counter Fraud Services requested data relating to randomly selected 3 Agency Workers (3 Total Workers).
- 'Agency 6' were compliant in returning the data within the specified 14-day time frame.
- 'Agency 6' were fully compliant across all requested information including DBS, qualifications and registration.

'Agency 7'

- Counter Fraud Services requested data relating to randomly selected 15 Agency Workers (108 Total Workers).
- 'Agency 7' were compliant in returning the data within the specified 14-day time frame.
- One of the workers provided a Malawi Passport, the Agency had gained relevant 'Right to Work' information in the form of a Residence Permit showing no restrictions on work.
- One worker provided a European Passport this Audit falls prior to any requirement to be registered with the Settlement Scheme or Skilled Worker Visa, being an EU citizen gave them the right to work in the UK with no further documentation required including DBS, qualifications and registration.
- 'Agency 7' were fully compliant across all requested information.

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'Agency 8'

- Counter Fraud Services requested data relating to randomly selected 12 Agency Workers (35 Total Workers).
- 'Agency 8' were compliant in returning the data within the specified 14-day time frame.
- Four workers were from non-EU countries, all four provided Residence Permits, two with no restricts/indefinite leave to remain however 2 had permits permitting only 20 hours of work per week during term time.
- Two workers provided a European Passport this Audit falls prior to any requirement to be registered with the Settlement Scheme or Skilled Worker Visa, being an EU citizen gave them the right to work in the UK with no further documentation required including DBS, qualifications and registration.
- 'Agency 8' were fully compliant across all requested information.

Further enquiries were made with 'Agency 8' regarding procedures in place in regard the residence permits with limits on working hours. They explained that when something of this nature is identified they flag this to their consultants, pay roll and their booking system will prevent the workers being booked for more than their allowance. They are also in the process of adding a self-declaration to their staff handbooks for the worker to sign to declare that their working hours should always be matching their visa allowance.

'Agency 9'

- Counter Fraud Services requested data relating to randomly selected 5 Agency Workers (15 Total Workers).
- 'Agency 9' were compliant in returning the data within the specified 14-day time frame.
- Two of the workers had previous convictions on their DBS check that were fully disclosed.
- 'Agency 9' were fully compliant across all requested information including DBS, qualifications and registration.

'Agency 10'

- The Agency were contacted however they did not supply any workers to the health board during the specified time period, therefore no checks conducted.

'Agency 11'

- Counter Fraud Services requested data relating to randomly selected 3 Agency Workers (7 Total Workers).
- 'Agency 11' were compliant in returning the data within the specified 14-day time frame.
- One of the workers provided a Nigerian Passport, the Agency had gained relevant 'Right to Work' information in the form of a Residence Permit showing no restrictions on work. This worker also had one conviction for a driving related offence on their DBS a letter of 'explanation' was provided by the worker on file.
- 'Agency 11' were fully compliant across all requested information.

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Other Agency - relating to different Health Board

- As referenced in the beginning of this report, whilst conducting this same exercise for a different health board one agency, who is in the framework, was unable to provide evidence of qualifications for a worker. The other checks (ID etc) were however completed satisfactorily.
- Enquiries identified that there was a disconnect in understanding between what was required/desirable in terms of qualifications on the request.

Recommendations

The Local Counter Fraud Services recommends the following:

1. When placing a requisition/'request' include a note that highlights that it is the Agencies responsibility to complete pre-employment checks as per the framework.

2. Conduct 'mini local audits' at regular intervals. At periodic intervals (3/4/6 Months) randomly choose a worker who is being supplied, request the agency to provide all of the pre-employment/due diligence check information. This will ensure regular random checks are completed to ensure standards are kept high.

3. Include in the requisition/'request' document any information regarding restrictions on working hours/visas. The agencies hold this information and should not allow working over these restrictions but it is important to know this as the end 'employer' to avoid any inadvertent breaches to these restrictions.

4. When recruiting for a role that requires specific qualifications or registration ensure that it is clearly set out in the requisition/'request' that they are required and that it is expected that the Agency will ensure that these are held by the worker prior to their commencing work.

5. In relation to Agency Suppliers, they should be informing the Health Board of any changes to agency workers situation or who are no longer working for them in order to provide a more effective service. This could be a quarterly or bi-annual process in order to keep Health Board records current and to reduce the risk of financial loss to the organisation.

Conclusion

This exercise has shown that the agencies supplying staff have completed the required checks effectively and accurately.

Recruiting through agencies and relying on an outside agency to complete checks will always carry some level of risk to the Health Board in relation to patient safety, staff safety and the financial

management within our health board. However, this risk can be limited by setting out clearly and precisely what is required and expected from the agencies and conducting regular checks that it is being completed, as detailed above in the recommendations.

Key Contacts

Name	Job Title	Contact
Nigel Price	Local Counter Fraud Specialist	Nigel.Price@wales.nhs.uk 02921 836481
Emily Thompson	Local Counter Fraud Specialist	Emily.Thompson@wales.nhs.uk 029218 36262
Henry Bales	Local Counter Fraud Specialist	Henry.Bales@wales.nhs.uk 029218 36265

Report Title:	Report of the Losses and Special Payments Panel			Agenda Item no.	7.9
Meeting:	Audit and Assurance Committee	Public	X	Meeting Date:	5th April 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Assistant Director of Finance (Financial Accounting and Services)				

Main Report
Background and current situation:

As defined in the Standing Financial Instructions, the Audit and Assurance Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit and Assurance Committee with this task, the UHB has established a losses and special payments panel, under the chairmanship of the Director of Finance (delegated to The Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.

The Losses and Special Payments Panel last met on 17th November 2021 to consider the 6 month period 1st April 2021 to 30th September 2021. This report informs the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Appendix 1.

The following losses have been identified for write off:

- Clinical Negligence claims of £10.946m and Personal Injury claims of £0.167m for the period 1st April 2021 to 30th September 2021;
- Bad Debt write-offs of £20,595 for the period 1st April 2021 to 30th September 2021;
- Ex gratia and other losses of £34,976 for the period 1st April 2021 to 30th September 2021;
- Small Claims losses of £11,490 for the period 1st April 2021 to 30th September 2021;
- Employment Tribunals settled of £22,000 for the period 1st April 2021 to 30th September 2021.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

In line with Standing Financial Instructions and the UHBs scheme of Delegation, these losses and special payments need to be considered for approval by the Audit and Assurance Committee. The write off of these identified losses is supported.

Recommendation:

The Audit and Assurance Committee are requested to:

- **APPROVE** the write offs outlined in this report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
Yes, as detailed in this report.
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 17th November 2021

PRESENT: Mr C Lewis – Deputy Director of Finance (Chair)
Mr A Crook – Head of Workforce Governance
Mrs H Lawrence – Head of Financial Accounting & Services
Mr S Monk – Losses & Taxation Accountant
Mrs S Wicks – Head of Clinical Negligence Claims & Inquests
Mr A Williams – Head of Financial Services

APOLOGIES: Mr R Cockayne – Security Manager
Mr N Price – Counter Fraud

1. Minutes of Last Meeting

The minutes of the last meeting were reviewed for accuracy and the group endorsed the minutes as an accurate record. There were no matters arising which were not covered elsewhere on the agenda.

2. Clinical Negligence and Personal Injury Losses

Mr Monk presented the financial report on Clinical Negligence and Personal Injury Income & Expenditure (I&E) losses for the six month period 1st April 2021 to 30th September 2021 and the finalised claims for the same period.

The I&E effect for the period was described as shown below: For comparison, the figures for the same period of 2020/2021 were also shown.

SUMMARY OF LOSSES

	2021/2022 £'000	**2020/2021 £'000**
Clinical Negligence	15,017	24,488
Personal Injury	-94	106
Total Loss	14,922	21,594
Less WRP Receipts Due	-14,264	-21,063
Total Net Cost to the UHB	658	531

With respect to Clinical Negligence claims, Mr Monk advised that the gross I&E charge for all recorded claims was £15.017m. Whilst the value of claims is broadly in line to last year the number of new cases has risen. Mr Monk

advised that following the easing of lockdown restrictions, enquiries to Solicitors have increased resulting in the number of claims being made comparable to pre-Covid levels. The number of claims received under the Welsh Government Putting Things Right (Redress) scheme remains consistent with previous financial years.

The impact of all recorded Personal Injury claims had been a gross I&E benefit of -£0.094m. The number and value of claims is comparable to previous years. Mr Monk advised that the UHB continues to use our in house Alternative Compensation Scheme which provides redress to injured individuals without the need for costly litigation. Improvements in working practice, safety at work and investigative process continues to result in individuals being dissuaded from seeking legal advice to pursue potential claims. This was evidenced by the general reduction in litigation claims that the UHB was receiving.

Recommendation

The Panel recommended that the Audit and Assurance Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £0.658m for the period 1st April 2021 to 30th September 2021.

Finalised Clinical Negligence (including Redress) Claims

During the six month period ending 30th September 2021, there were 35 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of £10.946m (which are treated as a loss). The UHB had also incurred £0.504m in defence fees and was successful in recovering £10.743m from the Welsh Risk Pool for these claims, resulting in a net cost to the UHB of £0.707m.

Finalised Personal Injury Claims

During the six month period ending 30th September 2021, there were 10 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of £0.167m (which are treated as a loss). The UHB had also incurred £0.028m in defence fees and was successful in recovering £0.087m from the WRP for these claims, resulting in a net cost to the UHB of £0.108m.

Mr Monk reminded the group that expenditure on defence fees on Clinical Negligence and Personal Injury cases was not treated as a loss and also that it should be remembered that the loss is accrued over the lifetime of a claim which can span many years.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 35 Clinical Negligence claims totalling £10.946m and 10 Personal Injury claims totalling £0.167m for the period 1st April 2021 to 30th September 2021.

3. Debt Write Offs

Mr Williams presented a report on proposed invoice write offs for the period 1st April 2021 to 30th September 2021.

These were as follows;

Category of Debt	Value	Number
Payroll	15,458	43
O/Seas Patients	3,829	2
Misc	1,308	25
Total	**20,595**	**70**

As in previous years the overpayment of salary for those employees who have terminated continues to prove difficult to collect. We continue to refer overdue invoices that we have been unable to collect to CCI Credit Management. As previously documented the panel will note that the majority of these overpayments relate to late notification of termination forms and managers unaware of appropriate cut-off times in the month. Members of the finance team recently met with IT to look at improvements, including the introduction of new forms and use of an RPA (Robotic Process Automation).

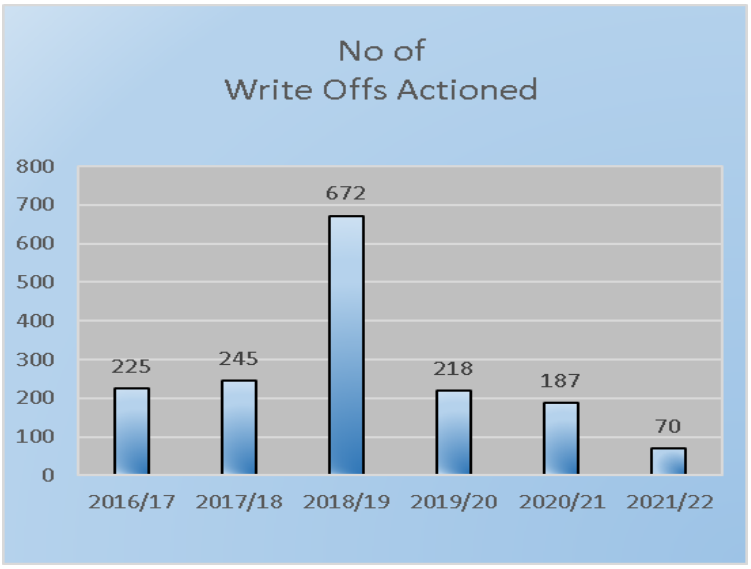
There 2 Overseas Patient invoices included in this report, one for £2k and one for £1.6k. Both of these debts were referred to CCI but they were unable to collect and advised against taking legal action as it would prove to be uneconomical for the Health Board.

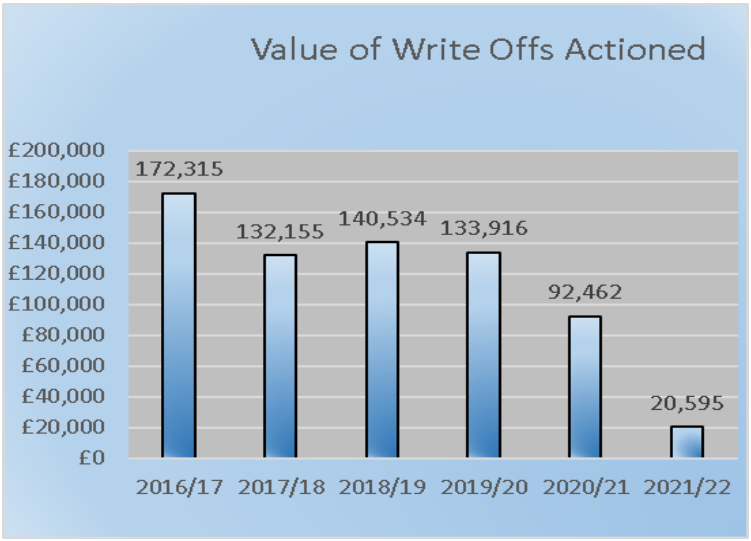
The majority of invoices included in the miscellaneous category are for under £100 and all, apart from those relating to exchange rate differences, have been referred to CCI.

Mr Williams presented a table and graphical analysis to highlight the number and value of write offs actioned for the previous 5 years;

Appendix 1

	2016/17		2017/18		2018/19		2019/20		2020/21		2021/22	
	Value	No	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	1,049	8	0	0	2,668	6	1,222	1	297	2	0	0
Dental	81	6	203	15	401	16	164	10	0	0	0	0
Medical Records	650	35	1,070	47	672	42	70	4	0	0	0	0
Payroll	20,025	53	12,639	26	11,262	31	21,733	67	15,469	69	15,458	43
Private Patients	24,325	28	23,764	63	2,887	27	16,048	27	3,928	3	0	0
O/Seas Patients	16,475	10	58,632	40	74,450	26	76,415	20	58,886	9	3,829	2
IVF Wales	31,026	24	0	0	0	0	0	0	0	0	0	0
Misc	78,685	61	35,847	54	48,194	524	18,265	89	13,881	104	1,308	25
	172,315	**225**	**132,155**	**245**	**140,534**	**672**	**133,916**	**218**	**92,462**	**187**	**20,595**	**70**





Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 70 bad debts totalling £20,595.08 for the period 1st April 2021 to 30th September 2021.

4. Ex Gratia and Other Losses

Mr Monk presented a report on the ex-gratia losses for the period 1st April 2021 to 30th September 2021. Mr Monk stated that there were 7 losses totalling £34,976.67 during the period.

There were 6 payments totalling £6,359.25 made as a result of complaints against the UHB where, following investigations, the Public Services Ombudsman for Wales (PSOW) made recommendation to the UHB to compensate the claimants. There was 1 loss of £28,617.42 where a fridge failure in Ophthalmology resulted in the loss of pharmacy issues. An appropriate checklist has been completed by the department. Procedures were in place to monitor and maintain the appliance, however, the fridge failed over a weekend resulting in the pharmaceutical products spoiling beyond use.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 7 ex-gratia & other losses totalling £34,976.67 for the period 1st April 2021 to 30th September 2021.

5. Small Claims Losses

Mr Monk presented a report on the small claims for the period 1st April 2021 to 30th September 2021. During the period 32 claims had been settled at a total cost of £11,490.32. A breakdown of the cases were as follows;

Breakdown of 32 cases:

Loss of jewellery – 3 claims = £800.00
Loss of hearing aids – 1 claim = £2895.00
Personal possessions – 10 claims = £2728.95
Damage to cars – 3 claims = £1328.00
Loss of spectacles - 7 claims = £1556.40
Loss of dentures – 2 claims = £753.00
Loss / damaged clothing – 6 (+ 3 half) claims = £1428.97

Directorate and location:

Medicine = 14 claims (UHW = 8, UHL = 4 & St Davids = 2)
Estates = 3 claims (UHW = 1 & UHL = 2)
Adult Mental Health = 7 Claims (UHL)
Specialist = 5 claims (UHW = 4 & UHL = 1)
Surgery = 2 claims (UHW)
Women & Children = 1 claim (UHW)

Mrs Wicks advised the Panel that in the previous year there were a higher number and value of cases due to the unprecedented pressure on the UHB's services due to the Covid-19 pandemic.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 32 small claims totalling £11,490.32 for the period 1st April 2021 to 30th September 2021.

6. Employment Tribunal Costs

Mr Crook presented a report outlining the claims and costs for the period 1st April 2021 to 30th September 2021. Mr Crook stated that during the period, Cardiff and Vale University Health Board had been involved with 12 Employment Tribunal claims. 2 of these cases had settled at a cost of £22,000, 1 case had been withdrawn and 1 case had been dismissed by the Employment Tribunal. 8 cases are ongoing.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 2 Employment Tribunal cases of £22,000 for the period 1st April 2021 to 30th September 2021.

7. Counter Fraud

Mr Price was unable to attend the meeting but had presented Mr Monk with a report for the period 1st April 2021 to 30th September 2021. Mr Monk stated that 4 investigations had concluded where the UHB had recovered £40,235.95. There remained 11 ongoing investigations which had a potential loss of £42,000.

The Panel noted the estimated potential losses. As there had been no cases closed during the period which had resulted in a loss there were no cases to be approved for write off.

8. Security Losses

Mr Cockayne was unable to attend the meeting but had presented Mr Monk with a report that there were no recorded thefts or losses to the Security Service during the period 1st April 2021 to 30th September 2021. Mr Monk advised that at the previous Panel meeting it was reported there had been a vehicle theft from the University Hospital Llandough site. The Police had closed the investigation of the theft and the vehicle had not been recovered. The cost and subsequent loss was currently being assessed and would be reported to the next Panel meeting.

The panel noted the report of the Security Manager.

9. Any Other Business

The next meeting of the panel would be in May 2022.

Report Title:	Declarations of Interest, Gifts and Hospitality Tracking Report			Agenda Item no.	8.1
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	05.04.2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

As agreed by Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality & Sponsorship would be provided to each Audit Committee for approval.

As described in the November 2021 report the procedure for Declarations of Interest now requires employees to make a single declaration of interest during the period of their employment, only altering it if their circumstances change (for example undertaking secondary employment). The declarations of Gifts, Hospitality and Sponsorship is unaltered and remains an 'as required' process.

The Risk and Regulation Team have worked with Corporate Communications to design and implement a Communication Plan that informs staff members of the following:

- The requirement to now submit a declaration of interest once. But, reinforcing the requirement to update if personal circumstances change.
- That Declarations of Interest can now be made on ESR, and signposting to User and Manager guides.
- The continuing need to declare Gifts, Hospitality and Sponsorship with specific emphasis being given in Autumn (for Autumn International Rugby Tickets) and Christmas/New Year (for seasonal gifts).

In addition to this plan the Risk and Regulation Team and the Health Board's ESR lead delivered a 'Declarations of Interest Power Hour' on the 11th March to provide a guided example of how to make use of ESR to declare interests and also to answer queries raised by those in attendance. Similar sessions will be delivered throughout the year and in between sessions a recording of the meeting is available online for all staff at the following address (which you will need to copy and paste into your browser):
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/url/ITEM/DA2BFD3832514293E0500489923C75EC

It is hoped that the number of declarations returned will increase significantly by enhancing visibility of the process, and the ease by which declarations can be recorded via ESR.

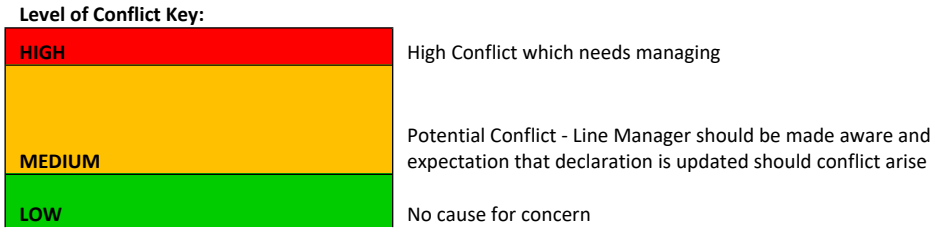
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The following Declarations have been received and included on the register which covers the period 01 Apr 20 to 04 March 2022:

- 1,503 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms have been recorded on the register. This represents a 5.99% increase in submissions following the February 2022 Committee Meeting. Following the 4th March (when the ESR report was compiled) a significant amount of returns and requests for support have been lodged and it is anticipated that this figure will increase significantly at the June 2022 Committee Meeting.

- 70% of staff banded 8a and above have returned their declaration forms. This figure has levelled off since the February 2022 Committee meeting. It is assumed that this is reflective of an increase in staff banded 8a and above coupled with similar numbers of staff leaving the organisation.

- The Declarations of Interests, Gifts, Hospitality and Sponsorship forms received are RAG rated by the Corporate Governance Officer to ensure appropriate action and monitoring. The RAG rating system is as follows:



- 97.4% of Declarations received are rated **Green** (260 Declarations).

- 2.67% of Declarations received are rated **Orange** (7 Declarations).

- 0.03% of Declarations are rated **Red** (1 Declaration).

The 8 entries recorded as medium and high potential conflicts can be summarised as follows:

- The 1 High Risk Conflict concerns a Health Board Director who has taken on secondary employment with a company that the Health Board has historically and continues to contract with. The arrangement has been and will continue to be overseen by senior executive colleagues to prevent any conflict from manifesting itself.
- The 7 medium risk conflicts can be broken down into two categories:
    - One declaration that would only result in a conflict in procurement scenarios and would be picked up by the Health Board's internal procurement systems in the event that a potential conflict could be perceived; and
    - Six instances of secondary employment or roles within external organisations that have been notified to appropriate line managers to me managed so as to avoid conflict arising.

A register of all interests can be found at the following link (which will need to be copied and pasted into a web browser): https://cavuhb.nhs.wales/about-us/governance-and-assurance/register-of-interests-gifts-and-hospitality/

Analysis of declarations of interest received suggests reasonable success from the recent 'advertising campaign'; there has been an above average increase in the quantity of declarations made, as well as increased use of ESR rather than the more administratively heavy use of hardcopy forms and email returns.

Additionally the ESR Manager will be asked to email reminders in July and Janauary to those who have made declarations, to remind them of the requirement to update if their personal circumstances have changed.

Recommendation:

The Committee are requested to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour
- **APPROVE** the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No
N/A
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

Mohamed-Sarah 03/28/2022 16:21:28

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
N/A	

High Conflict which needs Managing
Potential Conflict - Line Manager should be aware and expectation that declrations is updated should conflict arise
No cause for concern

Level of Conflict	First Name	Surname	Position held in UHB	Directorate / Specialty	Band	Clinical Board / Corporate Dept	Date Form Returned	Interests to Declare (Yes/No)	Third Party Contracts with Spouse/Partner (Yes/No)	UHB Address:	UHB Tel No	Confirmed read & understood Standards of Behaviour Frameworks Policy	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	Start - End Date	Financial / Other Benefits	b) Ownership or partnership, of private company, business, consultancy, which may cause a conflict or possibly relating to its business with the UHB	Start - End Date	Financial / Other Benefits	c) A personal or departmental interest in any part of the organisation's business which could be perceived as having an influence on decision making or on the provision of advice to members of the team	Start - End Date	Financial / Other Benefits	d) Sponsorship or funding from a known NHS supplier or associated company/industry	Start - End Date	Financial / Other Benefits	e) A position of authority in a charity or voluntary body in the field of health and social care	Start - End Date	Financial / Other Benefits	f) Any other connection with a voluntary, charitable or other organisation body that could create a potential conflict with responsibility for conflicting interests	Start - End Date	Financial / Other Benefits	g) Employment/self employment by any other body which may cause a conflict or possibly a conflict with NHS duties. This includes the undertaking of private practice	Start - End Date	Financial / Other Benefits	h) I undertake to notify the UHB of any changes to the above declaration as soon as they occur and understand that relevant information will be included in the Register which is available for public inspection	i) I confirm that the information accurately reflects my interests at the time of signing and understand that relevant information will be included in the Register which is available for public inspection	Signed	Date	Document Saved in Corporate Governance Mail Box / Office Use Only	Exceptions/Other details:
Low	Elijah	Aboirou	Consultant Transplant and General Surgeon	Nephrology and Transplant	Consultant	Specialist Services	04.11.20	No	Yes	Llntb	4647	Yes	Medigy Ltd. E&G Senior Care Ltd Spouse: Medigy Ltd. E&G Senior Care Ltd	Medi.gy: 2020/2012. E&G SC ltd: 2020/2012 Medi.gy: 2020/2012. E&G SC ltd: 22/1/2020		E&G Senior Care Ltd E&G Senior Care Ltd		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PP - Spire Cardiff		Yes	Yes	Yes	Yes	Elijah Aboirou	16.11.20	Yes	Secondary Work Form sent 26.11.20	
Low	Alana	Adams	Principal Pharmacist	Pharmacy	8c	CD&T	18.11.20	Yes	No	Llntb	43680	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Attended two meetings as a Specialist Pharmacist in a consultancy role for Pharmaceutical Industry and Marketing company	07.09.20 - 03.09.20	Honorarium received	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Participated in a podcast for Cardiff University	11.11.20 - 12.11.20	Payment received	Yes	Yes	Yes	Alana Adams	18.11.20	Yes	Secondary Work Form sent 01.12.20	
Low	Anjeev	Agarwal	Consultant Orthopaedic Surgeon	Orthopaedics	Consultant	Surgery	27.01.21	Yes	No	UHL		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Institutional funding from Zimmer Biomet for funding of a knee fellow in Orthopaedic Surgery	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship form sent 1.02.21	
Low	Sashin	Ahuja	Consultant	Trauma and Orthopaedics	Consultant	Surgery	22.09.21	No	No	Llntb		Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	No	Jun-21	Ongoing	None	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sashin Ahuja	29.09.21	S1R		
Low	Fiona	Aldridge	Clinical Psychologist / Clinical Lead of the Integrated Autism Service	Psychology and Psychological Therapies / Autism	8b	Mental Health	12.01.20	No	No	Awen House	2923834340	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I do some private work in my capacity as a psychologist - autism assessments, sometimes interventions and court reports. I do not access NHS patients for this work.	2012 - current	Financial	No	Yes	Yes	Yes	Fiona Aldridge	12.11.20	Yes	Secondary Work Form sent 30.11.20 Completed secondary work form received 05.01.21	
Low	Kathryn	Allen	Community Pharmacy Advisor	Pharmacy	8c	PCIC	18.11.20	Yes	No	Woodland House	30236	Yes	Glades Homes Ltd	2022 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Policy and planning Analyst Company Chemists Association	2021 - to date	Yes, salaried 7.5 hours per week	Yes	Yes	Yes	Yes	Kathryn Allen	18.11.20	Yes	Secondary Work Form sent 26.11.20	
Low	Louise	Allen	Pharmacist	Primary Care Medicines Advisers	6b	PCIC	17.11.21	Yes	No	Woodland House		Yes	Directorship of Glades Homes Ltd - a family building company - currently not actively trading	2022 - current	Dividends ad hoc	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Louise Allen	17.11.21	S1R		
Low	Sneha	Al-Rajoubi	Podiatrist	Podiatry	5	Specialist Services	10.11.21	Yes	No	UHL		No	No	N/A	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Locum 7 hours per week as a Podiatrist for Mumby	2021-ongoing	Fees	Yes	Yes	Yes	Yes	Sneha Al-rajoubi	10.11.21	Yes		
Low	Richard	Anderson	Consultant Cardiologist	Cardiothoracic	Consultant	Specialist Services	29.01.21	Yes	No	Llntb		41748	Yes	Shareholder of Richard Anthony Anderson Ltd	1.06.15 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Committee member of the Wales Heart research Fund	01/01/2010 - ongoing	N/A	N/A	N/A	N/A	N/A	Richard Anderson	05.01.21	Yes		
Low	Angela	Auderaite	Consultant Transplant Surgeon	Nephrology and Transplant	Consultant	Specialist Services	25.01.21	Yes	No	Llntb		Yes	N/A	N/A	N/A	Small number of shares in Pfizer	1.10.19 - ongoing	£500 shares as part of portfolio	Sanofi Frances, Novartis	31/10/2013 - 31.10.2015	£Nil provided for departmental research	Sanofi Frances, Novartis	31.10.2017 - ongoing	£Funding for an MD research project	Kidney Wales Trustee	01.10.2017 - ongoing	Board of Trustees, and to HR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Angela Auderaite	25.01.21		Yes	
Low	Philip	Akin	Consultant in Oral Medicine	Dental	Consultant	Surgery	18.02.21	Yes	No	Llntb	83460	Yes	1. Myomidi Ltd (orthodontics & prosthetic dentistry) 2. Auburn Medical Aesthetics Ltd (aesthetic medicine) 3. Spicule	2014 - current 2020 - current	Dividends ad hoc	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Philip Akin	18.02.21	Yes		
Low	Kirti	Akinlosot	Strategic Lead Occupational Therapist	Therapies / Occupational Therapy		CD&T	12/10/2020	Yes	No	UHL	Ext 20850	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Vice Chair of Royal College of Occupational Therapists	2018 - 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Kirti Akinlosot	12/10/2020	Yes		
Medium	Stephen	Austin	Consultant Surgeon	Trauma and Orthopaedics	Consultant	Surgery	28.01.21	Yes	No	UHL	25259	Yes	Director - Austin+Hay Solutions Ltd	24.05.2016 - ongoing	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Attendance pain precedent of dental nap Society																	Consulting fees aviator design and / or royalties with orthopaedic companies • Depuy - consulting fees education • Stryker - consulting fees, royalties, education • Smith & Nephew consulting fees, education & royalties • Orthofix - consulting fees, design & royalties • Limo - design & royalties • Adler - consulting fees, design & royalties • Pinnacle practice - Nuffield Hospital			Yes	Yes	Yes	Yes	Stephen Jones	28.01.21	Yes		
Low	Mayuro	Babu	Consultant Paediatric Palliative Care	Child Health	Consultant	Children & Women	4.12.20	Yes	No	Llntb	2920522200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have an honorary contract with Tu Hafan Children's Hospice as their consultant	1.11.01 to - ongoing	2 hrs/wk maximum part of my salary19 days annual leave	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Mayuro Babu	4.12.20	Yes		
Low	Sarah	Bailey	Senior Specialist Speech & Language Therapist	Neurosurg/Vlasky Service	7	Mental Health	17.11.20	Yes	No	Kelsey Cotel	28852	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I occasionally provide independent speech and language therapy assessments for clients who have had a brain injury litigation. The patients seen are always outside of the geographical and clinical remit of my Cardiff and vale caseload.	Current	Yes	Yes	Yes	Yes	Yes	Sarah Louise Bailey	17.11.20	Yes	Secondary Work Form sent 30.11.20	
Low	Philip	Ball	Mental Health Nurse	CAMT	6c	Mental Health	17.02.21	Yes	No				No	N/A	N/A	Nil	No			I have accepted an offer to join an Art Wales forum for mental health nurses sponsored by Iancare. The forum is for nurses working in mental health and the aim is useful for myself and other senior nurses to network and share our practice. There is one paid event scheduled for the 28th April 2021. But all other work is	Feb 21 - Ongoing	Yes	No		N/A	Nil	No			N/A	Nil	No			N/A	Nil	No			N/A	Nil	No			Philip Ball	17.02.21		Yes	
Low	Timothy	Banner	Pharmacist	Pharmacy Link	6d	CD&T	06.10.20	Yes	Yes	Link	91196704	Yes	N/A	N/A	Nil	No	Apr-19	N/A	40% work for Lloyds Pharmacy as Pharmacist manager	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	No	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	Timothy Banner	06.10.20	S1R		
Low	Miranda	Barker	Consultant Clinical Psychologist	MHSOP	Br	Mental Health	03.01.21	No	No	UHL	07732792	Yes	Join the Director of a UK company which has not traded since it started	2015 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Miranda Barker	13.01.21		Yes	
Low	Robert	Bavid	Principal Clinical Engineer / Design & Manufacture Team Leader / Health and Safety Advisor	Artificial Limb and Appliance Service		Specialist Services	22.09.20	No	No	Treforest	01443 661786	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Rehabilitation Engineer Associate Lecturer	01/09/2020 - 31/08/21	N/A	Yes	Yes	Yes	Yes	Robert Bavid	22.09.20			
Low	Gary	Baxter	Independent Member of the Board Independent Member of the Board	Executives / Corporate	Executive	Executive	10.03.21	Yes	No			Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member, Governance Board ACCELERATE (Life Sciences work	2016 - ongoing	N/A	N/A	N/A	N/A	British Heart Foundation research related work	1994 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University	2007 - ongoing	Salary	Yes	Yes	Yes	Yes	Gary Baxter	10.03.21	Yes		
Low	Andrew	Beamish	U H General Surgery	General Surgery	ST6	Surgery	19.01.20	No	No	Llntb		Yes	Director and Trustee of Limited Company "RUT Events"	2014 - ongoing	Nil (Voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director and Trustee ofAssociation of Surgeons in Training - Currently applying for its Limited company "RUT Events" to become a charitable company.	2014 - ongoing	Nil (voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Andrew Beamish	19.01.20	Yes	Secondary Work Form sent 01.12.20	
Low	Melissa	Beard	High Intensity Psychologist at Prescliffe/ Psychology & Psychological Therapies	Psychology & Psychological Therapies		Mental Health	8.04.21	Yes	No	Cardiff Royal Infirmary	2102-2150	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work on the bank of primary mental health	2017 - ongoing	Average £100 a month	Yes	Yes	Yes	Yes	Melissa Beard	8.04.21	Yes		
Low	Robert (Bryan)	Beattie	Consultant Obs & Gynae	Fetal Medicine	Consultant	Children and Women	18.01.21	Yes	No	Llntb		Yes	Founding Director of Innermost Secrets Ltd trading as Innermost Healthcare	21+ years - current 21+ years - current	Financial Financial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Founding Chairman of Innermost Learning Registered Charity			Shareholder in Time for Medicine			N/A	N/A	N/A	N/A	Yes	Yes	Yes	Robert Beattie	26.01.21	Yes	Secondary form sent 30.03.21	
Low	Freekkor	Bhat	Consultant Gynaecologist	Gynaecology	Consultant	Children and Women	28.01.21	Yes	No	Llntb		Yes	AEMI Healthcare Ltd Spouse	May 2013 - ongoing May 2013 - ongoing	Director Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Freekkor Bhat	28.01.21	Yes		
Low	Vaiwyanarsiddi	Biju	Consultant	Elderly Care Medicine	Consultant	Medicine	12.11.20	Yes	No	Llntb		Not Ticked	Medic Training Limited - private work from publication of articles, attending lab - listed	1.10.17 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Vaiwyanarsiddi Biju	12.11.20	Yes	Secondary Work Form sent 01.12.20	
Low	Robert	Bleehen	Medical Consultant	Consultant Haematologist	Consultant	CD&T	17.11.20	Yes	Yes	Llntb	35060	Yes	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Cardiff Medical Consulting Ltd Partner: North Cardiff Medical Centre (Partner) and Cardiff Medical Consultant Ltd		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)							Robert Bleehen	17.11.20		Secondary Work Form sent 30.11.20	
Low	Ellie	Boone	Consultant Endocrinologist	Endocrinology	Consultant	CD&T	4.02.21	No	No	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Jun-20 - ongoing	Nil	Medical Advisor to the Myotonic Dystrophy Support	Jun-20 - ongoing	Freelance	N/A	N/A	Ellie Boone	4.02.21	Yes	Secondary form sent 10.02.21	
Low	Sarah	Booth	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	18.02.20	No	No	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chairman of MEDSEVEN Wales, an immediate care charity based in South Wales	2019 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sarah Booth	18.02.20	Yes	Secondary form sent 20.02.20	
Low	Matthew	Boyd-Anderson	Physiotherapy Technical Instructor	Therapies		CD&T	03.05.2020	Yes	No	Llntb		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Support Worker - Prospect Health and Social Care Recruitment	13/05/2020	Salary	Yes	Yes	Yes	Yes	Matthew Boyd-Anderson	19/05/2020	Yes (Paper and Scanned)		
Low	Paul	Brackpool	Senior Property & Deputy Directorate Manager	Contract/Ophthalmology	Bs	Surgery	4.12.20	Yes	No	Llntb	68046	Yes	Active Director at Tre-Vale Court Management Ltd, Active Director at Tre-Vale Court Management (No.2) Ltd	N/A N/A	N/A N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Paul Brackpool	4.12.20	Yes		
Low	Caroline	Bradley	Biomedical Scientist	Biochemistry	6c	Laboratory Services	2021-01-20	No	No	Llntb		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Caroline Bradley	20.01.21	Yes		
Low	Patrick	Brady	Consultant Histologist	Pathology	Consultant	CD&T	17.11.20	Yes	No	Llntb	40068	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Assisted teaching equipment and a lecturing fee for a GE molecular imaging symposium	Aug-19	Lecturing fee and travel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Patrick Brady	17.11.20	Yes	Secondary Work Form sent 30.11.20	
Low	Joseph	Brain	Consultant Psychiatrist	Mental Health		Mental Health																																				
Low	Joseph	Tilina	Genetic Counsellor	All Wales Medical Genomics Services		AWMGS	7.04.21	Yes	No		Institute of Medical Genetics, LN6	2164 2577	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Tilina Joseph	7.04.21	Yes		
Low	Jacob	Joseph	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	4.02.21	No	No	Llntb		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Jacob Joseph	4.02.21	Yes		
Low	Mark	Kinder	Consultant Orthopaedic Surgeon	Trauma & Orthopaedics	Consultant	Surgery	8.03.21	No	No	Llntb		Yes	Cardiff Knee Surgery Ltd (private practice)	2021 - ongoing	Dividend	Director, Cardiff Knee Surgery Ltd (private practice)	2021 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Mark Kinder	8.03.21	Yes	Secondary form sent 10.03.21	
Low	Aaron	Fowler	Head of Risk and Regulation	Corporate Governance	8b	Corporate Governance	30.09.21	Yes	Yes	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	My wife is employed by NWSSP Legal and Risk, who the health board contact for legal advice.	2019-ongoing	N/A	Yes				Aaron Fowler	20.09.21	S1R		
Medium	Sarah	Gable	Cellular Pathology Service Manager / lead Cellular Pathologist	Cellular Pathology and Mortuary Services / Histopathology	8b	CD&T	12.01.20	No	No	Llntb		Yes	Director - Labcoat Ltd	Jul-18	Retainer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sarah Gable	12.01.20	Yes	Secondary Form sent 26.06.20	
Low	Simon	Gates	Consultant Neurologist	Neurosciences		Specialist Services	03.03.21	Yes	No	UHL	82782	Yes				Neurosurgery Services Ltd (Not seeking to do business with UHB)	20.11.17 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Research Involving but not funded by pharmaceutical companies: BOAD 96; Boston	2010 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Simon Gates	3.03.21	Yes		
Low	Claire	Gerdemann	Senior Pharmacist	AWTTC	Bc	CD&T	13.01.20	No	Yes	UHL	2921-918920	Yes	Director	13.09.17 - ongoing 13.09.17 - ongoing	Annual Dividend Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Claire Gerdemann	13.01.20	Yes	Secondary Work Form sent 24.01.20	
Low	Andrew	Goringe	Consultant in Haematology	Haematology Laboratory	Consultant	CD&T	13.11.20	No	No	Llntb	43030	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Help supervise the haematology laboratory at the Spire hospital in Cardiff including reporting accurate CellaVision and morning blood Trainchasers	June 19 - ongoing						Andrew Goringe	13.11.20	Yes	Secondary Work Form sent 25.11.20	
Low	Hazel	Gough	Consultant Surgeon	Surgery	Consultant	Surgery	23.12.20	No	No	Llntb		Yes	Director of Wirbel company Ort Soleyl Ltd	Oct 2014 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Breast Cancer Charity	2009 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Hazel Gough	23.12.20	Yes	Secondary form sent 6.1.20	
High	Jonathan	Gray	Senior Director of Transformation and Delivery	Executive	Executive	Executive	21.01.22	Yes	Yes	Woodland House	29216836200	Yes	Previous role as CEO of SWANSEA - a company Limited by Guarantee Wife owns private company delivering mindfulness / training resilience training Brother-in-law Director of Ernst Young	2014 - present 2014 - present 2014 - present	N/A	Formed a Ltd Company in Dec 21 called Jonathan Gray Ltd (No. 13966 7127) - currently the route I am paid for the work by QS and Becton Dickenson. I anticipate using the company for work after redundancy/scrutinising should they occur. I work 2 months a year in Singapore/Tokyo/Sydney- Zealand/USA contracted to deliver innovation work. I step my	2021 - ongoing	Financial	Wife links to Singapore Life Sciences Hub. I am a Member of Singapore Life Sciences Hub - non profit leadership group in New Zealand. Visiting Fellow Green Templeton College, Oxford Spouse works for (Mindfulness and Resilience) for Cardiff Met and Education Centre	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1. Trustee of Fathom Trust 2. Trustee of Cardiff Civic Board. 3. Fellow at Better Value Healthcare. 4. Visiting Chairs - Wellington (NZ), Exeter, Cardiff. 5. Adjunct Professor at the Health Services Research Centre, Faculty of Health at Victoria University of Wellington. 6. Honorary Clinical Professor, University of Exeter Medical School.	01/01/07 - present 2016 01/03/10 - present 01/07/21	N/A	Global Ambassador for Hillary Leadership Institute Trustee Health Foundation / Arthfoundation Member Institute of Directors.	2016 2010 2012 2020	Present Present	Employed by Singapore as previous - arranged through Jonathan Gray Ltd management - comp CEAHPA pay during 2 months Spouse: Maggie Centre and private work as previously mentioned Global Healthcare Advisor for QS Associates			Blank	Yes	Yes	Yes	Jonathan Gray	04/02/2020	Yes (Paper and Scanned)		
Low	Craig	Greenstock	Counterfraud Manager	Finance	8c	Finance	03.05.21	No	No	Woodland House	0843 4064	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Family works for another NHS Body	N/A	Nil	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of UKAEBNA Committee			Sponsorship for overseas	N/A	N/A	N/A	N/A	Craig Greenstock	04.06.21	S1R		

High Conflict which needs Managing
Potential Conflict - Line Manager should be aware and expectation that declrations is updated should conflict arise
No cause for concern

Low	Sian	Griffin	Consultant Nephrology & Transplantation	Nephrology and Transplant	Consultant	Specialist Services	26.01.21	Yes	No	UHW	48451	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Advisory Board attendance - Roche, Novartis, Retrophin, Astra, Zeneca	17.08.20 - 16.11.20	Honoraria	N/A	N/A	N/A	General Secretary British Transplantation Society	01.03.18 - 01.03.21	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sian Griffin	26.01.21	Yes	Secondary form sent 10.02.21
Low	Helen	Griffiths	Occupational Therapist	Community Resource Team	7	PCIC	14.10.20	Yes	No	Whitchurch Hospital	32501	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Work as occupational therapist for Stroke case management on ad hoc basis	Sept 2016 - ongoing	zero hour contract	Yes	Yes	Helen Griffiths	14.10.20	Yes	Secondary form sent 20.01.21
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.11.20	Yes	Yes	UHW	43533 / 42354	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Caridology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd My wife is a Director and Shareholder in Groves Cardiology Services Ltd	June 96 - current	Income and Dividends	Yes	Yes	Peter Groves	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.11.20	Yes	Yes	UHW	43533 / 42354	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and	3.07.11 - current 3.07.11 - current	nil Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd	June 96 - current	Income and Dividends	Yes	Yes	Peter Groves	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Tristan	Groves	Lead Cardiology and Anticoagulation Pharmacist	Adult Cardiology	8a	Specialist Services	18.11.20	Yes	No	UHW	20746826	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Receiving Honoraria for providing educational sessions from Pharmaceutical companies related to anticoagulation. Honoraria received from BMS/Pfizer alliance and Bayer. Sponsored attendance of educational meetings also supplied by the above companies	2016 - current	Honoraria and meeting travel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tristan Groves	18.11.20	Yes	Sponsorship Form sent 1.12.20
Low	Laura	Gwyther	CART Clinical Nurse Specialist	Haematology		Specialist Services	13/10/2020	Yes	No	UHW	Ext 48494	Yes	N/A	N/A	N	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have been asked along side all the other CART nurses across the UK to participate in a paid advisory board discussion hosted by Celgene. I would like to	19/10/2020	£140	Yes	Yes	Laura Gwyther	13/10/2020	Yes	
Low	Richard	Hain	Consultant and Clinical Lead, Paediatric Palliative Care	Child Health (Community)	Consultant	Children & Women	19.11.20	Yes		UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CVUHB Office space within Ty Hafan Children's Hospice	2018		Office space, coffee			Yes	Yes	Richard Hain	19.11.20	Yes	
Low	Sarah	Hale	Consultant Opthalmologist	Ophthalmmology	Consultant	Surgery	8.04.20	Yes	No	UHW	02920 748249	Yes	N/A	N/A	N/A	Nominated member of Cardiff Eye Surgeons LLP. Company that carries out ophthlamic work	2006 - current	Paid for any work carried out	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sarah Hale	8.04.20	Yes	Secondary Work Form sent 24.11.20
Low	Khalid	Hamandi	Consultant Neurologist	Epilepsy Unit	Consultant	Specialist Services	26.01.21	Yes		UHW	46662	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secretary, International League Against Epilepsy Britich Chapter. Chair Epilepsy Action Cymru National Advisory Council	2019 - present	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Khalid Hamandi	26.01.21	Yes	
	Kathrin	Hammer	Consultant Radiologist	Radiology	Consultant	CD&T	28.09.20	Yes	No	UHW		Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	Nil	No	N/A	nil	No	N/A	N/A	No	N/A	No	Fee for service at European scanning centre Cardiff and Spire Hospital Cardiff for radiology work	One session	One off payment	Yes	Yes	Kathrin Hammer	28.09.20	ESR	
	Kathrin	Hammer	Consultant Radiologist	Radiology	Consultant	CD&T	16.01.22	Yes	No	UHW	NK	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Clinical Private Practice	28.09.20 - Ongoing	Fees	Yes	Yes	Kathrin Hammer	19.01.22	ESR	
Low	David	Hanna	Consultant Paediatrician	Emergency Medicine	Consultant	Medicine	11.01.21	Yes	Yes	UHW	48008	Yes	N/A	N/A	N/A	My wife, Dr Alison Whyte is a partner in Clark Avenue Surgery, a GP Practice in Cwmbran, within the Aneurin Bevan UHB area. This practice does not currently do business or is it seeking to do business with Cardiff and Vale UHB	2019		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Hanna	11.01.21	Yes	
Low	Abigail	Harris	Executive Director of Strategic Planning	Strategic Planning	Director	Corporate	27.01.21	Yes	Yes	Woodland House		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	My husband is an Independent Board member of the Wales Council for Voluntary Action. My uncle is a Trustee of the Teenage Cancer Trust	Ongoing	No	I am an Independnet Board member of Social Care Wales.	Ongoing	No	Husband works for Competition and Markets Authority which on occasions rules in matters of fair competition in the NHS and healthcare	Ongoing	Husband's salary.	Yes	Yes		27.01.21	Yes	
Low	Mary	Hart	Consultant Radiologist	Radiology, Medical Physics, Clinical Engineering		CD&T	12.11.20	Yes	No	UHW	2920743538	Yes	Director Hart-Jones Consultancy LTD	Apr-19	Salary	N/A	N/A	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	Self employment: Hart-Jones Consultancy LTD	Apr-19	Salary						
Low	Jamie	Hayes	Pharmacist	AWTTC	8d	CD&T	13.11.20	Yes	Yes	UHL	26869	Yes	Director of JMH Collaborations	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Director of JMH Collaborations Ltd	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Honorary Senior Lecturer appointments with Cardiff University School of Medicine and School of Pharmacy and Pharmaceutical Sciences	2006 - ongoing	Honoraria	N/A	N/A	N/A	Elected Board member of the Royal Pharmaceutical Society and member of the Royal Pharmaceutical Society Assembly. Wife is Medical Director at Marie Curie, Cardiff and Vale Hospice, Penarth	June 2016 - ongoing	Honoraria, expenses	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jamie Hayes	13.11.20	Yes	
Low	Rhys	Hewett	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	44687	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsored by Fresnus Kabi to attend BAPEN conference Nov 2019		Paid for conference, hotel and flights	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Rhys Hewett	12.11.20	Yes	
Low	Julie	Highfield	Consultant Clinical Psychologist /Associate Director	Critical Care		Specialist Services	12/10/2020	Yes	Yes	UHW	45114	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National Director of Wellbeing Intensive Care Society	15/06/20 - Ongoing	secondment from NHS 0.4WTE at 8c	N/A	N/A	N/A	Occasional private practice	2005-Ongoing	adhoc salary	Yes	Yes	Julie Highfield	12/10/2020	Yes	
Low	Christopher	Hingston	Consultant Critical Care	Critical Care	Consultant	Specialist Services	13.11.20	Yes	Yes	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spouse: Director and Trustee of Latch Childrens Charity	2014 - current	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Chris Hingston	13.11.20	Yes	
Low	Emma	Hingston	Consultant & Honorary Senior Lecturer Paediatric Dentistry	Paediatric Dentistry	Consultant	Surgery	5.02.21	Yes	No	UHW	42458	Yes	Director of LATCH cancer charity	2014 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee for LATCH - Children's Cancer Charity	2013 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Emma Hingston	5.02.21	Yes	
Low	Thomas	Hockey	Consultant Histopathologist	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	Yes	UHW	41986	Yes	Director Director / Secretary	Dividend Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I perform post mortem examinations for HM Coroner and do some private histology reporting.	Jan 21-Ongoing	payment per case.	Yes	Yes	Thomas Hockey	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Jessica	Hodges	Physiotherapist	Frailty	5		13/10/2020	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Work as a Physiotherapist for Cardiff City Ladies Football Club	9/10/20 - ongoing	paid	Yes	Yes	Jessica Hodges	13/10/2020	Yes	
Low	Paul	Hodgson	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	16.11.20	Yes	No	UHL	2071 5677	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice (company name PDH Ortho Ltd)	Feb 2013 - ongoing	payment per case	Yes	Yes	Paul Hodgson	16.11.20	Yes	Secondary Work Form sent 26.11.20
~~Low~~	~~Ben~~	~~Hope-Gill~~	~~Consultant General Medicine~~	~~General medicine Llandough~~	~~Consultant~~	~~Medicine~~	~~22.06.21~~	~~Yes~~	~~No~~	~~UHL~~	~~2920716847~~	~~Yes~~	~~No~~	~~N/A~~	~~N/A~~	~~No~~	~~N/A~~	~~N/A~~	~~No~~	~~N/A~~	~~N/A~~	~~I was sponsored to attend the American Thoracic Society online conference May 2021 by Boehringer Ingelheim.~~	~~May 21-May 21~~	~~No~~	~~No~~	~~N/A~~	~~N/A~~	~~No~~	~~N/A~~	~~N/A~~	~~No~~	~~N/A~~	~~N/A~~	~~Yes~~	~~Yes~~	~~Ben Hope-Gill~~	~~23.06.21~~	~~ESR~~	~~Sponsorship Form sent 18.10.21~~
Low	Mathew	Hoskins	Locum Consultant Psychiatrist	Adult Psychiatry	Consultant	Mental Health	16.11.20	Yes	No	Barry Hospital	1446 454300	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am the Chief Investigator for a phase 2 clinical trial sponsored by the Multidisciplinary Association for Psychedelic Studies (MAPS, USA), which will take place in partnership with Cardiff Uni and Cardiff and Vale UHB in 2021. I have recevied training funded by MAPS.			I have done part time agency locum consultant work for Powys Health board. Finished in July 2020. No more planned as I'm no longer part time.		Yes	Yes	Yes	Mathew Hoskins	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Gary	Howell	Macmillan AHP Cancer Lead	Therapies	8a	CD&T	13.11.20	Yes	No	UHW	44294	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private dietetic practice	2008 - ongoing	Salary	Yes	Yes	Gary Howell	13.11.20	Yes	Secondary Work Form sent 03.12.20
Low	David	Howells	Consultant	MHSOP	Consultant	Mental Health	11.01.21	Yes	No	South East Cardiff team	2920536880	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Health Inspectorate Wales - SOAD work Schedule 2 Mental Health Act / Mental Capacity Act work Trustee for Charity 'RESEC' Private Mental Health Clinical Work at Cyncoed Consulting Rooms, Cardiff	Jan 21 - Ongoing	Yes	Yes	Yes	David Howells	11.01.21	ESR	Secondary Employment Form sent 18.10.21
Low	Richard	Hughes	Consultant Anaesthetist	Peri-Operative Care	Consultant	Surgery	12.11.20	Yes	No	UHW	44139	Yes	Director of R H Health Ltd (to manage private medical anaesthetic activities undertaken outside my NHS contract)	08/01/2013	Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Hughes	12.11.20	Yes	
Low	Sarah	Hunt	Consultant Anaesthetist	Anaesthetics and Critical Care	Consultant	Specialist Services	15.11.20	Yes	No	UHW		Yes	Vale Anesthetics Ltd	2014 - ongoing	I do not draw a salary or dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd I undertake private practice in Spire Hospital. They do	2014 - ongoing	I do not draw a salary or dividends	Yes	Yes	Jayne Sara Hunt	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Nicola-Xan	Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory		Medicine	15/10/2020	Yes	No	UHL	2920716847	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for European Respiratory Conference attendance fees by Boehringer Ingelheim	7-9/10/20	Financial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Nicola-Xan Hutchinson	15/10/2020	Yes	
Low	Louise	Ingleton	Avanced Paediatric Clinical Nurse Specialist	Community Child Health Neurodevelopmental	8a	Children and Women	13.01.21	Yes	No	St David's Hospital		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of UK Nurse Advisory Board-ADHD sponsored by Takeda Pharmaceuticals	March 20 - ongoing	honoria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Louise Ingleton	13.01.21	Yes	Secondary form sent 13.01.21
Low	Sharon	Irving	Senior Nurse ENT	ENT	8a	Surgery	07.02.21	Yes	No	UHW	02920 742783	Yes	No	N/A	N/A	No	N/A	N/A	A position with HIW as a nurse peer reviewer	2019-Present	No	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Sharon Irving	07.02.21	Yes	
Low	Carly	Jackson	Clinical Psychologist	Child Health	8a	Children and Women	14.12.20	Yes	No	St David's Hospital	2920536733	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Psychologist with Sport Wales (employed by Sport Wales) and Clinical Psychologist for Mindful Mindset (Self-Employed)	Sports Wales (1.09.19) both ongoing	Sports Wales Salary	Yes	Yes	Carly Jackson	14.12.20	Yes	Secondary form sent 5.1.20
Low	Charles	Janczewski	UHB Chair	Executives / Corporate	VSM	Executive	12.11.20	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Swansea University - Chair of Governance Board for Health & Wellbeing Academy	May 2018 - ongoing	Unpaid	N/A	N/A	N/A	Yes	Yes	Charles Jancewski	12.11.20	Yes	
Low	Fiona	Jenkins	Executive Director of Therapies and Health Science	Executive	Executive	Executive	03.03.22	Yes	No	UHW		Yes	Interim Executive Director Therapies and Health Science, Cwm Taf Morgannwg UHB	Nov 20 - tbc	Shared role with C&V UHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Fiona Jenkins	26.11.20	Yes	
Low	Lynda	Jenkins	Nursing Informatics Lead	Corporate Nursing		Corporate Nursing	09/10/2020	Yes	No	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake hospital inspections in other health boards/ private health care in Wales on invitation from health inspectorate Wales. These are infrequent			N/A	N/A	N	Yes	Yes	Lynda Jenkins	08/10/2020	Yes	
Low	Adam	Jones	Consultant Dental Surgeon	Dental	Consultant	Surgery	8.01.21	Yes	No	UHW	44365	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Merck Sharp & Dohme Ltd. funded travel / hotel and course expenses for training on 'PD-L1 testing (22C3) Professional Expert Course Head and Neck - Advanced Training'	13.01.21 - 14.01.21	Course, travel and hotel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Adam Jones	8.01.21	Yes	Secondary form sent 11.01.21
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	Consultant	Medicine	24.11.20	Yes	No	UHL	25653	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Amy Jones	26.11.20	Yes	
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	Consultant	Medicine	24.11.20	Yes	No	UHL	25653	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Amy Jones	26.11.20	Yes	
Low	Ceri Hopcyn	Jones	Consultant Haematologist (BMT & CAR T)	Consultant Haematologist	Haematology	Specialist Services	1.02.20	Yes	No	UHW	41976	Yes	I received sponsorship to attend various conferences including European Haematology Asssociation General meeting (EHA) 2019 and American Society of Hematolgy (ASH) 2019 from Abbvie, and EHA 2020, British Society of Haematology Annual General Meeting 2020 and ASH 2020 from Kite Gilead and Novartis	May 2019 - ongoing	Travel and registration costs only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ceri H Jones	1.12.20	Yes	Sponsorship Form sent 3.12.20
Low	Lisa	Jones	Clinical Psychology	Neuropsychology	8+	Specialist Services	21.02.21	Yes	No	UHW	43224	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work as a self employed clinical neuropsychologist	2014 - ongoing	salary	Yes	Yes	Lisa Jones	21.02.21	Yes	Secondary form sent 25.02.21
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	7	Mental Health	30.11.20	Yes	Yes		1446 454200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for Re-Live (Registered Charity Number: 1162546) Spouse is a Board Member with the charity 'Wish Upon a Star'.(Registered Charity Number 1168140).	01/07/2015 01/07/2015	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Jones	30.11.20	Yes	
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	7	Mental Health	30.11.20	Yes	Yes		1446 454200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for Re-Live (Registered Charity Number: 1162546) Spouse is a Board Member with the charity 'Wish Upon a Star'.(Registered Charity Number 1168140).	01/07/2015 01/07/2015	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Jones	30.11.20	Yes	
Low	Menna	Jones	Clinical Lead	Mental Health	8c	Mental Health	16.11.20	Yes	No	Global Link	02921 832200	Yes	Director of Vegan International Ltd	24.12.19 - ongoing	none	Self employed as complementary therapist	2018 - ongoing	sessional payments		N/A	N/A	N/A	N/A	N/A	Director of British Eating Disorders Society	10.01.18 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Menna Jones	16.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Sharon	Jones	Consultant Rheumatologist	Specialised Medicine	Consultant	Medicine	25.01.21	Yes	No	UHW	42886	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Educational funding from Lily for EULAR conference (virtual) in June 2021			Have been an advisor to NASS - National Ankylosing Spondylitis Society and received an award in 2018		N/A	N/A	N/A	N/A	Private rheumatology practice at Spire funded (self employment) since 2001	N/A	N/A	Yes	Yes	Sharon Jones	25.01.21	Yes	Secondary and sponsorship form sent 10.02.21
Low	Sharon	Jones	Consultant Rheumatologist	Specialised Medicine	Consultant	Medicine	25.01.21	Yes	No	UHW	42886	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Educational funding from Lily for EULAR conference (virtual) in June 2021			Have been an advisor to NASS - National Ankylosing Spondylitis Society and received an award in 2018		N/A	N/A	N/A	N/A	Private rheumatology practice at Spire funded (self employment) since 2001	N/A	N/A	Yes	Yes	Sharon Jones	25.01.21	Yes	Secondary and sponsorship form sent 10.02.21
Low	Nia	Jones	Podiatrist	Therapies	7	CD&T	11.11.21	Yes	No	CRI	029 20335370	Yes	No	N/A	No	No	N/A	N/A	No	N/A	N/A	Receives honoraria for speaking at wound care conferences	May 2019-Ongoing	Honoraria	No	N/A	N/A	No	N/A	N/A	Employed by Toetal Footcare Private Clinic.	May 2019 - Onwards	Fees	Yes	Yes	Nia Jones	11.11.21	Yes & ESR	
Low	Anurag	Joshi	Consultant	Cellular Pathology	Consultant	CD&T	02.09.21	Yes	No	UHW	428876	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	I report on cases referred to AWLP from Spire Hospital Cardiff when these are allocated to me	Sep 21-Ongoing	Yes	Yes	Yes	Anurag Joshi	02.09.21	ESR	Secondary Work Form sent 18.10.21
Low	Naushad Ali	Junglee	Consultant in Acute Medicine and Nephrology	Acute Medicine	Consultant	Medicine	17.11.20	Yes	No	UHL	46645	Yes	NAJ Clinical Services PLC. A PLC set up by me for the purposes of private medical practice	2018 - current	private practice earnings	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Nephrologist at Spire Hospital Cardiff	2017 - current	Private Practice earnings are paid	Yes	Yes	Naushad Ali Junglee	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Sridhar	Kamath	Consultant Radiologist	Radiology	Consultant	CD&T	29.01.21	Yes	No	UHW	44887	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have private practising privileges at Spire cardiff hospital, Nuffield hospital cardiff and St Josephs hospital Newport			Yes	Yes	Sridhar Kamath	29.01.21	Yes	Secondary form sent 12.02.21
Low	William Jonathan	Kell	Consultant Haematologist	Haematology	Consultant	Specialist Services	22.12.20	Yes	No	UHW	42654	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional requests from Pharmaceutical companies to give education (non-promotional) talks, or to sit on paid advisory boards	2002 - ongoing	Less than £2k	Treasure of UK MDS forum	2010 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jonathan Kell	22.12.20	Yes	Secondary form sent 6.1.20
Low	Emma	Kempshall	Consultant Haematologist	Haematology / BMT	Consultant	Specialist Services	10.02.21	Yes	Yes	UHW	47053	Yes	Director Gloucestershire Knee Surgery Ltd Spouse: Director Gloucestershire Knee Surgery Ltd	August - ongoing August - ongoing	No No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Emma Kempshall	10.02.21	Yes	
Low	Alexander	Kennedy	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Consultant	Surgery	12.11.20	Yes	No		7413908743	Yes	Director South East Wales Hang Gliding and Paragliding Club Ltd	16.03.17 - ongoing	No benefits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alexander Kennedy	12.11.20	Yes	
Low	Mohid	Khan	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	29.01.21	Yes	No	UHW	43443	Yes	Dr Mohid Khan Ltd	16.04.19	None	N/A	N/A	N/A	AAA	9.03.20	Speaker Fee	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mohid Khan	28.01.21	Yes	previous year 2019 - 2020
Low	Robert	Kidd	Consultant Psychologist	Mental Health	Consultant	Mental Health	16.11.20	Yes	Yes	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Partner is a Consultant Psychologist within Child Health at the Health Board.	Current	Salary	N/A	N/A	N/A	N/A	N/A	N/A	Declarant is a member of the All Wales Approval Panel for Approved Clinicians in Wales, which sits within BCUHB and carries out its functions on behalf of the other LHBs. Declarant is also an external examiner at Birmingham University & an honorary lecturer at Cardiff University & an honorary (consultant) assistant professor to the school of	Current	Salary	Declarant occasionally undertakes direct (private) instructions for Crown Court reports, but does not make recommendations for hospital bed disposals	Ongoing	Fees	Yes	Yes	Robert Kidd	16.11.20	Yes	Secondary Employment form completed. Manager content with external work.
Low	Anna	Kuczynska	Clinical Board Director	PCIC	8+	PCIC	12.11.20	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	GP partner, Highlight Park Medical Practice , Lakin Drive, Barry CF628GP		Yes	Yes	Yes	Anna Kuczynska	12.11.20	Yes	
Low	Howard	Kynaston	Consultant Urologist	Medicine	Consultant	Medicine	2.02.21	Yes	No	UHW	7834196104	ESR	Co Director of Bay Tree Wine Company - retiring from NHS 28.02.21 Spouse also co Director	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Howard Kynaston	2.02.21	Yes	Retiring from NHS 28.02.21
Low	Mary	Lawrence	Associate Specialist in Psychiatry	Mental Health	Consultant	Mental Health	20.11.20	Yes	No	Hamadryad CMHT	2046 3488	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private work in the form of reports for solicitors, DVLA, CPS, CICB, Child Services, Benefits Appeals, Immigration Applications, Occupational Health, Police etc. plus Mental Health Act Assessments. These are conducted in my own time (if undertaken during my normal working hours time slipping utilised with equivalent amount of NHS work	Ongoing		Yes	Yes	Mary Lawrence	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Mari	Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy	8a	CD&T	20.11.20	Yes	No	UHL	2071 5261	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University MSc in clinical pharmacy. Provide 2 hour teaching session every 12 or 24 months. Annual leave taken, therefore undertaken during my own time.	March 11 - present	Hourly rate for delivering presentation	Yes	Yes	Mari Lea-Davies	20.11.20	Yes	Secondary Work Form sent 01.12.20
	Robert	Letchford	Consultant Physiotherapist	Physiotherapy	8	CD&T	07.03.22	Yes	No	CRI		Yes	POBBEN Wellbeing PLC	2019 - Ongoing	Dividends	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Robert Letchford	07.03.22	Yes	
Low	Aled	Lewis	Consultant	Nephrology and Transplant	Consultant	Specialist Services	23.06.21	Yes	Yes	UHW	746645	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	My wife is a joint owner/director in a private physiotherapy company specialising in exercise/rehabilitation for Parkinson's disease. I have no direct interests in the company	Jun 21-Ongoing	none	Yes	Yes	Aled Lewis	23.06.21	ESR	
Low	Christopher	Lewis	Interim Executive Director of Finance	Finance	VSM	Executive	13.11.20	Yes	Yes	Woodland House	41507	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	President of Wales Branch of the Healthcare Financial Management Association(HFMA). HFMA is a registered charity	Oct 09 - Preesent	None anticipated	My wife is Samantha Lewis, Assistant/Deputy Director of Finance, Swansea Bay University Health Board	2011 - Present		N/A	N/A	N/A	Yes	Yes	Christopher Lewis	13.11.20	Yes	
Low	Kenneth	Lim	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children & Women	10.03.22	Yes	No	UHW	41249	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of South Wales Gynae Cancer Fund - registered charity	2009 - ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Kenneth Lim	13.11.20	Yes	
Low	Peter	Lindsay	Locum Consultant	Obs & Gynae	Consultant	Children & Women	13.11.20	Yes	No	UHL	21841268	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Treasurer - South Wales Gynaecological Cancer Fund	1997 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Lindsay	13.11.20	Yes	
Low	Kate	Littler	Principal Clinical Psychologist	Haematology		CD&T	11.03.2020	Yes	No	UHW	45558	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	01/07/2020 - Ongoing	Salary	Yes	Yes	Kate Littler	03.08.2020	Yes	
Low	Andrea	Liu	Consultant Neuroradiologist	Radiology	Consultant	CD&T	28.01.21	Yes	No	UHW	44325	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4Ways Healthcare and Spire Cardiff	2012 and April 2010		Yes	Yes	Andrea Liu	28.01.21	Yes	
Low	Andy	Lodwick	Lead Clinician Psychological Therapy Hub	Psychology		Mental Health	19/10/2020	Yes	Yes	UHL	2183 22249	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Andy Lodwick	2014 - ongoing	Self employed as a sole trader as Dr Neil Kitchiner. Personal website cbt cardiff attracts individuals seeking Private out-pt psychological therapy	Yes	Yes	Andy Lodwick	19/10/2020	Yes	
Low	Ne-on	Loh	Consultant Paediatrician	Child Health	Consultant	Children and Women	26.01.21	Yes	No	UHW	44291	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultant Paeditricin in Royal United Hospital Bath	February 2010 -	2PA	Yes	Yes	Boo-ron Loh	26.02.21	Yes	Secondary form sent 11.02.21
Low	Julie	Loxton	Clinical Lead Nurse	Vale Locality Office / Daytime Servi	7	PCIC	24.11.20	Yes	No	Barry Hospital	7989223435	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	I offer locum shifts to general practice as self employed. This does not conflict with my C&V role	March 22 - Ongoing	Salary	Yes	Yes	Julie Loxton	13.11.20	Yes	
Low	Alice	Loyal	Clinical Psychologist	Psych EMI Community	8C	Mental Health	30.11.21	Yes	No	N/K		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	I am company secretary for my husband's design engineering company. I hold a 7% share in the company. This does not conflict with my duties in C&V UHB	Nov 21-Ongoing	Dividends	Yes	Yes	Alice Loyal	30.11.21	ESR	
Low	Jill	Lubienski	Family Therapist	SHED	8a	Mental Health	14/10/2020	Yes	No	Global Link	2921 832200	Yes	N/A	N/A	N//A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have a private psychotherapy practice based at my home in Cardiff. I do not see clients privately where they could be seen in the SHED team. I am also a self employed Associate for Partnership Projects UK (www.partnershipprojectsuk.co.uk) providing NVR parenting therapy, and training to practitioners and therapists but again this work does not cross over with my SHED employment	13/10/20 - ongoing	Yes I have some income from my self employed work.	Yes	Yes	Jill Lubienski	14/10/2020	Yes	
Low	Helen	Ludlow	Macmillan Senior Nurse Band 8a	Medicine	8a	Medicine		Yes	No	UHW		Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	I have spoken at 3 non-promotional webcasts for Janssen, a pharmaceutical company that provides one of our Biologic drugs. 1 meeting was how IBD Nurses coped during COVID, and tips to keeps services running smoothly and then 2 (both the same presentation) on a case study of an IBD pt and also again keeping IBD services running during COVID	3 sessions	total amount received as honorarium: £105. I am registered as also self-employed for my outside speaking engagements and tax has been set aside for these payments and my books are up to date and available for	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Yes	Yes	Helen Ludlow	10.10.20	ESR	
Low	Jane	Maddison	Paediatric Physiotherapy	Acute Child Health	8a	Children and Women	13.11.20	Yes	No	Woodland House	365578	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of Chartered Society of Physiotherapy Welsh Board	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jane Maddison	13.11.20	Yes	
Low	Roger	Maggs	Laboratory Manager	Dental	8c	Surgery	16.11.20	Yes	No	UHW	42411	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Managing Director of a company for private work Wife - Director of same company	01/04/2015 - current 01/04/2015	salary	Yes	Yes	Roger Maggs	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Claire	Main	Interim General Manager of Criticare Care and Major Trauma	Critical Care and Major Trauma		Specialist Services	09/10/2020	Yes	No	UHW	ext 45069	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Executive member of Association of Nephrology Nurses UK representing nursing on various UK renal projects	29.05.2018 - ongoing	No	N/A	N/A	N/A	Yes	Yes	Claire Main	09/10/2020	Yes	
Low	Aleksander	Marin	Consultant Radiologist	Radiology	Consultant	CD&T	14.11.20	Yes	No	UHL	25563	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Medica Teleradiology Speciality Advisor in Thoracic Radiology, Spire Hospital Cardiff Reporting Radiologist	20.06.16	Monthly p0ayable fees for service	Yes	Yes	Aleksander Marin	14.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Carys	Marshall	Principal Clinical Psychologist	Clinical Health & Neuropsychology	8a	Mental Health	25.01.21	Yes	No	Global Link	20832243	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment - private practice	Mar-21	Ad hoc	Yes	Yes	Carys Marshall	2.03.21	Yes	Secondary work form sent 2.03.21
Low	Joanne	May	Locum Consultant Paediatric Rheumatologist	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43400	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Medical advisor to treat to target panel for systemic JIA	Nov 2020 - Nov 2021	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	The department is supported by Versus Arthritis family workers. We have a project (currently on hold) with ballet cymru and the Arts Council for Wales to provide patient support	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Joanne May	13.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Kenneth	May	Consultant Cellular Pathology	Cellular Pathology and Mortuary Service, Laboratory Medicine	Consultant	CD&T	12.11.20	Yes	No	UHW	48040	Yes	STTC Limited	Jul-19		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Histopathology reporting for backlogs Ltd				Yes	Kenneth May	12.11.20	Yes	
Low	Haydn	Mayo	Assistant Clinical Board Director, PCIC	Community Director	8+	PCIC	28.01.21	Yes	No	Woodland House		Yes	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	N/A			Forget Me Not Chorus Charity Trustee			Penarth Civic Society Member / Chair - Friends of Victoria Square sub group			N/A	N/A	N/A	Yes	Yes	Haydn Guy Mayo	28.01.21	Yes	Secondary form sent 12.02.21
Low	Neil	McCann	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	27.02.21	Yes		UHW	43105	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship by Medtronic UK to attend a day meeting in Leeds	4.12.19 - 5.12.19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Neil McCann	27.02.21	Yes	
Low	Annette	McLean	Dietetic Lead Mental Health	Dietetics	8a	CD&T	12.11.20	Yes		UHL	2071 5281	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc private dietetic work: Orbis education, plus dietetic consultation/training ad hoc on request, eg: cardiff uni/comaly/knights abroth	2005 - ongoing		Yes	Yes	Annette McLean	12.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Jan	Melichar	Consultant Psychiatrist	Addictions	Consultant	Mental Health	26.01.21	Yes	No	CRI	2920461788	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultancy & training for all UK pharmaceutical companies in this area	1995 - ongoing	Honoraria	Consultancy at third sector organisation (DHI) in Bath and Bristol	2011 - ongoing	Honoraria	Consultancy to LearnitOnline - online health education and training	2016 - ongoing	Honoraria	Self employed in private practice primarily Spire	2011 - ongoing	Fees	Yes	Yes	Jan Melichar	26.01.21	Yes	Secondary & Sponsorship form 10.02.21
Low	Angela	Miser	Associate Specialist, Paediatric Haematology / Oncology	Acute Child Health	Consultant	Children & Women	15.11.20	Yes	Yes	UHW	48805	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Chief Medical Officer, Lixte Biotechnology Holdings, Inc., East Setauket, New York 11733, USA	2020 - Present	Salary	N/A	N/A	N/A	1. Chairman of Board, Christian Salvation Service, Taipei, Taiwan (USA Office), 2. Chairman of Board, Desi Geestman Foundation (supports children with cancer), Los Angeles, USA	20+	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Angela Miser	15.11.20	Yes	
Low	Adul	Moideen	Consultant Spinal Surgeon	Trauma and Orthopaedics	Consultant	Surgery	12.03.21	Yes	Yes	UHL		Not Ticked	Director Private Practice Spouse - Director Private Practice	02.2022 02.2020	Salary Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director - Private Practice Spouse - Director Private Practice		Salary Salary	Yes	Yes	Abdul Moideen	12.03.21	Yes	Secondary work form sent 12.03.21
Low	Siobhan	Moore	Clinical Psychologists	Neurosciences	8+	Specialist Services	3.02.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	One off training session for a drug company (Biogen where I was paid during this financial year	Apr-20	Yes	N/A	N/A	N/A	Yes	Yes	Siobhan Moore	3.02.21	Yes	Secondary form sent 12.02.21
Low	Matthew	Morgan	Consultant in ICU	Critical Care	Consultant	Specialist Services	12.11.20	Yes	Yes	UHW	7760220095		Matt PG Morgan Ltd, Director - Author/Writing Business for a book publishing about ICU Spouse - Matt PG Morgan Ltd, Director - Author/Writing Business	01/11/2017 - present 01/11/2017 - present	Dividends Dividends and salary	N/A	N/A	N/A										I have donated £5000 to the 2 Wish Upon a Star charity and £200 to the C&V Health Charity.	2020		Writer for BMJ and BMJ Learning	2005 - present	Salary	Yes	Yes	Matt Morgan	12.11.20	Yes	
Low	Paul	Morgan	Consultant Critical Care	Critical Care	Consultant	Specialist Services	26.01.21	Yes	No	UHW	43064	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	Lead volunteer, the UK Sepsis Trust	2013		Lecturer for Doctors Academy	Apr-19		Yes	Yes	Paul Morgan	26.01.21	Yes	Secondary form sent 11.02.21
Low	Rhiannon Meleri	Morgan	Consultant in Cellular Pathology	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	No	UHW	41988	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board Member of Manon Jones Foundation - not yet established as a charity	01.01.20	None	Coronial post mortem work for South Wales Central Coroners Office	2004	£96 per individual PM	Yes	Yes	Meleri Morgan	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Consultant	Surgery	13.11.20	Yes	Yes	UHW	42083	Yes	Dan Morris Ltd Spouse: Director	2003 - present	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sambury Trust, Vale 4 Africa Keeler Trust (Trustee)	Ongoing	Nil	N/A	N/A	N/A	Work at Spire & Nuffield Paid via DM Ltd			Yes	Yes	Daniel Morris	13.11.20	Yes	
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Consultant	Surgery	13.11.20	Yes	Yes	UHW	42083	Yes	Dan Morris Ltd Spouse: Director	2003 - present	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sambury Trust, Vale 4 Africa Keeler Trust (Trustee)	Ongoing	Nil	N/A	N/A	N/A	Work at Spire & Nuffield Paid via DM Ltd			Yes	Yes	Daniel Morris	13.11.20	Yes	
Low	Jeffrey	Morris	Head of Electronic Assitive Technology Service for Wales	ALAS	8a	Specialist Services	12.11.20	Yes	No	Rookwood Hospital	02920 313852	Not Ticked	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Organising Committee and Scientific Committee member of the European Seating Symposium (ESS), based in Ireland	Jun-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jeffrey Morris	12.11.20	Yes	
Low	Jeffrey	Morris	Head of Electronic Assitive Technology Service for Wales	ALAS	8a	Specialist Services	12.11.20	Yes	No	Rookwood Hospital	02920 313852	Not Ticked	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Organising Committee and Scientific Committee member of the European Seating Symposium (ESS), based in Ireland	Jun-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jeffrey Morris	12.11.20	Yes	
Low	Sara	Moseley	Independent Member of the Board	Executives / Corporate	Executive	Executive	2.03.21	Yes	No	Woodland House		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director, Mind Cymru	01.11 - 04/.21	Salary	Head of GMC Wales	04/21 - current	Salary	N/A	N/A	N/A	Yes	Yes	Sara Moseley	2.03.21	Yes	
Low	Sara	Moseley	Independent Member of the Board	Executives / Corporate	Executive	Executive	2.03.21	Yes	No	Woodland House		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director, Mind Cymru	01.11 - 04/.21	Salary	Head of GMC Wales	04/21 - current	Salary	N/A	N/A	N/A	Yes	Yes	Sara Moseley	2.03.21	Yes	
Low	Richard	Motley	Consultant Dermatologist	Dermatology	Consultant	Medicine	25.01.21	Yes	No	UHW	44629	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake Private Practice at the Spire Cardiff Hospital and in The Welsh Institute of Dermatology	1994 - ongoing		Yes	Yes	Richard Motley	25.01.21	Yes	Secondary form sent 25.02.21
Low	Richard	Motley	Consultant Dermatologist	Dermatology	Consultant	Medicine	03.03.22	Yes	No	UHW	44629	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake Private Practice at the Spire Cardiff Hospital and in The Welsh Institute of Dermatology	1994 - ongoing		Yes	Yes	Richard Motley	25.01.21	Yes	Secondary form sent 25.02.21
Low	Sian	Moynihan	Consultant Paediatrician	Child Health	Consultant	Children and Women	4.02.21	Yes	No	St David's Hospital	2920536789	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am welfare Officer (Safegarding Officer) which is voluntary and unpaid for the Maindy Youth Cycling club- Im on the committee supporting decision making for the club that involves child welfare. It is recognised by British Cycling Authority and Welsh Cycling Authority and done necessary Safeguarding training. I do not believe there is any conflict of interest as this is done in outside work hours		None	N/A	N/A	N/A	Yes	Yes	Sian Moynihan	4.01.21	Yes	
Low	Peter	Mullaney	Consultant Radiologist	Radiology	Consultant	CD&T	11.12.20	Yes	No	UHW	43956	Yes	Yes	2019		Yes	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Mullaney	11.12.20	Yes	Secondary form sent 5.1.20
Low	Pippa	Mundy	Consultant Clinical Psychologist	Child Health	Consultant	Children & Women	16.11.20	Yes		Global Link	07976 702638	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Orbis Education & Care	2014	Payment for clinical services	Independent practice as psychologist	2014	Payment for clinical services	Yes	Yes	Pippa Mundy	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Alexandra	Murray	Consultant Medical Genetics	Genetics	Consultant	CD&T	26.11.20	Yes	No	UHW	44654	ESR	N/A	N/A	N/A	N/A	N/A	N/A	Paid a fee per patient to counsel them about private genetic test results purchased via Inntermost Healthcare	6.02.2017 - ongoing	Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am paid a month fee to provide a consultancy service to the National Pathology Manager about genetic tests	1.11.2017 - ongoing	monthly fee	Yes	Yes	Alexandra Murray	26.11.20	Yes	Secondary form sent 1.03.21
Low	Ravindra	Nannapaneni	Consultant	Neurosurgery	Consultant	Specialist Services	07.07.21	Yes	No	UHW	029 2074 8487	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Cardiff and St Joseph's Hospital, Newport	Jul 21 - Ongoing	Yes	Yes	Yes	Ravindra Nannapaneni	07.07.21	ESR	Secondary Employment Form sent 18.10.21
Low	Jones	Nia	Podiatrist	Podiatry	7	CD&T	26.10.21	Yes	No	UHL		Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Private Podiatry Work	Oct 2021-Ongoing	Fees	Yes	Yes	Nia Jones	26.10.21	ESR	
Low	Peter	O'Callaghan	Medical Consultant	Cardiothoracic	Consultant	Specialist Services	13.11.20	Yes	No	UHW		Not Ticked	Dr Peter O'Callaghan Ltd	2012 - ongoing	Private practice income	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter O'Callaghan	13.11.20	Yes	Secondary Work Form sent 24.11.20
Low	Balarao	Oruganti	Consultant in Psychiatry	Psychiatry	Consultant	Mental Health	18.11.20	Yes	No	UHL	47747	Not Ticked	Director of limited company but cannot see any conflict as not doing or seeking any business with UHB Spouse - Director of a limited company but cannot see any conflict as not seeking or doing any business with UHB			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Works for HIW and Judicial Appointment Committee for MHRT on ad hoc basis			Yes	Yes	Balarao Oruganti	18.11.20	Yes	Secondary form sent 21.12.20
Low	Craig	Parry	Consultant Radiologist	Radiology	Consultant	CD&T	26.01.21	Yes	No	UHW	43966	Yes	Craig Parry Diagnositics Ltd Co	Jul-17		Craig Parry Diagnostics Ltd Co	Jul-17	Salary	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice - Spire Hospital Cardiff		Salary	Yes	Yes	Craig Parry	26.01.21	Yes	Secondary form sent 11.02.21
Low	Frauke	Pelz	Associate Specialist in Clinical Genetics	All Wales Medical Genomics Service	Associate Specialist	All Wales Medical Genomics Service	20.11.20	Yes	Yes	UHW	48921	Not Ticked	Director of limited company	Since May 2016 - ongoing	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I hold a very small private psychotherapy practice, limited to very few monthly hours, well outside my job planned hours in NHS post			Yes	Yes	Frauke Pelz	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Thomas	Pembroke	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	45608		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University Employee			Yes	Yes	Thomas Pembroke	12.11.20	Yes	
Low	Richard	Penketh	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children and Women	26.01.21	Yes	Yes	UHW	44390	Not Ticked	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	N/A	N/A	N/A	N/A	N/A	N/A	Trustee Welsh Institue for Women's Health Trustee Welsh Institue for Women's Health			N/A	N/A	N/A	Private practice at Spire all the income goes into RPSF Ltd			Yes	Yes	Richard Penketh	26.01.21	Yes	Secondary form sent 11.02.21
Low	Ceri	Phillips	Independent Member of the Board	Board	Not Apllicable	Board	23.09.21	Yes	No	Woodland House	4366771	Yes	No	N/A	No	No	N/A	No	No	N/A	N/A	No	N/A	N/A	No	N/A	No	Emeritus Professor at Swansea University and Honorary Professor at Cardiff University	Sep 21-Ongoing	N/A	No	N/A	N/A	Yes	Yes	Ceri Phillips	23.09.21	ESR	
Low	Gwenda	Phillips	Clinical Psychologist	Psychology Therapies	8d	Mental Health	25.01.21	Yes	No	UHL	24850	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director in Carers Trust South East Wales	2018 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Gwenda Phillips	25.01.21	Yes	

High Conflict which needs Managing
Potential Conflict - Line Manager should be aware and expectation that declrations is updated should conflict arise
No cause for concern

Medium	Trevor	Pickersgill	Consultant Neurologist	Neurosciences	Consultant	Specialist Services	23.10.20	Yes	No	UHW	7971243314	ESR	N/A	N/A	N/A	N/A	N/A	N/A	I am a Chief Officer and Director of the BMA; and associated am a Director of BMA Charities and BMA Foundation for Research.			Over the last several years I have received travel bursaries/fees, conference registration sponsored by various pharmaceutical companies and occasional honoraria as follows: PHARMA REMUNERATION COI 2018: Novartis Chair symposium MS Trust - £1500 2017: Sanofi-Aventis ECTRIMS Paris travel/accom - £478.37 ECTRIMS registration - £536.36 Med Day Ad Board - £1000 Hilton Euston 2016: Roche Consultancy Cnicht climb project- £2,960; expenses £144 2015 - Teva Ad Board 2013 Biogen Ad Board Cardiff ECTRIMS 2018 Berlin no 2017 Paris yes Sanofi-Aventis 2016 London no 2015 Barcelona no 2014 Boston yes Novartis Biogen 2013 Copenhagen no 2012 Lyon yes- Novartis 2011 Amsterdam yes - Novartis 2010 Gothenburg - no 2009 Dusseldorf yes - Biogen 2008 Montreal yes-Merck Serono 2007 Prague yes Merck Serono 2006 Madrid yes Serono 2005 Thessaloniki yes Serono 2004 Milan yes Serono AAN 2008 Chicago - Biogen	Nothing of note for 2019-20		I am a Chief Officer and Director of the BMA; and associated am a Director of BMA Charities and BMA Foundation for Research.			N/A	N/A	N/A	I perform Private medical Practice based in Cardiff			Yes	Yes	Trevor Pickersgill	26.10.20	Yes	Secondary Work form sent 1.03.21
Low	Katie	Pink	Respiratory Consultant	Medicine	Consultant	Medicine	13.11.20	Yes	No	UHL	25088	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Katie Pink	13.11.20	Yes	Sponsorship Form sent 25.11.20
Low	Katie	Pink	Respiratory Consultant	Medicine	Consultant	Medicine	13.11.20	Yes	No	UHL	25088	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Katie Pink	13.11.20	Yes	Sponsorship Form sent 25.11.20
Low	Laura	Price	Assistant Psychologist	Neuroscience		Specialist Services	13/10/2020	Yes		Rookwood Hospital	02920 313713	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private healthcare work within the community	9/09/20 - ongoing	paid hourly	Yes	Yes	Laura Price	13/10/2020	Yes	
Low	Ann Marie	Procter	Consultant in Medical Genetics & Clinical Board Director	AWMGS	Consultant	Mental Health	17.11.20	Yes	No	UHL	24995	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Kaleidoscope Addictions Charity	2018	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ann Procter	17.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Michael	Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engine	6	CD&T	12/10/2020	Yes	No	Medicentre	02921 848676	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member of the catholic Medical Association Club	15/04/2018 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michal Pruski	12/10/2020	Yes	
Low	Rebekah	Pryce	Consultant Endocrinologist	Paediatric Endocrinology	Consultant	Children & Women	22.06.21	Yes	No	UHW	426965	Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Public Health Wales Clinical Lead for Congenital Hypothyroidism. Paid 6 sessions per year	Jun 21-Ongoing	Yes	Yes	Yes	Rebekah Pryce	22.06.21	ESR	Secondary Work Form sent 18.10.21
Low	Clare	Quinn	Consultant Clinical Psychologist	Psychology and Psychological The	8d	Mental Health	18.02.22	Yes	No	UHL		Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	Feb 22 - Ongoing	Fees	Yes	Yes	ESR	18.02.22	ESR	
Low	Jessica	Quirke	Consultant Clinical Neuropsychologist	Neuroscience	8c	Specialist Services	16.11.20	Yes	No	Rookwood Hospital	02920 313748	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	2008	Salary	Yes	Yes	Jessica Quirke	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Ella	Rafferty	Consultant Clinical Psychologist	Welsh Gender Service	Consultant	Medicine	16.03.22	Yes	No	St David's Hospital		Yes	Director of Raffery Psychology Ltd (Dormant Company)	Oct 13 - Ongoing	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed private practice	2011 - ongoing		Yes	Yes	Ella Rafferty	1.02.21	Yes	Secondary form sent 12.02.21
Low	Aled	Roberts	Clinical Board Director	Medical Consultant	Consultant	Medicine	19.11.20	Yes	Yes	UHW	42344	Yes	Co-Director SAGE Roberts PLC Co-Director SAGE Roberts PLC	2018 - ongoing 2018 - ongoing	dividend only (not taken this financial year)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Aled Roberts	19.11.20	Yes	
Low	Stuart Ashley	Roberts	Consultant Radiologist	Radiology	Consultant	CD&T	15.11.20	Yes	No	UHW	45207	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Whilst not a Trustee of the Intubation Box Charitable Trust, I was involved developing this protective device for COVID-19 staff protection. Charity Ref 7007662	21.04.20 - ongoing	Nil	Private Practice at Spire	1997 - Present	Fee per case payment	Yes	Yes	Stuart Ashley Roberts	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Debbie	Roberts	Health Visitor	Flying Start	7	Children & Women	15/10/2020	Yes	No	Eastmoors Road	029 2035 1375		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Volunteer with Breastfeeding Network and Volunteer on the National Breastfeeding helpline	2004 - ongoing	Reduced study costs	N/A	N/A	/A	Yes	Yes	Debbie Roberts	15/10/2020	Yes	
Low	Angus	Robertson	Consultant in Trauma and Orthopaedics	Trauma and Orthopaedics	Consultant	Surgery	25.01.21	Yes	No	UHW	7809839881	ESR	N/A	N/A	N/A	Managing Partner Cardiff Sports Orthtopaedics LLP	N/A	N/A	Occassional paid lecturing for Arthrex (Equipment Supplier) No recent activity - none currently planned	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Private Practice			Yes	Yes	Angus Robertson	25.01.21	Yes	Secondary work form sent 1.03.21
Low	Natalie	Robertson	Principal Physiotherapist in Mental Health	Physiotherapy		CD&T	13/10/2020	Yes	Yes	UHL	02921 824652	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Husband is Director of Operations for CD&T - Matthew Temby	01/12/2014 - Ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	Yes	Yes	Natalie Robertson	13/10/2020	Yes	
Low	Matthew	Rodd	Senior Clinical Perfusion Scientist	Perfusion	8a	Specialist Services	03.03.22	Yes	No	UHW		ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Second Employment with Assured Perfusion Services	2022 - Ongoing	Salary	Yes	Yes	ESR	03.03.22	ESR	
Low	Darren	Robinson	Registered Nurse	Addictions	7	Mental Health	8.01.21	Yes	No	UHW	2920744901	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trusteeship with Recovery Cymru	Jan-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Darren Robinson	8.01.21	Yes	
Low	Sheelagh	Rogers	Dental Consultant	Orthodontics		Surgery	24.11.20	Yes	No	UHW	42448	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Specialist Practitioner; Cathedral Orthodontics; Cathedral Road; Cardiff	N/A	N/A	Yes	Yes	Sheelagh Rogers	24.11.20	Yes	Secondary Work Form sent 3.12.20
Low	Clare	Rowntree	Consultant Haematologist	Haematology	Consultant	Specialist Services	28.01.21	Yes	No	UHW	42033	Not Ticked	N/A		N/A	N/A	N/A	N/A	Members of previous advisory Boards for Novartis and Amgen in past 3 years		Yes	N/A	N/A	N/A	Advisory role to Leukaemia Care		No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Clare Rowntree	28.01.21	Yes	Secondary form sent 11.02.21
Low	Rachel	Rushforth	Senior Nurse Education, Quality, Safety and Patient Experience	Mental Health	Not Known	Mental Health	03.03.22	Yes	No	Hafan Y Coed	02921 824617	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Associate Lecturer at the Open University	Jan 19 - Ongoing	Salary	Yes	Yes	Rachel Rushforth	03.03.22	Yes	
Low	Joanna	Rutkowska-Wheel	Specialist Occupational Therapist	neurology		CD&T	09.12.21	Yes	No	UHW	2920746809	Yes	No	N/A	N/A	No	N/A	N/A	I received an honoraria for presenting on a MS ACADEMY: Fatigue in MS webinar sponsorde by Novartis	22.11.21	22.11.21	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	Yes	Yes	Joann Rutkowska-Wheeldon	09.12.21	Yes	
Low	Ramsey	Sabit	Consultant Physician in General and Respiratory Medicine	Medicine	Consultant	Medicine	16.11.20	Yes	No	UHL		Yes	Director of Ramsey Sabit Ltd. This is a PLC for earnings from private practice Spouse is a fellow share holder and director for "Ramsey Sabit ltd"	23.05.18 - ongoing	share dividends in 2019 but not 2020	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for attendance at European Respiratory Society meeting by Chiesi (drug company) from 5/9/20 to 9/9/2020. Speaker fee meetings from Chiesi, TEVA and GSK (drug companies) for educational meetings for primary care. These were done outside working hours.		Payment for online registration at meeting	N/A	N/A	N/A	N/A	N/A	N/A	Outpatient private practice at Spire Hospital and Nuffield hospital	Aug 2014 - ongoing	Private Practice earnings are paid	Yes	Yes	Ramsey Sabit	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Seetal	Sall	POCT Lead	Laboratory Medicine	8a	CD&T	1.02.21	Yes	No	Ty Glas, Llanishen	45411	Yes	Yes	Jan 20 - Dec 20	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	S Sall	1.02.21	Yes	
	Annete	Schlaudrdaff	Consultant SRH	DoSH	Consultant	PCIC	3.02.21	Yes	No	CRI		Yes	N/A	N/A	N/A	N/A		N/A	DoSH ha sapplied fro for pharmaceutical funding for training and Waiting list reduction clinics from both Bayer plc and MSD succesfully. One such application that was approved was filed by myself			N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Annette Schuaudraff	3.02.21	Yes	Sponsorship form sent 12.02.21
Low	Stefan	Schwarz	Consultant Radiologist	CD&T	Consultant	CD&T	16.11.20	Yes	No	UHW	43042	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Practising privileges at SPIRE Hospital Cardiff, I also hold a honorary position at the University of Nottingham as a 'Clinical Associate Professor' since Nov 2016 for which I receive honoraria	Current	Honoraria	Yes	Yes	Stefan Schwarz	16.11.20	Yes	
	Jane	Scourfield	Speciality Doctor	CAMHS	Specialist	Mental Health	04.03.22	No	Yes			Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director APPERTA Foundation Charity	2019 - ongoing	No	No	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jane Scourfield	03.03.22	Yes	
Low	Prabhu	Sekaran	Consultant Paediatrician Surgeon	Child Health	Consultant	Children and Women	25.01.21	Yes	Yes	UHW		Not Ticked	Director - Novel Surgery	2019 - current	nil	N/A	N/A	N/A	Spouse shares in GlaxoSmithKine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertaken private practrice in the Spire, Cardiff	N/A	N/A	Yes	Yes	Prabhu Sekaran	25.01.21	Yes	Secondary Form sent 10.02.21
Low	Nimish	Shah	GP MHSOP	MHSOP	GP	Mental Health	25.01.21	Yes	No	UHL		Yes	Director Dr Nimish Shah Ltd	2016 - ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Nimish Shah	25.01.21	Yes	Secondary Form sent 10.02.21
Low	Swaroop	Shanbhag	Consultant Spinal Rehabilitation	Neurosciences	Consultant	Sepcialist Services	30.01.21	Yes	No	UHW	33800	Not Ticked	Abergavenny Hand Surgery Ltd - Director Partner - Vasudev Shanbhag	Mar-17	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Swaroop Shanbhag	30.01.21	Yes	
Low	Aarti	Sharma	Consultant	Obs & Gynae	Consultant	Children and Women	28.01.21	Yes	No	UHW	43758	Yes	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spire Hospital	Feb-18	Payment for seeing patients	Yes	Yes	Aarti Sharma	28.01.21	Yes	Secondary form sent 12.02.21
Low	Peter	Sharp	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	14.12.20	Yes	No	UHW	2921847089	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Consultant: Medtronic, Philips, Recor Medical, Penumbra	1.07.20 - ongoing	Speaker's and/or consultancy compensation for time	Research funding, Boston Scientific	1.10.20 - 2025	Executive committee recompense for time running study	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Andrew Sharp	14.12.20	Yes	Secondary form sent 5.1.20
Low	Timothy	Sheppard	Locum Consultant O&G	Obs & Gynae	Consultant	Children & Women	16.11.20	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Discussion and offer of employment in BPAS (not yet accepted, pending job planning)	2020	Sessional	203 Field Hospital, Army Reserve	1998 - Ongoing	Sessional / Daily Rate	Yes	Yes	Timothy Sheppard	14.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Hamsaraj	Shetty	Consultant Physician	Medicine Stroke	Consultant	Medicine	25.01.21	Yes	No	UHW	43837	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have received honoraria for GP lectures sponsored by Bayer on 7th October, 2020 and 28th January 2021) & from Portola/Alexion Pharmaceuticals for being a member of Delphi panel	6.10.20 - 19.10.	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Hamsaraj Shetty	25.01.21	Yes	Secondary Form sent 9.02.21
Low	Somashekara	Shivashankar	Consultant Psychiatrist	Adult Mental Health	Consultant	Mental Health	26.11.20	Yes	No	CRI	20335555	Yes	Director of a Limited company but have no actual or perceived conflict with the Health Board Spouse is also a Director of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019		Part ownership of a limited company but have no actual or perceived conflict with the Health Board Spouse is also a part owner of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Yes	Yes	Somashekara Shivashankar	26.11.20	Yes	
Low	Anju	Sinha	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children and Women	26.01.21	Yes	No	UHW	43238	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Cardiff Hospital	Ongoing	consultant fees charged	Yes	Yes	Anju Sinha	26.01.21	Yes	Secondary form sent 11.02.21
Low	Philip	Smith	Consultant Neurologist	Neuroscience	Consultant	Specialist Services	13.11.20	Yes	No	UHW	0292074 2834	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Co-Editor of BMJ journal, Practical Neurology (2011–present)	2011 - present	Honorarium	1. Chair of NICE Guidelines Panel on Heart Valve Disease 2. Member of NICE Guidelines Panel on Epilepsy	2019 - 2021	Nil	Member of GMC Tests of Competence Panel	2018 - present	ad hoc payment for specific tasks	Yes	Yes	Philip Smith	13.11.20	Yes	Secondary Work Form sent 25.11.20
Low	Alex	Speakman	PN Pharmacist	Pharmacy		CD&T	09/10/2020	Yes	No	UHW	02920 748109	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Offer of sponsorship to ESPEN nutrition conference from B.Braun, travel and conference fees, this was declined.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alex Speakman	09/10/2020	Yes	
Low	Sarah	Spencer	Deputy Head of Midwifery	Obs & Gynae	8b	Children & Women	4.12.20	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	Huntleigh Healthcare	2-14 - ongoing	£1,000	Yes	Yes	Sarah Spencer	4.12.20	Yes	Secondary form sent 2.12.20
Low	Pushplata	Srivastava	Speciality Doctor	Dermatology	Specialist	Medicine	21.03.22	Yes	Yes	UHW	2921845024	Yes	Cutis Consulting Ltd	Mar 19 - Ongoing	Dividends	Cutis Consulting Ltd	Mar 19 - Ongoing	Dividends	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	Clinical Lecturer Cardiff University 1 day per week	Apr 18 - Ongoing	Salary	Yes	Yes	Pushplata Srivastava	21.03.22	Yes	
Low	Mark	Stacey	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	16.11.20	Yes	No	UHL	2920716860	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board member of the Association of Anaesthetics	Oct 20 - Oct 24	Nil	N/A	N/A	N/A	I run a course called Medtrim - I occassionally run private courses	2017 - current	Yes	Yes	Yes	Mark Stacey	16.11.20	Yes	Secondary Work form sent 26.11.20
Low	Michael	Stechman	Consultant Surgeon	General Surgery	Consultant	Surgery	13.11.20	Yes	Yes	UHW		Yes	Director of KVMS Medical, Private Medical Practice Company Director of KVMS Medical, Private Medical Practice Company	June 2019 - present June 2019 - present	Dividends Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of the British Association of Endocrine and Thyroid Surgeons	October 2018 - Present	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michael Stechman	23.11.20	Yes	
Low	Emyr	Stephens	Prescribing Advisor	Pharmacy	8a	PCIC	25.01.21	Yes	No	Woodland House	36176	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I attended a Health Service Journal (HSJ) award dinner in London in Feb '20, as a project that I (and other C&V colleagues) was involved with was shortlisted for an award. This was in the category of 'Partnership working with the Industry', and so the company (LILL) paid for the dinner, accomodation	27.02.20 - 28.02.20	Attendance at awards event, accomodation and travel costs	N/A	N/A	N/A	I have taken part in an Advisory Board for various products over the last 10 years or so. These were all for 1 day only.	Various	Honoraria	N/A	N/A	N/A	Yes	Yes	Emyr Stephens	25.01.21	Yes	Secondary and Sponsorship forms sent 25.02.21
Low	Lawrence	Sunder Raj	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	25.01.21	Yes	Yes	UHW	44879	Yes	Yes Spouse Yes	6.01.19 - 18.02.20 18.02.20	Directors salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Cardiff Bay Hospital	N/A	N/A	Yes	Yes	Lawrence Sunder Raj	25.01.21	Yes	Secondary Form sent 10.02.21
Low	Indu	Thakur	Consultant Paediatric Oncologist	Child Health	Consultant	Children and Women	2.11.20	Yes	No	UHW	7533167483	ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I was given a sponsorship place on a Haematology update conference by Novartis amounting to registration and stay costs of £269.20		Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Indu Thakur	2.11.20	Yes	Sponsorship form sent 1.03.21
Low	Abraham David	Theron	Consultant Anaesthetist, CD Perioperative Care	Anaesthetics	Consultant	Surgery	13.11.20	Yes	No	UHW	43256	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	As Chair of the Royal College of Anaesthetist Welsh Advisory Board I am a co-opted member of college council. I am also Vice Chair of the Academy of Medical Royal Colleges of Wales	N/A		Executive Member of the Welsh Medical Committee. Part od the clinical reference group of the National Clinical Framework.	N/A	N/A	I have co-edited the Oxford Handbook of Obstetric Anaesthetsia for Oxford University Press. Royalties for this book is to be donated to SAFE Africa.	N/A	N/A	Yes	Yes	Abrie Theron	13.11.20	Yes	
Low	Lena	Thia	Consultant in Paediatric Respiratory Medicine	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43530	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honorarium for speaking to nurses on asthma sponsored by AstraZeneca. Honorarium for speaking at two webinars sponsored by Vertex	13.02.20 - 1.10.20	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Lena Thia	13.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Benny	Thomas	Consultant Neurophysiologist	Neuroscience	Consultant	CD&T	27.01.21	Yes	No		46690	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private Practice	2002 - Present	Reimbursement of fees	Yes	Yes		25.01.21	Yes	Secondary Employment Form and Policy sent 28.01.21
Low	Christopher	Thomas	Consultant Physician	Clinical Gerontology	Consultant	Medicine	25.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Previous sponsorship to attend international conferences and honoraria for teaching from pharmaceutical agencies (BIAL, GSK, Abbvie, Britannia) on various occasions between 2009 and 2019. I also sat on expert advisory panel for GSK for one day in approx 2012	2009 - 2019	Honori & Sponsorship	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Christopher Thomas	25.01.21	Yes	
Low	David Hywel	Thomas	Consultant Histopathologist	Histopathology	Consultant	CD&T	01.12.20	Yes	No	UHW	45316	Yes	Co-director of company to provide autopsy service for HM Coroner My wife is a co-director of the company	March 20 - ongoing March 20 - ongoing	payment from HM Coroner per autopsy salary from company	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Thomas	1.12.20	Yes	Secondary Work Form sent 3.12.20
Low	Gareth	Thomas	Consultant in Gastroenterology	Gastroenterology	Consultant	Medicine		Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Underake 1 session private work per week in uncontracted time	2001 - current		Yes	Yes	Gareth Thomas		Yes	Secondary Work Form sent 25.11.20
Low	Mary Annette	Thomas	Director Weqas	Weqas	8d	CD&T	17.12.20	Yes	No	Llanishen	48332	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Becton Dickinson - European Advisory Board member for Point of Care. Provided Advice and attended meetings. Invited Speaker at Siemens Healthineers meeting in Bangkok in 2019 and Brussels Oct 2018. Invited speaker at Nova Biomedical User Group meetings in Manchester and London November 2019	Aug 18 - current	Received travel expenses to attend meeting in London 2018, Aberdeen in 2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mary Thomas	17.12.20	Yes	Secondary form sent 6.1.20
Low	Matthew	Thomas	Consultant Restorative Dentistry	Dental	Consultant	Surgery	26.11.20	Yes	No	UHW	42519	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	West Coast Dental Care - Self employed private practice	ongoing		Yes	Yes	Matthew Thomas	26.11.20`	Yes	Secondary Work form sent 4.12.20
Low	Nerys	Thomas	Radiographer	Radiology	8b	CD&T	03.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PHW Ultrasound Adviser. 10 sessions per annum paid to radiology dept. No personal financial gain		none	Yes	Yes	ESR	03.03.22	ESR	
Low	Rhian	Thomas	Independent Member of the Board	Executive / Corporate		Executive / Corporate	28.01.21	Yes	No	Woodland House		Yes	N/A	N/A	N/A	Owner of consultancy business	01.03.19 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Glas Cymru Cyf (Welsh Water) Co-opted Board Director of Cardiff & Vale Credit Union	01.10.19 - present 15.05.20 - present	Voluntary Voluntary	Senior Lecturer - University of South Wales	04.05.20 - ongoing		Yes	Yes	Rhian Thomas	28.01.21	Yes	
Low	Andrew	Thompson	Psychologist	Whit Psychology Training	9	Mental Health	02.10.20	Yes	No			Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Trustee for the charity Changing Faces, also member of research board for The Vitiligo Society. Occasional spokesperson for The British Psychological Society, The British Skin Foundation, The British Association of Dermatologists. All are unpaid occasional activities	Oct 20 - Ongoing	Nil	No	N/A	Nil	Occassional clinical psychology private practice (registered with HMRC as a sole trader) - medico-legal reports, invited talks/workshops, occassional psychological therapy	Oct 20 - Ongoing	Yes	Yes	Yes	Andrew Thompson	02.10.20	ESR	
Medium	Jared	Torkington	Consultant	General Surgery	Consultant	Surgery	12.11.20	Yes	Yes	UHW	44158	Yes	Director - Moondance Cancer Initiative Wife is a director of Cardiff Medical Events Ltd- a company that organises meeetings and conferences	2020 - 2019 -	N/A	N/A	N/A	N/A	Shareholding in Alessi Surgical Instruments - spinout from Cardiff University. Also act as a chair of medical advisory board	2015 -	N/A	Consultancy to a trial management team from Medtronic Ltd for scientific study	2020	Consultancy	Medical Advisory Board Bowel Cancer UK Charity	2017 -	N/A	N/A	N/A	N/A	Private Practice at Spire	current	Salary	Yes	Yes	Jared Torkington	12.11.20	Yes	Secondary Form sent 26.01.21
Low	Ryan	Trickett	Consultant Head Surgeon	T&O	Consultant	Surgery	12.11.20	Yes	Yes	UHL	25234		Director: Vale Hand Surgery (Private Practice) & Dragon Locums Spouse - Director: Vale Hand Surgery & Cardiff NHS GP Partner		salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member BSSH, BOA, BMA Spouse: Member BMA, RCGP	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ryan Trickett	12.11.20	Yes	
Low	David	Tuthill	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes		UHW	46725	Yes	Director Cardiff Paediatrics Partner: Director Cardiff Paediatrics	ongoing ongoing	Dividends	N/A	N/A	N/A	I am chair of the Paediatric formulary committee of the BNF. I have advised the company AI Immune on Palforzia.	2021	Fee paid	Organiser of the South Wales Paediatric Allergy Forum (in Cardiff) - aannually over the last 10 years. This meeting has been sponsored by a variety of pharmaceutical companies	2012 - Ongoing	N/A	I am a boiard member of Medicines for Children	2008-Onwards	Nil	Cub Scout Leader	2008-Onwards	N/A	N/A	N/A	N/A	Yes	Yes	David Tuthill	05.03.22	Yes	
Low	John	Union	Independent Member of the Board	Executives / Corporate	Executive	Executive	23.02.21	Yes	No	Woodland House		Yes	NED, Swansea Building Society Ignious Ltd (Subsidiary of Cadwyn Housing) Cardiff Business Club Ltd	1.11.17 - ongoing 1.1.20 - ongoing 1.1.20 - ongoing	Salary No salary No salary	John Union Ltd	1.4.16 - ongoing	No Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board Member/Vice Chair Cadwyn Housing Ltd Board member, Cambria Cudfuddiannol Ltd (Will step down shortly)	1.1.20 - ongoing 1.1.10 - ongoing	No salary No Salary	N/A	N/A	N/A	Yes	Yes	John Union	23.02.21	Yes	
Low	Stephen	Usher	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Consultant	Surgery	16.03.22	Yes	No	UHW	2920743107	Yes	No	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private Practice at Spire Hospitals	Mar 22 - Ongoing	Fees	Yes	Yes	Stephen Usher	16.03.22	Yes	
Low	Vinod	Varghese	Consultant Clinical Geneticist	AWMGS	Consultant	AWMGS	7.12.20	Yes	Yes	UHW	43976	Yes	One of the directors of a ltd complany - Apps4Medics Ltd. Not linked to NHS or Cardiff & Vale UHB	11.01.2011 - ongoing Spouse - 11.01.21	Both have shares	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Vinod Varghese	7.12.20	Yes	
Low	Andrew	Vidgen	Consultant Psychologist	Mental Health	8c	Mental Health	15.04.20	Yes	No	Whitchurch Hospital	2921832610	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	private medico-legal work. Approximately 1.5 sessions / month outside normal working hours. Undertaken in Gwent area	Apr-17		Yes	Yes	Andrew Vidgen	12.11.20	Yes	
	Andrew	Vidgen	Consultant Clinical Psychologist	Applied Psychology	8d	Mental Health	04.03.22	Yes	No			Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private medico-legal work. Approx 1.5 sessions mper month. Undertaken in Gwent area	2022 - Ongoing	Fees	Yes	Yes	Andrew Vidgen	08.03.22	ESR	
Low	Karen	Visser	Professional UHB Lead for Speech & Language	Community Child Health	8c	Children and Women	17.11.20	Yes	No	Riverside Health Centre	029 2183 6585	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Community Music Wales	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Karen Visser	17.11.20	Yes	Secondary form sent 5.1.20
Low	Ulrich	Von Oppell	Consultant Cardiac Surgeon	Cardiac Services	Consultant	Specialist Services	16.11.20	Yes	No	UHW	45078	Yes	Director - U & C Von Uppell Ltd	Mar-10	Private Practice	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ulrich Von Oppell	16.11.20	Yes	
Low	Amar	Wahid	Consultant Paeds Gastroenterology	Paediatric Gastroenterology	Consultant	Children and Women	26.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Secretary for Private Practice	November - ongoing November - ongoing	Salary Salary	Yes	Yes	Anwar Wahid	26.01.21	Yes	Secondary form sent 11.02.21
Low	Fiona	Walker	Head of Prescribing	Cardiff North and West Locality	8c	PCIC	12.11.20	Yes	No	Woodland House	7812554527	ESR	N/A	N/A	N/A	N/A	N/A	N/A	I am a NICE Medicines and Prescribing Associate. This is a role that does not attract a salary or any payment. I am standing down from this role at the end of 2020.		Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	Yes	Fiona Walker	12.11.20	Yes	
Low	Ruth	Walker	Executive Nurse Director	Executive	VSM	Executive	13.11.20	Yes	No	Woodland House	36006	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member of the Nursing and Midwifery Council	2016 - ongoing	salary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ruth Walker	13.11.20	Yes	Secondary Work Form sent 25.11.20
Medium	Stuart	Walker	Executive Medical Director	Executive	VSM	Executive	30.09.20	Yes	Yes	UHW	2921836001	Yes	Sister - Gilead employee, Father ILC CEO (both healthcare companies we may have relationships with)	N/A	risk of direct influence				see above re. sister/father - Gilead and ILC are pharma companies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	N/A	N/A	N	Yes	Yes	Stuart Walker	30.09.20	Yes	
Low	Mark	Wardle	Consultant Neurologist	Neurology	Consultant	Specialist Services	09.11.21	Yes	No	UHW	44016	Yes	ELDRIX	21.05.14 - ongoing	Company Director- Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Wardle	09.11.21	Yes	
Low	Peter	Welsh	Senior Hospital General Manager Llandough/Barry	Executives / Corporate	VSM	Executive	17.11.20	Yes	Yes	UHL	20715698	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Magistrate - Cardiff Bench	1989 - ongoing	N/A	N/A	N/A	N/A	Wife - Optician for Roberts Opticians Whitchurch Road, Cardiff Son has own web design business	1985 - ongoing 2014 - ongoing		Yes	Yes	Peter Welsh	17.11.20	Yes	
Low	Simon	White	Consultant Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	12.11.20	Yes	No	UHW	48044	Yes	Director, Simon P White Ltd	2008 - Present	Nil	N/A	N/A	N/A	Educational contract with Zimmer Biomet	2018 - present	Paid to lecture in annual leave	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Simon Paul White	12.11.20	Yes	
Low	Kathrin	Whitehouse	Consultant Neurosurgeon	Neurosurgery	Consultant	Specialist Services	01.10.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member for British Neurological Surgeons	N/A	N/A	N/A	N/A	N/A	Neurosurgical Tutor for online MSc with Learna LTD	Jan 22-Ongoing	Fees	Yes	Yes	ESR	01.10.21	ESR	
Low	Joy	Whitlock	Head of Quality and Safety Improvement	Patient Safety and Quality Improver	8b	Corporate Nursing	23.11.20	Yes	No	Woodland House	36311	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sole trader of Joy Whitlock Coaching and Business Development www.joywhitlock.co.uk . Since I work part time for the UHB there will not be conflict with NHS duties. I'm declaring this, however, in the name of transparency.	2016 - ongoing	Hourly fee as work arises. Mostly pro bono	Yes	Yes	Joy Whitlock	23.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Richard	Whitson	Consultant Vascular Surgeon	General Surgery		Surgery	14/10/2020	Yes	No	UHW	Ext 43356	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Haven Homecare	2010 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Whiston	14/10/2020	Yes	
Low	Lauren	Whittington	Clinical Psychologist	CAMHS	8+	Children and Women	3.12.20	Yes	No	St David's Hospital	36730	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I currently work 1 session a week for Oxford Health NHS Foundation Trust as a clinical psychologist	27.11.20 - current	Salary as sessional worker	Yes	Yes	Laura Whittington	3.12.20	Yes	Secondary Employmet Form and Policy sent 3.02.21
Low	Simon	Wilkins	Associate Editor Pharmacist	Therapeutics & Toxicology	8b	CD&T	1.02.21	Yes	No	UHL	26868	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secondment (0.4FTE) to, and employment (0.2FTE) by, Cardiff University School of Medicine as a Senior Lecturer and Programme Director of two MSc programmes	2006	Salary	Yes	Yes	Simon Wilkins	1.02.21	Yes	Secondary form sent 12.02.21
Low	Ian	Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital		Children & Women	08/10/2020	Yes	No	St David's Hospital	2920536789	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Tutoring with the Open University - Nursing	01/10/2020	Salary	Yes	Yes	Ian Williams	01/10/2020	Yes	
Low	Paul	Williams	Principal Clinical Scientist	Therapies and Health Science	8b	CD&T	3.02.21	Yes	No	UHW	42010	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	25.10.20 - 31.10.20	One off payment	Yes	Yes	Paul Williams	3.02.21	Yes	Secondary form sent 12.02.21
Low	Claire	Wilson	Consultant Clinical Psychologist	Neuropsychology	8c	Specialist Services	13.09.21	Yes	No	UHW	029 2074 3224	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am a partner at Positive Neuro Rehab. I work as a Consultant Clinical Neuropsychologist with people who present with neurological conditions either privately or as part of a medicolegal claim. I conduct this work outside of my NHS contracted hours. I do not take on any patients where there is a conflict of interests (e.g. on my NHS waitinglist, a previous patient, or someone who might be referred to me, or	Sep 21 - Ongoing	Yes	Yes	Yes	Claire Willson	13.09.21	ESR	Secondary Employment Form sent 18.10.21
Low	Justyna	Witczak	Consultant Physician	Medicine	Consultant	Medicine	12.11.20	Yes	No	UHW	42341	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes. I received travel grants and honoraria for talks from the following companies: Napp, Boehringer-Ingelheim, Novo-Nordisk	Nov 19 - Ongoing	Travel grants/honoraria for talks/lectures	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Justyna Witczak	12.11.20	Yes	
Low	Joon	Wong	Specialty Doctor in Paediatric Cardiology	Child Health	8+	Children & Women	13.11.20	Yes	No	Childrens Hospital for wales	02920 744743	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Employed by Independent General Practice Cardiff on	Oct 2017 - ongoing	Fees	Yes	Yes	Joon Wong	13.11.20	Yes	
Low	Andrew	Wood	Consultant	Radiology	Consultant	CD&T	11.03.22	Yes	Yes	UHW	3955	Yes	N/A	N/A	N/A	Wife has a private garden design business (Eileen Garden Landscapes): currently working on the 'Orchard' project at Llandough	2008	Ongoing	N/A	N/A	N/A	Occassional Lecturing Honoraria	Last date 2016	Fees	Treasurer - Heart Research Fund Wales	2000 - Ongoing	N/A	N/A	N/A	N/A	Private Medico-Legal Cases	Current	Fees	Yes	Yes	D Andrew M Wood	12.11.20	Yes	
Low	Karen	Wright	Clinical Endoscopist	Gastroenterology		Medicine	16.03.22	Yes	No	UHL	2921926688	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Agency work in off duty time for an insourcing company	2020 - Ongoing	payments	Yes	Yes	Karen Wright	16.03.22	Yes	
Low	Meinolfus	Wulf	Consultant Anaethesia	Perioperative Care / Anaesthetics	Consultant	Surgery	1.02.21	Yes	No	UHL	26660	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Research Cooperation (History of Technology): Draeger Company, Luebeck, Germany & Wood Library Museum, Schaumburg, ILL, USA	2001/2015 - ongoing	No	Occasional sponsorship of conference and travel expenses	2001 - ongoing	nil recent	N/A	N/A	N/A	Welsh Medical Committee (Member)	2018 - 2021	No	N/A	N/A	N/A	Yes	Yes	Meinofus Tratling	1.02.21	Yes	
Medium	Zaheer	Yousef	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	18.11.20	Yes	No	UHW	42972	Yes	ZY Consultant Ltd - Director	31.07.19 - ongoing	Shareholder: ad hoc dividend payments (nil to date)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chairman: Heart Research Wales and Medical Director Pace4Life	2015 - ongoing	N/A	N/A	N/A	N/A	In receipt of honoraria, lecture fees and research funding from Astra Zeneca, Pfizer, Servier, Beoringer Ingelheim, Bristol Meyers Squibb, Lilly, Novartis, Abbott, Medtronic . Undertake private practice at Spire Hospital and Nuffield Healthcare and provide sports cardiology screening services to elite athletes (e.g. Cardiff City football club, Swansea Football club, Football Association of Wales, Welsh Rugby Union,	2005 - ongoing	Yes	Yes	Yes	Zaheer Yousef	18.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Syeda	Zatman	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	25.01.21	Yes	No	UHW	43106	Yes	Brockweir Clinic Ltd	Apr-19	Nil	Brockweir Clinic Ltd	Apr-19	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tahsin Zatman	25.01.21	Yes	

Report Title:	Regulatory Compliance Tracking Report			Agenda Item no.	8.2
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	05.04.2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

The purpose of this report is to provide Members of the Audit and Assurance Committee ('the Committee') with assurance on the implementation of recommendations which have been made by external regulatory and legislative bodies, of which the Health Board is obliged to comply with. Assurance in this regard if provided by means of a Legislative and Regulatory Compliance Tracking report.

An internal audit into the Corporate Governance Legislative and Regulatory Compliance Tracker was undertaken during July and August 2021. The outcome of that audit, provided an agreed 'reasonable' assurance rating.

Only 1 recommendation from this Audit remains on the Health Board's Internal Audit Tracker. This relates to the management of Welsh Health Circulars and will be reported as complete within the Internal Audit Paper reported at this Committee Meeting (Please see agenda Item 8.4 for additional detail).

Following the implementation of recommended best practice work has continued to refine and improve the content of the Legislative and Regulatory Compliance tracker so that it provides more robust assurance to Committee members. Most notably, this covering report continues to include commentary on the Health Boards management of Welsh Health Circulars and Patient Safety Solutions: Alerts and Notices which will continue to be reported as a matter of course.

Whilst progress has been made additional work remains ongoing to ensure that the feedback shared by recommendation owners and shared with the Committee is provided in a consistent and easy to read manner across each of the trackers shared with the Committee.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The tracker provides the following details:

- All Regulatory Bodies that have active recommendations with the Health Board. Also contained within the tracker are the details of Regulatory Bodies that have previously inspected the Health Board despite there being no live recommendations. This is to ensure that the tracker remains a comprehensive list of all potential regulatory bodies.
- The Regulatory Standard which is being inspected is listed where this information is available.
- The Lead Executive in each case is detailed as is the accountable operational lead so that it is clear who is responsible for completion of the recommendation at an executive and operational level.
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection. This column, coupled with the comments section,

provides assurance to the Committee that progress against and compliance with recommendations is being routinely monitored and scrutinised.

- A Red, Amber, Green (RAG) rating that highlights where the recommendation sits against the agreed implementation date. Entries are rag rates as follows:

Green – Over 1 month until due date for implementation of recommendation
Amber – Due date for implementation of recommendation within 1 month; and
Red – Due date for implementation of recommendation met or exceeded.

In addition to the above the below updates are also shared in relation to the Health Board's Management of Welsh Health Circulars (WHCs) and Patient Safety Solutions: Alerts and Notices (PSN's). Separate Tracker documents are held for the monitoring of WHC's and PSN'S and are managed by the Risk and Regulation and Patient Safety teams respectively.

An extract from the WHC tracker is copied below as an example of the information recorded:

Welsh Health Circular (WHC) No	Name of WHC	Date Issued	Status	Action Needed By	Category	Overarching Actions Required	Lead Executive	Work in Progress	Work Completed	Status RAG Rated: Blue Complete; Green On track to Meet deliner; Red	Comments
2021f006	Elections to Senedd Cymru May 2021 Guidance for NHS Wales	11.03.21	Action	24.03.21	Governance	The principles set out in the guidance apply to the NHS at all times, but particular note should be taken in the period between the start of the formal campaign on 25 March and up to and including polling day 6 May.Chief Executives of NHS organisations should ensure that the principles in this guidance are followed.	CEO		Yes		Guidance shared with CEO and Chair and Board Secretary and referred to in various meetings where discussions or decisions could be election relevant.

A regular update on progress made against WHC recommendations is reported at Management Executive Meetings so that the full Executive Team is sighted on the most recently issued WHC's and progress made against each circular. An update was last shared with the Management Executive Team on the 28th March 2022. Since the February 2022 Committee meeting the following Circular has been added to the tracker and triaged to executive colleagues for action.

Recording of Dementia Read Codes: https://gov.wales/recording-dementia-read-codes-whc2022007

As of the 23.03.2022 the Health Board's WHC tracker was fully up to date and each WHC detailed on the Welsh Government website had been allocated to an Executive Lead to monitor and action.

Patient Safety Solutions: Alerts and Notices

PSN's are monitored and managed by the Patient Safety and Organisational Learning Manager ("PSOLM") who maintains a tracker of all PSN's that are received and ensures that each PSN is shared with relevant clinical and corporate directorates for action. The PSOLM also regularly chases colleagues to ensure that actions are undertaken and reported through the use of compliance forms which record completion of required actions. Once a PSN is recorded as complete the PSOLM notifies the relevant Welsh Government delivery Unit and copies of all such notifications and completed compliance forms are logged by the PSOLM and the Risk and Regulation Team.

An extract from the PSN Tracker is copied below.

Document Numbe	Notice	Type of Documen	Status	Date PS Team Notified	Date sent to Distributionl ist	Date Responses Due	Date Compliance Declare	CW	Medicine	CD&T	MH	PCIC	Spec Servic	Surgery	Dental	Corporat
PSN062	https://gov.wales/files/notices/psn062-liguefie	Patient Safety Notic	Active	04/10/2021	04/10/2021	25/02/2022		15/10/2021	05/10/2021	08/10/2021		11/10/2021		14/10/2021	11/10/2021	
PSN057	Patient Safety Notices\PSN057 Adrenal Crisis\PSN0	Patient Safety Notic	Active	28/05/2021	28/05/2021	31/01/2022		21/06/2021	01/06/2021	01/06/2021		02/06/2021	30/09/2021			

An update on progress made against PSN's was shared at the December 2021 Quality, Safety and Experience Committee for further scrutiny.

As of 21st March 2022 there were 18 Active PSN's, of which 12 are overdue. These entries will continue to be monitored and will be subject to further scrutiny at local quality and safety meetings and also at future Quality, Safety and Experience Committee meetings.

Regulatory Tracker

The Regulatory Tracker attached to this report is up to date as of the 23rd March 2022 and will continue to be updated throughout the organisation and reported to the Committee on a bi-monthly basis as well as being reported to Management Executive meetings for executive oversight.

Following February's Committee Meeting a total of 7 completed entries were removed from the register. A further 4 entries have been reported as complete (2 of which sit within the Capital and Estates entry within the Tracker) since February's meeting and are recorded on the attached tracker.

Since February's meeting no additional entries have been added to the register however work remains ongoing in relations to recommendations made by the All Wales Toxicology Centre which may feature at the June Committee meeting.

The improvements made to the tracker and the ongoing review of progress against regulatory body inspections and recommendations should reduce the risk that key regulatory requirements are missed.

The procedure for tracking such progress will also enable the Committee and Board to have oversight of the Health Board's compliance with regulatory requirements so that appropriate action can be taken to address emerging trends.

Recommendation:

The Committee are requested to:

(a) Approve the assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations.
(b) To note the continuing development of the Legislative and Regulatory Compliance Tracker.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Mohamed,Sarah
03/28/2022 16:21:28

Clinical Board	Directorate	Regulatory body/inspector	Service area	Initial - Inspection Date:	Title of Inspection/Regulation/Standards	Lead Executive	Assurance Committee or Group	Accountable individual	Next Inspection Date	Recommendation Narrative / Inspection outcome	Date for Implementation of recommendations:	Management Response / Update	RAG Rating	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES THERAPEUTICS AND TOXICOLOGY CENTRE														
ALL WALES QUALITY ASSURANCE PHARMACY														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	27.01.2020	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	TBC	166 actions update 21/5/21 - 16 overdue actions remain update 8/10/21 - 4 overdue actions remain	15.07.2021	Pharmacy Quality System recovery action plan developed and under weekly review by the Clinical Board. 5 oldest incidents, non-conformances and change controls now closed. Awaiting April audit. Delayed due to implementation of PN compounder and Well sky projects to April 2022.		**PC**
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	06.08.2020	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	TBC	91 actions update 21/5/21 - 4 overdue actions remain update 8/10/21 - 4 overdue actions remain	15.07.2021	4 overdue actions remain. Work remains ongoing within the clinical board to ensure that these are closed as soon as possible. **Update shared at assurance committee on the 04/01/2022.**		**PC**
BRITISH STANDARDS INSTITUTE														
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
CAPITAL EXPENDITURE INTERNAL REVIEW														
Estates	Estates Management and Finance	Internal	Procurement Arrangements	01.09.2021	Internal Review	Executive Director of Finance	Finance Committee	**Director of Capital Facilities and Estates**	N/A	A total of 21 recommendations were made concerning the governance and contracting arrangements regarding Procurement Processes within the Capital, Estates and Facilities Directorate.	31.12.2021	Of the 21 recommendations 20 are recorded as complete. The remaining action, which relates to the review of contract documents is nearing completion as the CEF team await final documents from appointed solicitors.		**PC**
COMMUNITY HEALTH COUNCIL														
FIRE AND RESCUE SERVICES														
Mental Health	Capital and Asset Management	Fire and Rescue Services	Hafan Y Coed UHL	20.07.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	10/12/2021	Duty of Works: EN01 - (EN3/21) Article 8 - Duty to take general fire precaution's is not being complied with EN3/21 Schedule states: "During the inspection carried out on 14th April 2021 there was evidence of illicit smoking found throughout the premises. These matters have previously been raised by this Authority and also within previous FRA's carried out by the UHB fire safety advisor. This is unacceptable. The UBN's smoking policy should be appropriately managed to ensure that smoking and ignition sources are controlled and monitored to reduce the potential for accidental and deliberate fire setting."	10.12.2021	Robust control measures have been agreed and implemented between the Director of CEF and senior premises managers. This has been communicated to the enforcing authority. A further inspection was carried out on 20th May by the enforcing authority and due to a number of non compliances found at that time an EN 03 was served i.e. ' Enforcement Notice not complied with'. This matter is now in the hands of the Fire Authority's Compliance team for deliberation. N.B. An Article 27 letter dated 15th September 2021 was served on the CEO requiring pertinent information to be forwarded to the Fire Authority within 14 days of the date of the letter. Information the Authority require is 1.Copies of contract of employment for employees employed to work in the premises on 20th May 2021 2.Copies of all fire risk assessments in force on 20th May 2021 3.Copies of all maintenance and testing of physical fire precautions from 21st April to 31st August 2021 4.The person managing the smoking policy between 21st April to 31st August 2021 5.Copies of paperwork detailing the UHB's smoking policy between 21st April to 31st August 2021		**PC**
Medicine	Capital and Asset Management /UHW - Ward A4	Fire and Rescue Services	UHW Ward A4	29.09.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	06.04.2022	Duty of Works: EN59/21 - Article 8: Duty to take general fire precautions Article 13: Fire fighting and fire detection Article 15: Procedures for Serious and Imminent Danger and for Danger Areas Arcile 21: Training	06.04.2022	Measures have been agreed with and implemented by senior managers in Estates. This has been verbally communicated to the enforcing authority inspector. Communication with the Fire Authority remains ongoing - A request for an extension of time to comply has been shared with the Fire Authority.		**PC**
Mental Health	Capital and Asset Management /HYC UHL	Fire and Rescue Services	Hafan Y Coed UHL	20.06.2021 and 29.09.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	Unknown	Article 27: 5 actions urgently required	06.04.2022	EN59/21 dated 8th October 2021 was served on the CEO outlining a number of contraventions under the following articles to be addressed by 06/04/2022 i.e. Article 8 Duty to take general fire precautions. Article 13 Fire Fighting and Fire Detection. Article 15 Procedures for Serious and Imminent Danger and for Danger Areas. Article 21 Training. Required Actions Complete		**C**
HEALTH EDUCATION AND IMPROVEMENT WALES														
HEALTH INSPECTORATE WALES														

Children & Women	Maternity	HIW	Maternity Services	TBC	HIW	Executive Nurse Director	QSE Committee	Head of Midwifery	**TBC - Matter on Hold**	HIW are undertaking a national review of maternity services across Wales (Phase 2). **Letter recevied 13/1/21 from HIW Phase 2 on hold.**	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.	On hold. An update on all HIW inspections are shared at each Quality, Safety and Experience Committee. Updates were last shared at the June QSE Committee. No update since November's meeting.	**N/A**
Mental Health	Community Mental health	HIW	Community Mental Health	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing for Mental health Services	**TBC**	National Review of Mental Health Crisis prevetnion in the Community	**N/A**	The terms of reference have been published by HIW and the final report was due to be published in December 2021 and is awaited.	**PC**
HEALTH AND SAFETY EXECUTIVE													
HUMAN TISSUE AUTHORITY													
INFORMATION COMMISSIONERS OFFICE													
Digital Health Intelligence	IM&T and Information Governance	ICO	Digital Health	13.03.2020	ICO Data Protection Audit	Director of Digital Health	Digital and Health Intelligence Committee	Head of Information Governance	TBC	25 recommendations were made in relation to Governance and Accountability. 1 of these recommendations required urgent action, 14 were rated high, 7 medium and 3 low. 20 recommendations were made in relation to Cyber Security. 1 of these recommendations required urgent action, 9 were rated high, 9 medium and 1 low. An overall assurance rating of reasonable was achieved in both areas.	25.10.2021	9 of the 25 recommendations made by the ICO remain outstanding. The ICO undertook a follow up investigation in November 2021 and concluded that there was still a risk of non-compliance with data protection legislation and recommended urgent action tto complete outstanding recommendations. An update was shared at the February Digital Health and Information Committee in February 2022.	**PC**
JOINT EDUCATION ACCREDIATION COMMITTEE													
Specialist Services	Haematology	JACIE	South Wales BMT Programme	TBC	6th edition of JACIE standards	Executive Director of Medicine	QSE Committee	Executive Director of Medicine	01.02.2023	Minor deficiencies noted	01.10.2019	Programme received formal re-accredition notice - There are ongoing discussions with the executive board regarding a new facility for BMT/Haematology as the service will not achieve re-accredition post the next inspection cycle. **No update since November 2021**	**PC**
MEDICAL GENETICS													
MHRA													
CD&T	Pharmacy	MHRA	Pharmacy UHL	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	3 majors 2 others	31.03.2020	Descalated from MHRA Inspection Action Group 1st July 2020 Outstanding Estates issues to resolve to meet requirements of the regulator	**PC**
NATURAL RESOURCES WALES													
OFFICE FOR NUCLEAR REGULATION													
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES													
RESEARCH AND DEVELOPMENT													
UKAS													
Surgery	Perioperative	SGS/UKAS	HSDU	15.07.2021	ISO 13485:2016	Executive Director of Therapies and Health Science	QSE Committee	Executive Director of Therapies and Health Science	N/A	2 minors	15.07.2022	Re-validation. Audit Minor 1, was for audit of audits. We should have someone independent from HSDU to audit our audits, SSU Llandough will Audit HSDU and we will audit SSU. Update, Llandough SSU has audited UHW HSDU. HSDU are in the process of auditing SSU Llandough. all working instuctions have been ammended for future use and audits. Minor 2, not currently registered to MHRA. Update, HSDU is in the application process. update, HSDU are now registered to MHRA. all evidence of both minors has been compilled and ready to be closed out at the next audit	c
WELSH WATER													
WSAC													
Surgery	Audiology	WSAC	Newborn hearing screeing wales	04.11.2021	Audiology / Newborn Hearing Screening QS	Executive Director of Therapies and Health Science	QSE Committee	Paediatric Cochlear Implant Lead - Razun Miah/Rhian Hughes/Ellen Thomas	01.11.2021	Results awaited.	31.01.2022	Results have not yet been released by PHW.	**NA**
Surgery	Audiology	WSAC	audiology - paediatrics	04.11.2021	Audiology / Paediatric QS	Executive Director of Therapies and Health Science	QSE Committee	Paediatric Cochlear Implant Lead - Razun Miah/Rhian Hughes/Ellen Thomas	01.11.2021	85% target met in individual standards and 90% overall target met - 95.22% overall compliance score achieved	31.01.2022	5 recommendations made relating to Standards, 1a.3, 2a.8, 3a.5 &3a.6, 6a.1 and 7b.1. All recommendations are reported as partially complete with action plans in place.	**PC**

WEST MIDLANDS QRS															

Report Title:	Audit Wales Recommendation Tracking Report				Agenda Item no.	8.3	
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	05/04/2022	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Audit Wales by means of an external audit recommendation tracking report ("the Tracker").

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Twenty External Audit Recommendations are recorded on the Tracker, 11 of which have been brought forward from February's Audit and Assurance Committee ("the Committee"). Nine additional recommendations have been added to the Tracker since February's Committee meeting.

Of those additional nine entries:

1) Six recommendations relate to the Taking Care of Carers report shared at the February Committee meeting;
2) One recommendation relates to the Radiology Services: Update on Progress Report shared in February; and
3) Two recommendations relate to the Structured Assessment 2021 (Phase 2) Report shared in February.

All of the 20 recommendations recorded on the Tracker are recorded as partially complete.

The status of the recommendations are as follows:

- Two recommendations are over 12 months overdue.
- Two recommendations are over 6 months overdue (but less that 12).
- One recommendation is over three months overdue
- Seven recommendations are less than 3 months overdue; and
- 9 of the recommendations are on target to be completed within the agreed implementation date.

A review of all outstanding recommendations has been undertaken with executive and operational leads for each recommendation since February 2022. This work will continue and be reported at each Audit and Assurance Committee to provide regular updates in the movement of recommendations.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken during the years **2019/20, 2020/21** and **2021/22** as at 21st March 2022.

This report and appendices will also be discussed at Management Executive meetings so that the leadership team of the Health Board have an overview of progress made against External Audit Recommendations.

Recommendation:

The Committee are requested to:

(a) Note and receive assurance from the progress which has been made in relation to the completion of Audit Wales recommendations.
(b) To note the continuing development of the Audit Wales Recommendation Tracker.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No
N/A

Safety: Yes/No
N/A

Financial: Yes/No
N/A

Workforce: Yes/No
N/A

Legal: Yes/No
N/A

Reputational: Yes/No
N/A

Socio Economic: Yes/No
N/A

Equality and Health: Yes/No
N/A

Decarbonisation: Yes/No
N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
N/A	N/A

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	Director of Digital and Health Intelligence	James Webb	PC	b)The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments Head of IG working with Medical Record's Directorate Manager to implement regular auditing function.
2019-20	Mar-20	Audit of Financial Statements Report Addendum - Recommendations	R4	4: the Phase 2 and Phase 3 continuing healthcare claims require concluding The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly.	Director of Finance	Deputy Finance Director	PC	Phase 2 – all cases completed Phase 3 – 3 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet. One case requiries a face to face meeting which has not been possible due to Covid, meeting is now in the process of being arranged. Two other claims were awaiting corret legal authority which has now been received and claims are progressing. The position was last shared with the Audit and Assurance Committee at its November 2021 meeting.
2019-20	Dec-21	Implementing the Wellbeing of Future Generations Act	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	Director of Planning	Director of Operations, PCIC	PC	Programme of business cases in development with engagement on design detail of services required to meet local needs taken forward as part of business case. First scheme (Maelfa) in constuction on track to be completed Dec 2021 and planning for Penarth and Ely hubs well underway. **Additional support secured in relation to planning of key future schemes which will include public and key stakeholder input. Work to be undertaken by end March 22.**
2020-21	Mar-22	Follow-up of Operating Theatres	R1	Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment: • prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.	Chief Operating Officer	Ceri Chinn	PC	We have bid for additional investment through recovery to increase POAC activity. This has been supported and some staff have been appointed. We are also working to relocate this service in conjunction with estates and planning team and have a provisional area identified. Also work with external partners "Foureyes" Qtr 4 of this financial year to review the POAC service focussing on booking, clinic flow and standardisation of clinic templates.
2020-21	Mar-22	Follow-up of Operating Theatres	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	Chief Operating Officer	Ceri Chinn	PC	Good progress is being made with regular 2:1 Theatre Manager/Lead Nurse and General Manager meetings and also regular 2:1 Clinical Leader, Lead Nurse and General Manager meetings. There is also a Directorate Management meeting on a bi-weekly basis and Clinical Leaders meeting with Theatre Managers occurs on a regular basis. These meetings offer the opportunity to ensure that the Managers and Leaders within the Directorate are being supported and any issues can be discussed through a standardised agenda. Workforce Manager appointment has been made and we are awaiting a start date. This role will ensure that the staff engagement work that is being carried out will continue and will drive not only workforce redesign but also the professional standards of the directorate. This project approach will be imnplemeted by the end of the year 2021 and progress will be monitored. A development booklet for clinical leaders has been developed which outlines the professional standards for our clinical leaders. A development plan will be developed by the workforce programme mangaer to support clinical leaders to achieve these.
2020-21	Jun-21	Assessment of Progress Against Previous ICT Recommendations	R4/5	Rollout appropriate and regular offline information governance training to employees without PC access.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	An IG presentation has been produced that can be delivered by the individual service for staff who are unable to undertake online training. This has been circulated to those services with a dedicated training function. **No change for February meeting**
2021-22	May-22	Audit of Accounts Report Addendum - Recommendations	R1/6	The Health Board should issue its annual related party declarations to associate members	Director of Corporate Governance	Head of Risk and Regulation	PC	This will be undertaken as part of year end arrangements for 2021/22.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	Windows 7 replacement - February 22 Servers - March 2023	Audit of Accounts Report Addendum - Recommendations	R2/6	The Health Board should replace its unsupported servers and devices. Where replacment is not currently feasible, the Health Board should ensure that robust mitigating arrangments are in place. Looking forward, the Health Board needs to be proactive, with better planning for its timely replacement of unsupported IT operating systems and devices.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	There are ongoing programmes in place to replace or upgrade all affected devices. Jan 2022 Update: The majority of the CAVUHB workstation estate has now been upgraded with less than 8% left to complete. In Nov 2021 the server team in CAVUHB began decomissioning legacy server operating systems and upgrading where possible, this work is planned to continue throughout 2022/23. DHCW Nessus and SIEMs solutions have also been implemented in Dec 2021, along side a dedicatedIvanti patch management solution. A new Anti-Virus solution has been implemented for the CAVUHB server estate in Dec 2021.
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R3/6	The Health Board should test its DR plan to gain assurance that IT systems can be restored if needed. The Health Board should review the DR plan regularly, and in doing so ensure that changes to the infrastructure and network are fully considered. Once updated and finalised, the Healht Board should test rhe revised DR plan to ensure that it works as intended.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	The IT DR Plan is being reviewed and upated as part of a progamme to refresh IT Security documentation. Jan 2022 Update: HPE StoreOnce backup and archiving solution with a capacity of 1PB has been purchased and due to be implemented in Feb 2022. This will form part of a new Backup and DR approach for CAVUHB. This will be achieved by retiring tape media and consolidated with Veeam software throughout, to be carried out during early 2022.
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R4/6	The Health Board should update its IT chang control policy and procedure	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	The change control policy is being updated and will be implemented as part of the new Ivanti helpdesk implementation project which includes change control functionality. Jan 2022 Update: Ivanti Helpdesk and Change Management Module is scheduled to be implemented W/C 10th Jan 2022.
2021-22	Nov-22	Audit of Accounts Report Addendum - Recommendations	R5/6	The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls, or, decommissioning and replacing them with a better, fit for purpose, data centre.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	Future reliance on these rooms is being reviewed and potential part decommissioning will be considered. Jan 2022 Update: Additional funding has been allocated for these improvements. Further consolidation of the two datacenters has progressed and a remote DR/Backup location in UHL has been identified. This new DR site will be developed over the next 12 months, subject to appropriate funds being available.
2021-22	Feb-25	Taking Care of the Carers	R1/6	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as eing at higher risk from COVID-19.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Cardiff and Vale University Health Board (CAV UHB) continues to maintain a strong focus on wellbeing through a variety of initiatives. The overarching framework for this is the development of a People and Culture plan. The UHB People and Culture Plan 2022-25 sets out the actions we will take over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce through the 7 themes:
2021-22	Mar-25	Taking Care of the Carers	R2/6	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	Executive Director of People and Culture	Executive Director of People and Culture Assistant Director of Organisational Development Assistant Director of Resourcing	PC	The impact of COVID-19 on the health and care system has been immense. While many of our people were able to adapt, innovate and face the challenges presented to them, the physical and emotional strain of doing so, as well as the toll of simply doing their jobs in such unprecedented conditions cannot be overstated. The People and Culture Plan sets out the actions we will take over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce. This Plan is aligned with the Operational plan; thereby ensuring a whole-system approach, that is working at pace to achieve the greatest positive impact, and can adapt to rapid service change and workforce pressures
2021-22	Mar-22	Taking Care of the Carers	R3/6	**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	A significant part of the Health Intervention team's initial and ongoing engagement with staff and managers has been to evaluate both existing wellbeing resources available pre-pandemic and those implemented during the pandemic. This feedback has resulted in changes to the resources available e.g. collating and streamlining of wellbeing advice to make it easier to access and has also influenced the development of the People and Culture plan.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	Nov-23	Taking Care of the Carers	R4/6	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Cardiff and Vale UHB have a number of representatives who actively participate in the National Health and Wellbeing Network. Participation ensures a two-way sharing of best practice which has included the sharing of Cardiff and Vale's experience in regard to the reintroduction of virtual Menopause Cafés. Attendance at this group ensures access to up to date health and wellbeing initiatives within the wider public and social sectors.
2021-22	Feb-25	Taking Care of the Carers	R5/6	**Providing continued assurance to boards and committees** NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Quarterly updates to the Board / more regular reports for management executive team meetings Updates and discussions at Local Partnership Forums and LNCs Update, discussion and feedback at Clinical Boards Bi-monthly Wellbeing Strategy Group meetings Ongoing evaluation of staff wellbeing offer, including access, impact and value Feedback and discussion at staff networks to inform priorities / direction of travel Attendance of AD of OD at key strategy meetings / COVID recovery meetings to ensure staff wellbeing at forefront of decisions EQIA completion to support policy / process and decision making Staff feedback regarding wellbeing also obtained via NHS Wales Staff Survey, MES, localised surveys and trial of engagement tool with nursing staff (March-May 2022)
2021-22	Mar-23	Taking Care of the Carers	R6/6	**Building on local and national staff engagement arrangements** NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Existing staff engagement mechanisms include: • NHS Wales Staff Survey • Medical Engagement Scale • Freedom to Speak Up • HR Processes and Procedures • Respect and Resolution Policies and Procedures • Trade Union Representatives • Existing Staff Networks – LGBTQ+; Black, Asian, Minority Ethnic; Long Covid • 4,000 voices campaign (on-site visits / staff groups / teams etc) • Live, online 'Ask the CEO / Exec etc' sessions held bi-monthly • Localised engagement aligned to specific strategic projects, e.g. Shaping our future clinical services
2021-2022	Feb-23	Radiology Services: Update on Progress	R2/7	Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff.	Chief Operating Officer	Chief Operating Officer	PC	1. Whilst the target compliance rate of 85% has not been reached, a demonstrable improvement has been made with the most recent report figures showing 80% appraisal compliance rate for Radiology A&C (Non clinical) staff. 2. N/A 3. Due to high levels of vacancies and sickness, workloads are high for staff in post and the supporting managers which has presented challenges to providing time to undertake appraisals, however they have managed to make a significant improvement. 4. Due to be submitted at March Performance Review
2021-2022	01/01/2022 Jan 2022 Dec 2021 Dec 2021 Jan 2022 Jan 2022 Apr 2022	Structured Assessment 2021 (Phase 2)	R1/2	The Health Board has taken a number of positive steps to enhance public transparency of Board business since our 2020 structured assessment report. However, there is scope for the Health Board to strengthen public transparency further by: a. ensuring all recordings of public Board meetings are uploaded to the Health Board's website in a timely manner after each meeting, and ensuring that links to previous meetings remain active; b. making recordings of public Committee meetings available on its website or publishing unconfirmed minutes of Committee meetings as soon as possible afterwards; c. uploading all Committee papers to the Health Board's website in line with agreed timescales; d. updating the membership details of Committee on the Health Board's website as soon as changes are approved; e. listing the matters to be discussed in private by Committees on the agenda of their public meetings on an ongoing basis; f. signpost the public to Board and Committee papers and recordings of public Board meetings via the Health Board's social media channels on an ongoing basis; and g. ensuring counter-fraud and procurement papers are considered by the Audit and Assurance Committee in public, with only sensitive matters reserved for private meetings.	Director of Corporate Governance	Head of Corporate Governance	PC	a. The Corporate Governance Department has just purchased software to enable the team to upload the recordings of the Board meetings in a suitable format and so that the same can be published within 2/3 days of the relevant Board meeting. The recordings of the Board meetings held in November and December 2021 should be published as soon as the new software has been installed (in January 2022). The intention is to make each recording available on the website for a period of 12 months. Thereafter, copies of the recordings would be available upon request. b. As of December 2021 the Corporate Governance Team has started to record public Committee meetings. From the New Year the recordings will be published on the Health Board's website. Further, our plan is to "livestream" the public Committee meetings from the New Year. c. This has now been completed and SOPs amended to ensure, that going forward, all relevant Committee papers received by the Corporate Governance Team are routinely published in line with agreed timescales (i.e. 7 clear working days before the Committee meeting). d. This has now been completed and SOPs amended to ensure that Membership details are updated, on an ongoing basis, once approved by the Board. e. Noted. This will be implemented with effect from January 2022. f. Noted. Arrangements will be put in place so that this can be implemented with effect from January 2022. g. Arrangements have been put in place so that this recommendation can be implemented with effect from April 2022.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-2022	Apr-22	Structured Assessment 2021 (Phase 2)	R2/2	The Health Board's approach to planning remains robust. However, the Health Board's arrangements for monitoring and reporting on plan delivery are less robust. The Health Board, therefore, should strengthen its arrangements for monitoring and reporting on the overall delivery of its Annual Plan and future Integrated Medium Term Plans by: a. ensuring these plans contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; and b. providing more information to the Board and Strategy and Delivery Committee on progress against delivery of these plans to enable full scrutiny and assurance .	Director of Corporate Governance	Executive Director of Strategic Planning	PC	a. It is intended that the IMTP for 22/23 will have clear actions, timescales and deliverables which can be tracked. This is already well established for the Recovery Programme and the Strategic Programmes so we will ensure it covers the other areas included within the IMTP. b. We will look at how best to report on the key deliverables set out in the Annual Plan/IMTP to ensure the Board is able to scrutinise and seek assurance. We will do this in a way that aims to minimise duplication with the Performance Report that is provided to the Board regularly.

Audit Wales Recommendations 2019/20 – 2021/22 (April 2022)

External Audit	Complete	No action	Partially complete	Date not Reached	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Assessment of Progress Against Previous ICT Recommendations	-	-	1	-	-	-	1	-	1
Audit of Accounts Report Addendum - Recommendations	-	-	5	3	2	-	-	-	5
Audit of Financial Statement – Report Addendum - Recommendations	-	-	1	-	-	-	-	1	1
Clinical Coding Follow-up from 2014	-	-	1	-	-	-	-	1	1
Follow-up of Operating Theatres	-	-	2		2	-	-	-	2
Implementing the Wellbeing of Future Generations Act	-	-	1	-	-	1	-	-	1
Radiology Services: Update on Progress	-	-	1	1	-	-	-	-	1
Structured Assessment 2021 (Phase 2)	-	-	2	-	2	-	-	-	2
Taking Care of Carers	-	-	6	5	1	-	-	-	6
Total	-	-	**20**	**9**	**7**	**1**	**1**	**2**	**20**

From the above table it can be seen that since the last report to Committee in February 2022, nine recommendations have been added to the tracking report and the number of recommendations now stand at 20 which are all partially complete. Two outstanding actions are 1+ years overdue, seven are less than 3 months overdue, one is greater than 3 months overdue and 1 is greater than 6 months overdue. The remaining 9 actions have not exceeded their agreed implementation date.

Report Title:	Internal Audit Recommendation Tracker Report				Agenda Item no.	8.4
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	05.04.2022
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Head of Risk and Regulation					

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Internal Audit by means of an internal audit recommendation tracking report.

The internal audit tracking report was first presented to the Audit Committee in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by internal audit.

The tracker continues to highlight progress made against previous years recommendations albeit in a more streamlined manner. The tracker attached to this report sets out the progress made against recommendations from 2019/20, 2020/21 and 2021/22.

It should be noted that at the May 2021 Committee an additional 7 historic Audits will be added to the tracker that were not added following the February 2020 committee meeting. These audits are:

1. Surgery Clinical Board Medical Finance Governance Follow-up Final
2. Deprivation of Liberty Safeguards Final
3. Charitable Funds Final
4. PCIC Business Continuity Final
5. Wellbeing at Maelfa Final
6. PCIC CHC Adults Follow-up Final
7. Children and Women Clinical Board - CHC Children Follow-up Final

Each of the above Audits were shared with Executive and operational leads in 2020 and it is anticipated that significant progress will have been made against the recommendations made.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

As can be seen from the attached summary tables the overall number of outstanding recommendations has reduced from 85 individual recommendations to 84 during the period February 2022 to April 2022. The reduction in recommendations can be attributed to the removal of 18 completed entries from the tracker following February's Committee meeting. A further 17 entries have been added to the tracker since February 2022. The audit reports added to the tracker on this occasion are:

1) Core Financial Systems (2 recommendations)
2) Theatre Utilisation – Surgery Clinical Board (4 recommendations)
3) Retention of Staff (5 recommendations, 3 of which are complete)
4) Welsh Language Standards (6 recommendations)

Of the 85 recommendations listed 18 are recorded as completed, 64 are listed as partially complete and 3 are listed as having no action taken.

A review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the internal audit tracker was presented (February 2022). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

It should be noted that the narrative at Column J (Management Response/Executive Update) of the attached tracker are the updates provided for this meeting. Where no update has been shared for an individual entry this is confirmed within narrative.

The table below shows the number of internal audits which have been undertaken between 2019/20 and 2021/22 (to date) and their overall assurance ratings.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Rating N/A - Advisory	Total
Internal Audits 2019/20	10	25	2	2	39
Internal Audits 2020/21	7	18	1	3	29
Internal Audits 2021/22	1	6	3	-	10

Attached at Appendix 2 are summary tables which provide an update on the February 2022 position as of the 22/03/2022.

ASSURANCE is provided by the fact that a tracker is in place. This assurance will continue to improve over time with the implementation of regular follow ups with the Executive Leads.

Recommendation:

The Committee are requested to:

(a) Note the tracking report for tracking audit recommendations made by Internal Audit.
(b) Note and be assured by the progress which has been made since the previous Audit and Assurance Committee Meeting in February 2022.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
N/A
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
N/A	

Mohamed,Sarah
03/28/2022 16:21:28

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	01/07/2020	Medical Staff Study Leave - Reasonable	R1/6	Medium	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: - roles and responsibilities – of Directorates, Managers, Consultants; - funding and budget guidance. - monitoring and compliance arrangements including KPIs; and - reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	Executive Director of People and Culture	Executive Director of Workforce and OD & Medical Director	PC	Draft Procedure is still with the BMA. The BMA unfortunately did not meet the required deadline of the 7th Jan 2022, although they have assured us that the document will tabled at LNC in March 2022. Therfore will not be presented to the Strategy and Delivery Committee in March 2022 as previously indicated.
2019-20	01/09/2020	Medical Staff Study Leave - Reasonable	R4/6	Medium	The following arrangements are reviewed and strengthened:- - budget setting, monitoring and reporting; - payment of honorary staff expenses; and - ability to access Trust funds to support study leave budgets.	Executive Director of People and Culture & Medical Director		PC	Was briefly discuss at LNC in Jan 2022, it was agreed that a meeting would be arranged by the Medical Director, Director of Finance, Chair of BMA & Assistant Secretary for BMA. Awaiting outcome of meeting.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R1/5	High	The UHB should ensure policies are reviewed and updated within appropriate timescales.	Director of Corporate Governance	Head of Corporate Governance	PC	This piece of work is partially complete. Further time is required to undertake this significant piece of work. Due to other prioriites and given that the Head of Corporate Governance is required to attend Jury Service for 2 weeks in February, it is anticiapted that a thorough review of the policies will be completed by the end of March 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R2/5	Medium	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Further time is required to undertake this significant piece of work. Due to other priorities and given that the Head of Corporate Governance is required to attend Jury Service for 2 weeks in February, it is anticipated that this piece of work will be completed by the end of March 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R3/5	Medium	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet. 2. Correct and improve accessibility of documents. Review publishing process to ensure documents are circulated through correct location in internet and/or intranet sites. 3. A combined EHIA should be completed for all policies or where a Health Impact Assessment is not required this should be clearly stated. 4. The Corporate Governance Department should ensure the integrity of the 'Register', by reviewing accuracy of all key information.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Further time is required to undertake this significant piece of work. Due to other priorities and given that the Head of Corporate Governance is required to attend Jury Service for 2 weeks in February, it is anticipated that this piece of work will be completed by the end of March 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R4/5	Low	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Further time is required to undertake this significant piece of work. Due to other priorities and given that the Head of Corporate Governance is required to attend Jury Service for 2 weeks in February, it is anticipated that this piece of work will be completed by the end of March 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R5/5	Low	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Further time is required to undertake this significant piece of work. Due to other priorities and given that the Head of Corporate Governance is required to attend Jury Service for 2 weeks in February, it is anticipated that this piece of work will be completed by the end of March 2022.
2019-20	N/A	Pre-employment Checks	R10/10	Low	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.	Executive Director of People and Culture	Executive Director of People and Culture	PC	Work current taking place, led by the Workforce Resourcing team to review and update all of our Trac adverts and associated documentation

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2020-21	31/12/2020	Management of Serious Incidents	R3/6	Medium	Management should ensure that all outstanding actions are completed.	Executive Nurse Director	Assistant Director Patient Safety and Quality	PC	Serious Incidents are managed using the closure forms which should be completed by the Clinical Boards and submitted to the Asst. Director of Patient Experience or Quality Safety to sign off. The NRI (Nationally reported Incident) policy has been implemented. Clinical Boards are regularly advised of the closure forms required through a robust monitoring process. The closure forms are quality checked through the Head of Patient Safety and/or Assistant Director prior to submission to the Delivery Unit. From 14th June 2021 the reporting of and management of Serious Incidents changed. They are now called NRIs (Nationally Reportable Incidents) and some categories which had previously been reported asd an SI are no longer considered an NRI (example is adolescent in an adult setting and unexpected death in the community of a Mental Health patient). NHS Organisations now have longer to fact find before reporting (now 7 days from date of incident/knowledge of incident). NHS Organisations are now able to determine the level of and timeframe for investigation (which was previoulsy the remit of the DU). Dependant on the findings of the invetsigation, one of 3 closure forms will be submitted dependant on whether there were any causative or contributory factors identified through the investigation process. The Head of Patient Safety and the Patient Safety Facilitators meet regularly with the Clinical Board Directors of Nursing to review progress and actions against the open and overdue NRIs to improve closure timeframes. Whilst the AD Patient Safety post is vacant, the NRI reporting and closure forms are signed off by the Executive Nurse Director.
2020-21	30/09/2021	UHB Core Financial Systems	R1/3	Medium	Management should ensure the FCPs are updated as soon as possible.	Director of Finance	Helen Lawrence – Sept 2021	PC	FCPs are currently being reviewed to ensure up to date and reflective of current procedures. The position was last reported to the Audit and Assurance meeting at its November 2021 meeting.
2020-21	31/03/2021	Consultant Job Planning 2nd Follow-up	R4/4	Medium	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	Executive Medical Director	Kirsten Mansfield	PC	The Allocate e-job planning system has been purchased and continues to be rolled out across the UHB. **Update Oct 2021** - As of 1st October 2021 54% of the Consultant and SAS grades have a job plan on the system. We are currently also working at aligning them to an annualised Job Plan cycle where all job plans will start from 1st April 2022 and will be reviewed yearly from then on. **Update Dec 21** - We now have 74% of job plans held in the system. Engagement is excellent and Job plan meetings are taking place accross the board despite winter pressures and Covid. The plans are moving through the sign off process and we hope to reach our target of 85% compliance by April 1st. This allows for long term sickness and maternity leave. Engagement has been our biggest challenge with many feeling that the timing of implementation was ideal Regardless of this we have seen a significant increase in engement and are moving closer to our target. **Update Mar 22** - 81% of job plans held in the Allocate, almost reaching our target of 85% by April. Concentration is now on getting them fully signed off and a plan for departments moving forward to ensure all consultants have a vaild job plan as of 1st April each year.
2020-21	30/06/2021	IM&T Control and Risk Assessment	R1/18	Not Rated	An IG Forum should be established for the IG leads from each clinical board to meet to discuss issues and to coordinate IG matters across the Health Board at an operational level.	Director of Digital & Health Intelligence	IG Manager by 30 June 2021	PC	We agree with the recommendation; the intention is for IG issues to be picked up at Clinical Board Q&S briefings but this will require additional capacity to ensure that the IG function is able to support the Clinical. This function is supplemented by the monthly IG Sub Group which meets to discuss operational IG issues. Representation from CB as required.
2020-21	31/05/2021	IM&T Control and Risk Assessment	R2/18	Not Rated	The revised governance framework for IM&T / digital should be implemented to ensure that there is a holistic structure for the organisation, with participation from Clinical Boards. Where control over aspects of IM&T has devolved to departments, the assurance flows to the DHIC should be clarified to ensure the committee can maintain oversight over the whole organisation.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence 31 May 2021	PC	Jan 2022 Update: The Digital Service Management Board, to include Clinical Board representation, was re-established to meet on a quarterly basis, from 27 May 2021 onwards. As part of the DSMB function, alignment of those services incorporating informatics and ICT services that sit outside D&HI directorate are mapped and included for oversight at UHB level.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R3/18	Not Rated	A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence 31 July 2021	PC	Jan 2022 Update: A register of compliance for all IM&T related legislation and standard is under development to support the NIS Directive and data security standards, which will be implemented through the Head of Digital Operations.

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2020-21	30/09/2021	IM&T Control and Risk Assessment	R4/18	Not Rated	Management should consider providing an annual report that identifies risks that have a low likelihood but have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise. Management Response	Director of Digital & Health Intelligence	Director of D&HI 30 September 2021	PC	The D&HI directorate risk register is shared with the D&HI Committee at each meeting. An annual report to capture the low risk high impact risks will be produced and shared at the committee and with the Management Executive team.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R5/18	Not Rated	The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	Director of Digital & Health Intelligence	Head of IG and Cyber 31 Oct 2021	PC	The risk identification process to support the event and problem management process will be developed for inclusion as part of the management or risk assurance documentation. Jan 2022 Update: IT support staff have successfully completed the ITIL foundation course and are developing the incident and problem management procedure during Q4 21/22.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R7/18	Not Rated	Departmentally managed systems should comply with good practice for the management of digital. The D&HI Directorate should produce good practice guidance documentation for the health board overall as leaders of the digital services provision, with all departments required to comply for areas such as change control.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The D&HI directorate will produce updated good practice guidance documentation, based on ITIL and industry standards, for dissemination across all IM&T functions across the UHB. Jan 2022 Update: using the new IT helped desk tool. Ivanti, Standard Operating Procedures have been developed, linked to ITIL processes, being implemented in Q1 22/23
2020-21	30/09/2021	IM&T Control and Risk Assessment	R8/18	Not Rated	A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The D&HI directorate will undertake a complete baseline assessment against the digital maturity standards (HIMMS) to assist in determining the current position and help inform the digital strategy roadmap. This will be presented at D&HI committee.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R9/18	Not Rated	The roadmap should be fully defined in order to help deliver the Digital Strategy.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The current roadmap has been produced to align with the channel programme boards; a more detailed roadmap to include resources and dependencies will be developed for approval at D&HI committee. Jan 2022 Update: an overhaul of the digital strategy and supporting roadmap is in progress, supporting the emerging UWH2 requirements (SOFH), to be completed by 31/03/22
2020-21	30/09/2021	IM&T Control and Risk Assessment	R10/18	Not Rated	The Strategy should be available on the Health Board website, and flagged, with a communication plan to push awareness with all stakeholders	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The digital strategy is available as a public document and is accessible via the UHB's website. A communication plan for internal consumption is being developed. Jan 2022 Update: the refreshed digital strategy will be submitted to Board in March 2022.
2020-21	31/08/2021	IM&T Control and Risk Assessment	R11/18	Not Rated	The D&HI Directorate budget should be set to reflect the actual need of the organisation. The capital expenditure budget should be reviewed with the intent to providing a stable funding position to allow for delivery of the digital strategy.	Director of Digital & Health Intelligence	Director of D&HI 31 Aug 2021	PC	A Case for Investment has been produced and shared with the Management Executive team which sets out the capital and revenue requirements for the life of the digital strategy (2020-2025). Discussions on affordability and potential sources of funding are taking place with executive management. Decisions on funding are expected to be made during the second quarter of 2021/22
2020-21	30/09/2021	IM&T Control and Risk Assessment	R12/18	Not Rated	A full assessment of the current skills within the directorate, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	All staff within the D&HI directorate are expected to complete the PADR and objective setting process, which will identify current training and development needs. These will be compared with the known and expected requirements to deliver the digital strategy and will form the annual plan of training and development.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R13/18	Not Rated	A formal cyber security workplan should be developed. This should be based on a formal assessment of the current position of the health board and define the actions needed to improve the position.	Director of Digital & Health Intelligence	Head of IG and Cyber 31 Oct 2021	PC	A full cyber security work-plan, including NIS directive requirements will be completed as soon as the cyber team is in place. Jan 2022 Update: The UHB has completed the Cyber Assessment Framework (CAF) benchmarking exercise as part of the implementation of the NIS Regulation. It will work through the recommendations once received in Q4 21/22.
2020-21	30/06/2021	IM&T Control and Risk Assessment	R14/18	Not Rated	The national cyber security training should be mandated for all staff.	Director of Digital & Health Intelligence	Director of D&HI 30 June 2021	PC	Accepted. The national cyber resilience unit at Welsh Government has been approached for assistance in producing the training plan for staff across the UHB. Jan 2022 Update: a pilot phishing exercise successfully completed in Dec 21 and will be scaled up across the UHB in Q4 21/22.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R15/18	Not Rated	Formal reporting on cyber security should be established, along with a suite of cyber security KPIs in order to show the status of cyber security and the progress of the team in managing issues.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	A formal report on cyber security will form part of the suite of documents to be shared regularly at the D&HI committee. Jan 2022 Update: an update on cyber security work is to be taken to private meeting of DHIC in February 2022.

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2020-21	30/09/2021	IM&T Control and Risk Assessment	R16/18	Not Rated	Consideration should be given to developing a single register of assets and their configuration status for the Health Board. This should include a process for identifying critical assets and ensuring regular assessment of the need for replacement of these.	Director of Digital & Health Intelligence	Head of Digital Operations, Russell Kent 30 Sept 2021	PC	Jan 2022 Update - The new Service Management solution within CAVUHB Ivanti Helpdesk contains an Asset Management Module. This will be used to collate IT Assets throughout the organisation. - Technical implementation commences Jan 2022.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R18/18	Not Rated	The organisation should develop an overarching BCP / DR process. This should: • consider all the systems and use a business impact analysis to identify the business critical systems to prioritise for recovery; • departments with devolved control should feed into this process to ensure all system have appropriate plans and that the plans do not conflict; • RTO / RPO should be agreed for each system with the key stakeholders; and • The full position should be defined and agreed with executives to ensure that they accept the position and associated risks.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	Agreed. Working with colleagues in corporate planning, a full BCP/DR process will be developed and shared with Management Executive. Jan 2022 Update: additional resource procured to update and refresh existing documentation to delivery comprehensive set of processes for sign for at Management Executive - end Q4 21/22.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R1/5	Medium	Management should continue as planned to finalise the review of the Data Quality Policy (UHB 298) (to reflect the General Data Protection Regulation framework), and the Data Quality Procedure (UHB 288). Once finalised, formal approval of the documents should be sought from the Board.	Interim Chief Operating Officer	Director of Digital and Health Intelligence September 2021	PC	The Data Quality policy is complete but not yet reviewed. It will be completed and taken through the relevant committee for approval by end of Qtr4 21/22.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R5/5	Low	Management should consider implementing an issues log to capture discrepancies in the data and help identify any negative trends.	Interim Chief Operating Officer	Cancer Services Lead Manager, 30 September 2021	PC	There is an issues and action log used by the team to raise technical concerns and training requirements to the IT development team. The Cancer Services team have a single point of contact in IT for this.
2020-21	31/10/2021	Infrastructure / Network Management	R1/5	Medium	A formal patch and update policy and procedure should be developed which clearly articulates the decisions relating to patching and updates, and which sets out the process for applying patches and updates in a secure manner to reduce the risks associated with these. We note that this recommendation was also included in the IT Assessment Internal Audit Report.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital operations October 2021	PC	Jan 2022 Update - A comprehensive network audit and review is in flight and will be completed by March 2022. This report will provide revised patching and security update recommendations and policies, all of which will be enforced from May 2022.
2020-21	30/11/2021	Infrastructure / Network Management	R2/5	Medium	A configuration management policy / procedure should be defined in order to enable efficient and effective control over IT assets and fully understand the configuration of each component that contributes to IT Services in order to: • account for all IT components associated with the Service; • provide accurate information and documentation to other Service Management processes; and • to provide a sound basis for Incident, Problem, Event, Change and Release Management (e.g. reduction of the amount of failed Changes). This should be underpinned by a configuration management record which records all items and their status.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital Operations November 2021	PC	Jan 2022 Update - Ivanti Helpdesk and Change Management module is scheduled to be installed in Jan 2022.
2020-21	31/12/2021	Infrastructure / Network Management	R3/5	low	An overall statement or procedure should be developed that sets out the aims for network monitoring and management, and how this will be done. The procedure should note that the aim is to ensure that that relevant staff have alerts and reports so that imminent problems are detected and reported for prompt response and actions. Guidance should then be provided on the mechanism by which this is done	Director of Digital & Health Intelligence	Russell Kent, Head of Digital Operations December 2021	PC	Jan 2022 Update - As part of the implementation of an ITIL compliant Ivanti Helpdesk, ten support staff members have particpated and passed their initial ITIL certification.

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2020-21	15/12/2021	Rostering in Community Children's Nursing Service	R4/7	Low	The CCNS Memorandum of Understanding: Home Based Continuing Care Packages should be updated, approved by senior management at both departmental and Clinical Board level for dissemination to parents / guardians as soon as is practicable so as to formalise mutual arrangements between the UHB and parent(s)/carers of children under the department's care.	Interim Chief Operating Officer	Paula Davies, Lead Nurse Alison Davies, Senior Nurse 15th December 2021	PC	MOU is with the legal team and awaiting clarification on a recent clinical issue. Once returned it will be sent out to families with a covering letter and opportunity to discuss with the management team via a telephone or virtual meeting.
2020-21	30/11/2021	Rostering in Community Children's Nursing Service	R7/7	Low	Management should continue as planned to ensure the gaps in staff training across CCNS are addressed.	Interim Chief Operating Officer	Paula Cooper, Operational Manager Jayne Keddie, Operational Manager November 2021	C	The service is now compliant with mandatory training and service specific training.
2020-21	31/07/2021	Staff Recruitment	R1/3	Low	Management should consider developing a system that is able to record key recruitment data for the different recruitment 'areas' for registered nurses in order to assess the effectiveness of each one.	Executive Nurse Director	Clinical Board Directors of Nursing are re-setting establishments in ESR by July 2021.	PC	Information data re nursing workforce has been strengthened to what is currently available. This includes recruitment, turnover, sickness etc and numbers of staff deployable. Real recruitment figures are confirmed in month and predictions placed dependent on overseas nurses recruitment, post grad students leaving universities etc. This is information is also available by Clinical Board NB some data is retrospective e.g. sickness figures. Each month a report is created to provide the actual position with regard to all of the above. Overseas nurses recruitment continues with a further 90 posts agreed. It is being considered that C&V join the All Wales OSN procurement led by shared services.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R8/13	Medium	Adviser agreements should be executed in a timely manner prior to duties commencing (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	All documents have been completed
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R1/5	Medium	Management should ensure that the Health Board's practical guide to engagement and associated flowchart is updated to reflect the current processes and made available on the HB intranet.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	UHB will work with South Glamorgan CHC to review and update internal practical guide to engagement and associated processes. However, first step is to review the Local Framework for Engagement and Consultation on Changes to Health Services agreed between UHB and CHC in 2018, as this underpins the advice provided in the practical guide. Local Framework reviewed and updated internally by December 2021, including provision of advice from Corporate Goverance. Sharing for discussion with CHC delayed pending outcome of mediation on a disuputed service change, in which Local Framework is material. Once agreed, internal practical guide and associated suite of resources which have also been reviewed and updated, will be issued internally.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R2/5	Medium	In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	Director of Planning	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle	PC	Importance of timely completion of CHC Service Change Proforma for discussion with CHC when service change proposals are being developed will be reinforced with Clinical Boards; consideration given to building it into IMTP templates. Service Change Proforma has been reviewed and updated, pending discussion and agreement with the CHC. It forms a part of the Local Framework that has been reviewed as above and will be reissued to Clinical Boards once agreed between the UHB and CHC. Note decision to delay discussion with CHC pending outcome of mediation described in section 52
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R5/5	Low	In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, has been reviewed and updated to include stakeholder mapping advice based on current best practice. Once the actions in section 52 on Local Framework have been completed, the Practical Guide and suporting resources will be re-issued to Clinical Boards and put on the UHB intranet.
2021-22	9.11.2021	Legislative, Regulatory & Alerts Compliance	R4/8	Medium	The following should be taken forward to enhance the oversight of Welsh Health Circulars: a) The tracker should be regularly reconciled to the Welsh Government website to ensure no gaps are identified. b) The tracker should be regularly updated to ensure meaningful information is collected. c) An effective follow up process should be embedded so that assurance can be gained that actions are being completed.	Director of Corporate Governance	Head of Risk and Regulation	C	Required Actions complete – a) The WHC is fully up to date with all current WHC's. The WG website is also checked at least once a month to ensure that the most up to date circulars are noted. b) The tracker is reviewed and updated at least monthly. c) Regular reminders are sent to executive leads for WHC's to ensure that adequate action is taken and noted. Updates on WHC'S are now also reported to Management Executive Meetings and the Audit and Assurance Committee.
2021-22	30.09.2021	Legislative, Regulator & Alerts Compliance	R7/8	Low	Assurance reports regarding Patient Safety Alerts should be provided to the Quality, Safety and Experience Committee or appropriate group during 2021/22.	Director of Corporate Governance	Assistant Director of Patient Safety and Quality	C	Agreement of future reporting arrangements for PSAs within the revised QSE Committee structure. Agreement of a regular schedule of reporting for PSAs

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2021-22	30.09.2021	Healthy Eating Standards - Hospital Restaurant & Retail Outlets	R1/3	Low	At the next review of the Standards consideration should be given to the following, which may also assist in raising the profile: - Testing the reference links to ensure they are still live and current; - Noting the governance forum which endorsed the Standards on the cover sheet; - Direct reference to the Well-being of Future Generations (Wales) Act 2015; and - Reference to Strategic change programmes, which underpin the Shaping our Future Wellbeing Strategy, such as Shaping our Future Population Health.	Executive Director of Public Health	Principal Health Promotion Specialist	C	1) Review and update all paperwork 2) Confirm governance arrangements with Executive Director of Public Health 3) Ensure referencing to strategic drivers are incorporated in the documentation. **1. General update on 04/03/22** All paperwork actions are complete and governance/ reporting channels agreed with Healthy Eating Standrads Steering Group. **2. Implementation update** - complete **3. Challenges -** the ongoing impact of Covid (on staffing levels and customer footfall) and Brexit (supply and demand) delayed timing of meetings but all up to date now. **4. Recommendation last updated for comittee on** 04/01/22 (update provided)
2021-22	31.10.2021	Healthy Eating Standards - Hospital Restaurant & Retail Outlets	R2/3	Medium	To enhance the governance arrangements currently in place to support and direct the Standards, the governance arrangements should be reviewed, and draft governance documents finalised and approved to provide clarity.	Executive Director of Public Health	Principal Health Promotion Specialist	C	Review governance and reporting mechanisms to ensure the standards are implemented and applied in accordance with UHB governance processes. **1. General update 04/03/22** - Exec. Director of PH has agreed with Exec. Director of Therapies that this workstream will report into the Nutrition & Catering Steering Group. The updates will take on a more formal approach. **2. Implementation date -** This change was implemented in November 2021 - new arramgements now in place. **3. Challenges -** The ongoing impact of Covid/Brexit, with staff deployed to other areas/priority work, has delayed progress/schedule of meetings. A follow up meeting is planned for the Exec. Director for Public Health with colleagues from Capital, Estates and Facilities to maintain awareness of the workstream and monitor progress. It was agreed this will take place in the Spring, to assess situation again once current pressures are reduced. **4. Assurance Comittee** - 04/01/22 (update provide)
2021-22	31.10.2021	Healthy Eating Standards - Hospital Restaurant & Retail Outlets	R3/3	Medium	Consideration should be given to taking forward the following to enhance the audit process and associated outputs: - To reflect on the system of scheduling audits, weighing the benefits and possible value added by performing some unannounced spot checks; - Follow up visits should be documented to determine if there is a noted improvement, or if compliance issues remain; - To develop a process for capturing and sharing good practice; and - The audit checklist should be updated to reflect the requirement of the Standards to incorporate the display of the traffic light system.	Executive Director of Public Health	Senior Health Promotion Specialist (Helen Griffith) Public Health Practitioner (Chloe Barrell)	C	1) Revise audit schedule to include unannounced spot checks in addition to scheduled audit visits. 2) Audit documentation revised to ensure audit results , in particular non compliance, is highlighted and appropriate actions identified to improve compliance. 3) Develop communication tools to highlight examples of good practice, for example, newsletters, performance dashboards etc. 4) Include traffic light system in audit documentation. **1.General update 04/03/22** - all actions completed ahead of this years audits in september 2022. We have finalised dashboards for the audits completed in September 2021 and a follow-up audit at Woodland House in January 2022. These have been shared with Healthy Eating Standards Steering Group/Operational Group and will inform our planning ahead of next audit cycle. A communication pack for has been drafted for staff on the Standards /audit process so that the wider catering team are included in the process and understand the rationale for the Standards/changes to food provision. Also in early stages of developing a more accurate digital process for audits that will enhance access to sales reports/nutritional analysis, allowing us behavioural insights into customer choice/healthy food provision. Funding successfully secured to allow this through the Welsh Health Hack. **2. Implementation date** - audits/spots checks were delayed as access to site was restricted during Covid, however now all up to date with audits. Spot checks will be ongoing throughout the year. **3. Challenges** - staffing shortages have had an impact but showing steady improvement in recent weeks, allowing more capacity to progress work. Supply chain challenges remain, however it is expected that some of the issues will be resolved by the Spring. **4.Assurance Committee** - 04.03.22 (provided update)
2021-22	22/06/2021	Cancellation of Outpatient Clinics Follow-up Mental Health CB	R1/5	Low	Clarification of the approving forum and next review date should be added to the written procedure for the Cancellation of Outpatient Clinics.	Interim Chief Operating Officer	Clinical Board Director	PC	Document to be formatted to usual UHB standard, with version control, date, authorising body.

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2021-22	22/06/2021	Cancellation of Outpatient Clinics Follow-up Mental Health CB	R5/5	Medium	1. A continued period of testing, bedding in and fine tuning of the cancellation report should be undertaken so that outstanding data accumulation and presentation issues can be identified and cleared. This should involve input from all recipients of the report. 2. Any further changes which need to be made in connection with the monthly cancellation report should be reflected in the Cancellation of Outpatient Clinics written procedures.	Interim Chief Operating Officer	Clinical Board Director, Daniel Crossland, Deputy Director of Operations and Delivery	C	Each Directorate has a 6 weekly scheduled performance meeting. The O/P cancellation procedure will be a recurrent agenda item until the iterative process is satisfied by the time of the 3 year procedure review. This is reflected in the procedure.
2021-22	31.10.2021	Ultrasound Governance CD&T CB	R1/5	High	The Executive Director of Therapies and Health Science should be provided with assurance that the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) has been adequately communicated within the Health Board.	Executive Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	C	The Policy and Procedure, along with the USCGG ToRs, will be promoted through the Medical Equipment Group, Medical Device Safety Officer's group, Clinical Board operational teams as well as through the Clinical Executive's Office of Professional Leadership. The audit findings have been discussed at the Office of Professional Leadership on 4th October and the Medical Equipment Group on the 11th October. A follow up meeting with CD&T Clinical Board members took place on 17th Nov 2021 where the proposed action of setting up the USCGG was agreed. The USCGG group was added to the Medical Equipment Group (MEG) ToRs and agreed by the MEG on 8th Dec 2021. The 'in draft' USCGG ToRs have been updated to reflect the conversations at these groups. Delay to implementation date due to agreeing reporting structure and feedback from USCGG membership. Meeting in Jan 2022 with Exec DoTH to confirm assurance before cascading USCGG ToRs and Policy and Procedures through UHB via QSE. ToRs signed off by EDoTH. Position papers have been sent to OPL and QSE for information and assurance. The minutes of the USCGG meetign on 23/02/2022 were communicated to the Medical Equipment Group, chaired by the EDoTH.
2021-22	31.03.2022	Ultrasound Governance CD&T CB	R2/5	Medium	Consideration should be given to the mechanisms for Clinical Boards to provide assurance to the Executive Director of Therapies and Health Science, to satisfy the assurance responsibilities set out within the Medical Ultrasound Risk Management Procedure (UHB 322).	Executive Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	PC	An annual audit template will be developed by the membership of the USCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework. Opportunities to develop a digital audit tool will be explored with corporate IM&T teams. An on-line training module is planned. This work will form part of the actions for the Ultrasound Clinical Governance Group.
2021-22	26.08.2021	Ultrasound Governance CD&T CB	R3/5	Medium	Following feedback through the course of the review, consideration should be given to: • Producing an abridged version of the Medical Ultrasound Risk Management Procedure, summarising key themes, to underpin the full procedure; and • The renaming of the procedure to reflect the actual content of Ultrasound Governance and to align with the role of the Ultrasound Clinical Governance Group.	Executive Director of Therapies and Health Science	Principal Clinical Scientist (Paul Williams)	C	An Abridged version of the USCGG Procedure has been written will be shared with the Policy and USCGG ToRs, as in R1/5. For consistency it is recommended that the naming of the documents be 'Ultrasound Clinical Governance Policy' and ' 'Ultrasound Clinical Governance Procedure'. Also that the policy and procedures be located under 'U' in the C&V UHB Patient Safety and Quality policies, rather than 'T'. Will approval from Exec QSE.
2021-22	31.10.2021 30.11.2021	Ultrasound Governance CD&T CB	R4/5	High	Ultrasound governance arrangements should be reviewed as follows: • The placing of the Ultrasound Clinical Governance Group (UCGG) within the Health Board's governance structures. • The appointment of appropriate person(s) to Chair the UCGG meetings with sufficient seniority to escalate issues as they arise. • The reporting mechanisms to facilitate the escalation and cascade of ultrasound governance. • Membership of the UCGG should be sourced from all ultrasound using Directorates. • Actions and attendance (including quorum) are recorded for the meetings. On completion of review, the governance arrangements should be revised and formalised through an updated Terms of Reference.	Executive Director of Therapies and Health Science	UCGG / Assistant Director of Therapies and Health Science Assistant Director of Therapies and Health Science	C	The USCGG ToRs will be formally reviewed to ensure that it has appropriate governance arrangements. The USCGG will formally report through the Medical Equipment Group (MEG) which is chaired by the Executive Director of Therapies and Health Science. The MEG will receive minutes and a written report. USCGG and MEG ToRS now in draft to reflect these changes and will be signed off by EDoTH. A review of the USCGG ToRs will be set for around 6 months, date to be agreed at first USCGG meeting on 23/02/2022 The membership of the USCGG will be signed off by the Executive Director of Therapies and Health Science. Communication on expected attendance from clinical areas at the USCGG will be disseminated through the operational Clinical Board structures and the Office of Professional Leadership. Delay to implementation date due to agreeing reporting structure and feedback from USCGG membership. Meeting in Jan 2022 with Exec DoTH to confirm assurance before cascading USCGG ToRs and Policy and Procedures through UHB via QSE. USCGG ToRs signed off by EDoth.

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2021-22	30.09.2021	Ultrasound Governance CD&T CB	R5/5	Medium	In accordance with Sections 2 and 3 of the UHB Ultrasound Risk Management Procedure, the three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor should be formalised within the sampled audit areas.	Executive Director of Therapies and Health Science	Directorate Ultrasound Governance Lead (Mark Denbow)	PC	The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics. Ultrasound Clinical Governance Group meetings will be setup, the first of which is starting in February 2022. Within this we will be formalising roles and working through each aspect of the policy inc: roles and responsibilities and communication plan around this. Delay in implementation as USCGG membership and ToRs had first to be agreed.
2021-22	31.01.2022	Clinical Audit	R1/9	High	A Clinical Audit Strategy should be developed, cognisant of the Business Case to support Quality, Safety and Experience Framework (2021 – 2026), currently under consideration by executive management, to ensure the Health Board aligns with HQIP guidance.	Executive Medical Director	Head of Patient Safety and Quality Assurance and Associate Medical Director	PC	A Clinical Audit Strategy will be developed considering the HQIP guidance. (Time frames of completing this action will be dependent on the timing of, and amount of investment has been agreed which may influence the approach) 5/1/21 Still Awaiting approval of investment, the basis for the strategy has been commenced but delayed due to long term sickness. Level of investment is required to inform the strategy as will impact on the apporach taken.
2021-22	31.01.2022	Clinical Audit	R2/9	High	The Health Board should develop a Clinical Audit Policy and subsequent Procedure, which will require formal approval, to provide a mandate to direct staff on a consistent basis. The policy and procedures should be developed in keeping with HQIP guidance, so that national and local clinical audits are carried out consistently and comply with current information governance legislation and guidance.	Executive Medical Director	Head of Patient Safety and Quality Assurance and Associate Medical Director	PC	A Health board specific Clinical Audit policy will be developed and subsequent procedure which will provide a mandate to direct staff in a consistent way. The policy will be approved through the Clinical Effectiveness Committee Meeting (As with the clinical audit strategy time frames of completing this action will be dependent on the timing of and amount of investment has been agreed which will also influence the approach. 5/1/21 Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness, level of inve3stemetn will be required to complete as will impact on approach to guide staff.
2021-22	31.03.2022	Clinical Audit	R3/9	High	Management should continue as planned, to present the proposal for the future organisational structures to support Quality, Safety and Experience to management executive, to ensure identified resource issues are mitigated. Specifically, that the Health Board are able to: • Monitor the progress or completion of action plans / improvements in response to National Clinical Audits; • Monitor and support the development of Quality and Safety priority audits (Tier 2); and • Monitor the progress, completion and reporting of clinical audits and action plans that have identified the need for improvement.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	A Business Case to support the Quality, Safety and Experience Framework (2021 – 2026) is currently under consideration by Executive Management. The required investment will allow for purchase of the AMaT monitoring and tracking system and the team to progress this work. This action is dependent on the timing and level of investment. 5/1/21 Still Awaiting approval of investment.
2021-22	31.03.2022	Clinical Audit	R4/9	High	Management should ensure they have appropriate systems and processes to effectively record, track and monitor clinical audit outcomes, comparable to the size of the Health Board.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	Currently submission of part A's and B's are being recorded, but neither the capacity or IT management system is in place to monitor and track the improvement plans (Part B) A management system for monitoring and tracking clinical audits has been identified (AMaT) along with the required resource to implement and administer the work has been included in the Business Case to support QS&E Framework (2021 – 2026) is under consideration by the Executive Management Team. 5/1/21 Still Awaiting approval of investment to purchase AMaT and required resource.
2021-22	30.04.2022	Clinical Audit	R5/9	Medium	There is currently no Clinical Audit Training Plan in place to prioritise which Clinical Boards and Directorates require training. Potential risk of: • Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place Recommendation 5 Priority C	Executive Medical Director	Head of patient Safety and Quality Assurance/Senior Clinical Audit Coordinator	PC	An evaluation of training needs will be undertaken across the health boards to prioritise clinic audit training. Investment in the clinical audit team is required to deliver training and support clinical audit across the health board, as illustrated in the business plan. **5/1/21** Still Awaiting approval of investment. Clinical audit training has recomneced, however difficulties with capasity to continue to undertake this work fully without additional resource and long term sickness. The function of the clinical aduit team has also had to focus on National Audits and meeting mandatory requirments over recent months.

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2021-22	30.04.2022	Clinical Audit	R6/9	Medium	In conjunction with recommendation 2, the Clinical Audit Policy and underpinning procedure should detail the process for Clinical Boards to produce local Clinical Audit Plans. All Clinical Audit Plans should be made available to the Clinical Audit Team so that they are sighted on all local clinical audits that are being undertaken.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy, strategy and purchase of AMaT will transform the way in which tier 2 local audits are registered and monitored and will allow centralisation of clinical audit plans and reports, improving accessibility and ownership to clinicians for their audits and improvement plans and for Clinical board to have ability to track progress. The Clinical Audit Policy and Strategy will detail roles and responsibilities with a clearly defined process for staff to follow and refer to. Training will be provided and aligned with the policy and strategy for clinical audit. Completion of this action is dependent on the timing and level of investment in response to the business case. **5/1/21** Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness. It is difficult to progress this work without investment in the team and IT manangment system to establish the approach that will be taken. Long term sickness and clinical audit team having to prioritise National Mandatory audits has also had an impact
2021-22	30.04.2022	Clinical Audit	R7/9	Medium	In conjunction with recommendation 2, the mandate to complete a 'Clinical Audit Project Proposal Form' for all tier 2 and 3 audits, which are to be forwarded to the Clinical Audit Team, should be directed by Clinical Audit Policy and Procedures.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy and strategy will include mandated guidance for the proposal, authorisation and registration of Tier 2 and 3 clinical audits aligned with the Health Board information Governance arrangements This action is dependent of the timing and level of investment in response to the business case. 5/1/21 Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness. It is diffuclt to progress this wok without investment in the team and IT manangment system. Long term sickness and clinical audit team having to prioritise National Mandatory audits has also had an impact
2021-22	30.04.2022	Clinical Audit	R8/9	Medium	The governance arrangements to challenge and support local clinical audits requires clarity and to become embedded within the revised quality, safety and experience governance arrangements, to ensure the following: • There is effective oversight of local clinical audit plans and their delivery; • Local Clinical Audits are being reported upon and monitored, to ensure performance is being measured and action taken to implement change where needed, which is sustainable.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy, strategy and purchase of AMaT will transform the way in which tier 2 local audits are registered and monitored, including implementation of any necessary improvements. The Clinical audit policy and strategy will include a clearly defined process for clinicians and clinical boards in relation to governance arrangements for the delivery and quality monitoring of clinical audit activity.
2021-22	30.10.2021	Clinical Audit	R9/9	Low	Whilst the remit of the Clinical Effectiveness Committee is developing and embedding, consideration should be given to the good practice sighted in another Health Board, and the potential remit of the Committee to consider pertinent risks that they have the ability to challenge and support.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	Outlier status is a standard item on the Clinical Effectiveness Committee meeting agenda, outliers would remain on the agenda and actions updated until issues resolved. Clinical Leads and/or clinical boards are invited to attend CEC to discuss risks when identified, including any improvement plans and obstacles in place Implementation of a risk register has been added to the agenda for October Clinical meeting for consideration. 5/1/21 To be discussed in January CEC due to CEC meetings capacity
2021-22	31.03.2022	Five Steps to Safer Surgery	R1/7	High	Mechanisms need to be established that enable the Health Board to record Step One (Briefing) and Step Five (Debriefing) of Five Steps to Safer Surgery. Whilst considering options, attention should be given to the ability to report on quantitative data from Theatreman to identify areas of concern with steps two through to four.	Executive Medical Director	IT Service Manager and Interim Lead Nurse	PC	The Perioperative Care Directorate has worked in collaboration with Trisoft (The Manufacturer of TheatreMan, our Theatre Operating system within Cardiff & Vale UHB) to develop a mechanism for recording all 5 stages of the '5 Steps to Safer Surgery' electronically. This development will allow for quantitative data collection. All stages of the '5 Steps to Safer Surgery' will be compulsory. Prior to full implementation, the Theatre Informatics Team will need to undertake a period of testing to confirm that the correct pathways are active. The Perioperative Care Directorate will also need to ensure staff are aware of the change in process and provide any necessary training. Update :12/1/22 Trisoft have placed the questionnaires into other test environment and are awaiting our instruction to place into live. A help guide has been written but reports have not yet been explored due to the development not being attached to the current live system.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.03.2022 30.11.2021 31.03.2022	Five Steps to Safer Surgery	R2/7	High	Staff should be reminded of the importance for accurately completing the safer surgery checklist and if gaps are noted, these should be escalated and resolved appropriately.	Executive Medical Director	IT Service Manager Interim Lead Nurse Director of Nursing & Clinical Director	PC	In line with Agreed Management Action 1, The Perioperative Care Directorate aim to record all 5 stages of the 5 stages of the '5 Steps to Safer Surgery' electronically. This will eliminate duplication of information and all stages of the '5 Steps to Safer Surgery' will be mandatory fields within TheatreMan.Update : 31.12.21 This has been confirmed as being possible and we are awaiting a date from the Theatre IT team as to when this will be fully implemented. If a stage of the '5 Steps to Safer Surgery' is not completed staff will have to explain the reason why. Non-compliance reports can be generated and addressed with individuals involved. Update 31.12.21 Non compliance reports will be discussed at Theatre Manager 2:1's with the General Manager and Lead Nurse for Peri-Operative Care.A draft flow chart has been devised which shows escalation process for non-conformance. The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification. Update 31.12.21 will be agreed at the next Perioperative Care Policy Meeting To improve the non-compliance culture associated with the '5 Steps to Safer Surgery' the Senior Team within Surgery Clinical Board have engaged with the Patient Safety Team and Natssips lead for the PST with the view of securing senior support from the Executive Team within Cardiff & Vale UHB challenge the noncompliance culture associated with the '5 Steps to Safer Surgery. Update 12.1.22 The PST and Natssip lead are supportive of this change
2021-22	30.11.2021	Five Steps to Safer Surgery	R3/7	Medium	In conjunction with Recommendation 5, management should ensure that the processes within the 'Procedure for Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' (UHB Reference 58 v4), are effectively embedded within the Health Board and fully complied with for all surgical procedures.	Executive Medical Director	Interim Lead Nurse	PC	The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification. Update 31.12.21 will be agreed at the next Perioperative Care Policy Meeting
2021-22	31.03.2022 31.03.2022	Five Steps to Safer Surgery	R4/7	Medium	Staff should be further educated around the value of the Five Steps to Safer Surgery and reminded of the requirement to actively engage in the process.	Executive Medical Director	Director of Nursing and Clinical Director	PC	To improve the non-compliance culture associated with the '5 Steps to Safer Surgery' the Senior Team within Surgery Clinical Board have engaged with the Patient Safety Team with the view of securing senior support from the Executive Team within Cardiff & Vale UHB challenge the non-compliance culture associated with the '5 Steps to Safer Surgery'Update 31.12.21 - This has been discussed and has been supported by the Medical Director and the CD for Surgery Clinical Board The Perioperative Care Directorate has undertaken a benchmarking exercise to understand how other Health Boards educate new staff and reinforce the value of the Five Steps to Safer Surgery amongst existing staff members. The Benchmarking exercise highlighted how other Health Boards have developed a training video which is shared at induction. The Perioperative Care Directorate would like to develop a training video to educate new and existing staff members about the application and importance of the '5 Steps to Safer Surgery'. To maximise the effectiveness of the video Senior Leaders within the UHB will be invited to participate. Update: the directorate have been working with the other Theatre Managers across Wales to establish whether this could be a joint project with neighbouring health boards. A working group has been set up to take this forward.
2021-22	30.11.2021	Five Steps to Safer Surgery	R5/7	Medium	As part of the scheduled review in 2021 of the 'Procedure for Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' (UHB Reference 58 v4), the following should be included: • Step Five – Debriefing, of the Five Steps to Safer Surgery; and • Clarification of the process for employees to highlight non-compliance or concerns with Five Steps to Safer Surgery.	Executive Medical Director	Interim Lead Nurse	PC	The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting. Update 31.12.21 will be discussed at next Perioperative Care Policy Meeting

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	30.11.2021	Five Steps to Safer Surgery	R6/7	Medium	Risk surrounding Five Steps to Safer Surgery need to be incorporated within the Directorate / Clinical Boards risk management processes.	Executive Medical Director	Interim Lead Nurse	PC	A risk assessment for 'Word Health Organisation (WHO) Safety checklist' has been completed (22/07/2021). This will be updated to reflect the recommendations of this Audit and will be shared with the Directorate and Surgery Clinical Board. Update 31.12.21 The risk assessment has been updated and will be added to Surgery CB risk register.
2021-22	31.03.2022	Five Steps to Safer Surgery	R7/7	Low	Consideration should be given to the opportunities available to raise the profile of thematic issues of Five Steps to Safer Surgery outside of the Clinical Board, through the Health Board's revised Quality and Safety governance arrangements and to raise the profile of the work undertaken by the Peri-Operative Care Directorate to address common themes.	Executive Medical Director	Interim Lead Nurse	PC	The Perioperative Care Directorate has undertaken a benchmarking exercise to understand how other Health Boards educate new staff and reinforce the value of the Five Steps to Safer Surgery amongst existing staff members. The Benchmarking exercise highlighted how other Health Boards have developed a training video which is shared at induction. The Perioperative Care Directorate would like to Develop a Training video to educate new and existing staff members about the application and importance of the '5 Steps to Safer Surgery'. To maximise the effectiveness of the video Senior Leaders within the UHB will be invited to participate. 21/1/22 update- The representative from the PST has shared a story board for a video and accessed posters used by other HB's . It is hoped that this work will be taken forward by several health Boards in Wales A risk assessment for 'Word Health Organisation (WHO) Safety checklist' has been completed (22/07/2021). This will be updated to reflect the recommendations of this Audit and will be shared with the Directorate and Surgery Clinical Board. Update 31.12.21 A letter has been drafted to share with the staff the results of this audit and the actions that will be taken.
2021-22	31.03.2022 31.03.2022	Core Financial Systems	R1/2	Low	As a point of good practice, consideration should be given to the following updates to the Financial Control Procedures: - Referencing the Health Board's Standing Financial Instructions and Standing Orders within the procedures, to demonstrate the line of sight to key Health Board documents; and - The Accounts Receivable Control Procedure should include an owner and next review date.	Director of Finance	Head of Financial Accounts and Services Financial Services Manager	PC	Agree to update and reference Health Board's Standing Financial Instructions and Standing Orders within the procedures. Accounts Receivable Control Procedure has been updated with Owner Title and next review date.
2021-22	31.03.2022	Core Financial Systems	R2/2	Low	A review of controls should be undertaken to ensure all leavers of the Health Board have their user access to the Oracle system removed in a timely manner, particularly those outside of central finance.	Director of Finance	Director of Finance	PC	Agree to review controls and implement more robust process to ensure all leavers have access removed in timely manner
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R1/4	High	Peri-operative Care should continue as planned to complete and seek approval of a Health Board Theatre Utilisation Procedure, in addition to a Policy. In doing so, the following should be incorporated: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; - Clarity of roles and responsibilities, including but not limited to the distinction between Peri operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). Additionally, historical information which is no longer valid should be fully removed from the Intranet to avoid confusion and incorrect action occurring.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	The Peri-Operative Care Directorate will continue to write a procedure titled 'Operating Theatre Scheduling, Cancellation and Utilisation. This will be a standard operating procedure which explains the process of how theatre lists should be utilised, who should attend the scheduling and utilisation meetings and how the meetings will be run. This policy will be approved by the Peri-Operative Care directorate Governance forum and will also be sent to all stakeholders that use the Peri-Operative Care service and attend the scheduling and utilisation meetings. We have contracted with a company to support developing this policy. "Foureyes Ltd" are working with us until end of March and the focus will be on utilisation and efficiency. The Directorate will also write a Health Board policy which states the rules around the booking process of theatre lists and how performance and utilisation will be monitored and adhered to. This policy will need to be approved by the Peri Operative care Directorate and Surgery Clinical Board but will also need executive approval by the Board.These two policies will incorporate the recommendations: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; Clarity of roles and responsibilities, including but not limited to the distinction between Peri-operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). These policies/procedures will be available on the Health Board's intranet pages. The Policy and procedure will be found under the policies section within the Peri Operative Care Directorate web site. All old policies relating to theatre scheduling, utilisation and systems and processes in relation to these will be removed from Cardiff and Vale UHB intranet pages.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R2/4	Medium	In conjunction with recommendation 1, which will provide clarity of roles and responsibilities mandated by procedure, all specialties should be reminded of their responsibility to close down their theatre sessions (at the end of each session), so that the information recorded is complete and accurate to enhance utilisation intelligence.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	The policy on Operating Theatre Scheduling, Cancellation and Utilisation will clearly state the responsibilities and ownership with regards to ensuring that all theatre sessions are completed. Time frames will be set against individual directorates to ensure that the sessions are completed after receiving the information from the Peri-Operative Care directorate. If the timeframe is exceeded the policy will state the escalation protocols that will be followed.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R3/4	Medium	The current systems and processes for managing theatre utilisation should be enhanced, to ensure that utilisation is maximised, cognisant of the risks faced by the Health Board. The policy and procedure developed as part of Recommendation 1 should reflect the enhanced systems and processes to help ensure they are consistently applied.	Interim Chief Operating Officer	Lead Nurse Peri-operative care Deputy General Manager Peri Operative Care General Manager Peri-Operative Care Head of Operations Surgery Clinical Board	PC	Partially complete. Further time is required to undertake this significant piece of work. Due to other priorities, it is anticipated that this piece of work will be completed by the end of February 2022.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R4/4	Medium	The current systems and processes for managing theatre utilisation should be enhanced, to ensure that utilisation is maximised, cognisant of the risks faced by the Health Board. The policy and procedure developed as part of Recommendation 1 should reflect the enhanced systems and processes to help ensure they are consistently applied.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	Opportunities to maximise theatre resources will be achieved through the following actions: • Increase the workforce within the Peri-Operative Care directorate to ensure that there is sufficient amount of staff to work in the theatres. • Work with Specialist Services Clinical Board to ensure that the PACU service provision is increased. • Work with Theatre IT to ensure that theatre overview reports are sent to appropriate teams. • Theatre overview will be discussed with Theatre Managers and General Manger and Lead Nurse for Peri-Operative Care at their regular 2:1 meetings. • Theatre overviews will be discussed at Theatre scheduling meetings with each individual directorates. • If utilisation falls below the agreed performance rate this will be escalated to the appropriate Clinical Board. • Engagement with partner (FourEyes Ltd) to adopt best practise following GIRFT recommendations • Directorates will not be given extra sessions if their utilisation is below the agreed performance rate continuously and is due to reasons within their control. • Theatre performance reports will also be sent to Pre-assessment General Manager so that any issues of poor performance due to pre-assessment issues can be addressed. • The associate Clinical Director for Peri-Operative Care will continue to work with the deputy General Manager for Peri-Operative care to ensure theatre lists are fully booked and utilised. The Deputy General Manager will discuss this at the theatre scheduling meetings with the Directorates. • Theatre performance and utilisation and the action points above will all be written into the policy on Operating Theatre Scheduling, Cancellation and Utilisation
2021-22	31.03.2022	Retention of Staff	R1/5	Medium	Following the finalisation of the People and Culture Plan, management should consider the value of subsequently producing a Recruitment and Retention Strategy, given that the People and Culture Plan has a dedicated section on 'Attract, Recruit and Retain'.	Executive Director of People and Culture	Assistant Director of Workforce Resourcing	C	The People and Culture Plan has superseded the need for a separate Recruitment and Retention Strategy. A detailed set of objectives sit behind the high-level plan and will be the mechanism to monitor performance against the agreed key deliverables. We accept the recommendation not to develop a separate strategy, instead monthly meetings have been arranged with the Workforce & OD managers who are leading on each theme. The purpose of these meetings is to discuss progress against key deliverables and to provide assurance to the Executive Director of People and Culture.
2021-22	28.02.2022	Retention of Staff	R2/5	Medium	In conjunction with managements review of the BAF, which was in progress at the time of the audit debrief, the following should be considered: • A review of 'Current Controls' to ensure that they can be relied upon as a control; • Consideration of the completion dates of the actions recorded in the 'Gap in Assurances' and update in instances where the date has passed; and • A clear distinction between 'Current Controls' and 'Gap in Assurances' and the removal of any duplicate entries.	Executive Director of People and Culture	Assistant Director of Workforce	C	The BAF has been reviewed for March Board in line with the audit recommendations

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.03.2022	Retention of Staff	R3/5	Medium	The available resources to deliver the Nurse Retention Action Plan and associated workstreams requires review, to determine if current capacity will facilitate effective delivery of the plan and improve nurse retention, if it is a Health Board priority.	Executive Director of People and Culture	Director of Nursing Strategic Nursing Workforce & Assistant Director of Workforce Resourcing	PC	The Nurse Retention Steering Group has now started to meet and a comprehensive nurse retention framework with a number of themes and actions has been developed, however progress has been slowed down due to the operational pressures Actions: • Steering Group meets monthly, these meetings need to have minutes and actions captured. • Workstream Leads will update the Retention Action Plan with key objectives, timescales, progress, etc. • Progress with the plan will be reported into the monthly meetings with the Executive Director of People & Culture in accordance with the theme 'Attract, Recruitment & Retain'.
2021-22	31.03.2022 1.04.2022	Retention of Staff	R4/5	Medium	In alignment with the People and Culture Plan, the design of future retention initiatives should clearly state how the effectiveness of the initiatives will be measured and the means of evaluation.	Executive Director of People and Culture	Assistant Director of Workforce Resourcing Director of Nursing Strategic Nursing Workforce & Assistant Director of Workforce Resourcing	C	Retention measures are set out in the People and Culture Plan and are reported on a monthly basis through the People Dashboard to the Strategy and Delivery Committee and monthly progress meetings with the Executive Director of People and Culture e.g. turnover rates (by staff group and Clinical Boards), response to exit questionnaires and starter surveys
2021-22	31.03.2022	Retention of Staff	R5/5	Medium	Consideration should be given to mandating the Leavers' checklists through Health Board approved procedures, to minimise the risks to the Health Board.	Executive Director of People and Culture	Assistant Director of Workforce Resourcing	NA	Incorporate the leavers checklist into a 'Leavers Toolkit' accessible for managers and staff. The Toolkit will also include the exit questionnaire process, details on completing a termination form, etc.
2021-22	30.04.2022	Welsh Language Standards	R1/6	Medium	The Equality Strategy and Welsh Language Standards Group should reconsider the approach to the cascade of actions to Clinical Boards and Corporate Departments, to ensure implementation and compliance with the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Office & Assistant Director of OD	NA	Clinical Boards and Corporate Departments will be supported to develop individual action plans. These areas will then maintain responsibility to develop, own and report upon progress at the ESWLSG meetings.
2021-22	30.04.2022	Welsh Language Standards	R2/6	Medium	To continue as planned to ensure there are Welsh Language Champions across all Clinical Boards and Corporate Departments, to facilitate, support and ensure compliance with the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Office & Assistant Director of OD	NA	Create an agreed role description for the Welsh Language Champions. Support CB and Corporate Departments to introduce and embed, learning lessons from areas where this is already in place.
2021-22	30.04.2022	Welsh Language Standards	R3/6	Medium	As proposed by management, a Resource Needs Analysis to facilitate implementation, compliance and assurance with the Welsh Language Standards should be undertaken.	Executive Director of People and Culture	Welsh Language Office & Equality Manager	NA	Undertake a demand, capacity and resource review. Report initial findings to ESWLSG to shape recommendations / actions.
2021-22	28.02.2022	Welsh Language Standards	R4/6	Medium	The Equality Strategy and Welsh Language Standards Group should consider if they have appropriate capacity to provide effective oversight of the implementation of the Welsh Language Standards, and how they may wish to be further supported to ensure implementation of the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Officer Equality Manager ESWSLG Chair	NA	Feedback report, recommendations and management action plan to ESWLSG. Discuss and agree equal focus of WL and ED&I on agendas, with flexibility to reframe meeting depending on need. Ensure meeting updates include WL and ED&I from Clinical Boards and Corporate Areas.
2021-22	15.03.2022	Welsh Language Standards	R5/6	Medium	To ensure complete implementation of Welsh Language Standard 79, the Welsh Language Policy (UHB 462) should be published and available to staff. A review of the Policy would benefit from: - Further signposting to supporting procedures and written control documents; and - The supporting documents should also be clearly dated, also noting the date of next review and the link to the Welsh Language Policy.	Executive Director of People and Culture	Welsh Language Officer Equality Manager Assistant Director of OD	PC	Continue review of policy, including supporting documentation. Present initially . 21/02/2021 - The policy has been drafted and has been consulted by the Trade Union. to Strategy and Delivery Committee for consideration and recommendation to the Board. Present to Board for approval. Upload to website.
2021-22	30.04.2022	Welsh Language Standards	R6/6	Medium	To enhance the maturity of the risk management arrangements, the recording of the risks associated with the Welsh Language Standards should be strengthened to include risk mitigation and the nature of the risk score, to better inform the oversight and assurance forums.	Executive Director of People and Culture	Welsh Language Officer Equality Manager	PC	Develop an enhanced dashboard to reflect recommendations. Present to ESWLSG for comment / agreement. Finalise for effective updating and reporting of risk. 21/02/2021 - WLO met with the IT official. Explained that it might be a long term objectives with numerous challenges to overcome.

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (April 2022 Update)

	Update April 2022				Update April 2022				Update April 2022			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months			1				4				2	
No date set											1	
Total	**1**		1		**4**		4		**3**		3	

Total number of recommendations outstanding as of 22nd March 2022 for financial year 2019/20 is 8 compared to the position in February 2022 when a total of 10 outstanding recommendations were noted.

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (April 2022 Update)

	Update April 2022				Update April 2022				Update April 2022			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Overdue under 3 months												
Overdue by over 3 months under 6 months					4		4		4	1	3	
Overdue over 6 months under 12 months					4	1	3		2		2	
Overdue more than 12 months					1		1					
Total					**9**	1	8		**6**		5	

Total number of recommendations outstanding as of 22nd March 2022 is 31(*) (2 of which are listed as complete) compared to the position in February 2022 2021 when a total of 45 outstanding recommendations were noted. *NB: Within the Medium rated recommendations section reported to the February meeting only 5 entries were recorded as complete. The correct figure should have been 6, this has been rectified and is reflected in the figures reported above.*

* It should be noted that 16 recommendations from the IM&T Control and Risk Assessment advisory review are not included in the above table as the report was not rated. All 16 recorded entries are recorded as partially complete and are overdue by over 6 months, but less than 12.

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2021/22 (April 2022 Update)

	Update April 2022				Update April 2022				Update April 2022			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached					8		5	3				
Overdue under 3 months	7		7		12	3	7	2	3		3	
Overdue by over 3 months under 6 months	2	2			6	3	3		1		1	
Overdue over 6 months under 12 months					3	2	1		3	2	1	
Overdue more than 12 months												
Total	**9**	2	7		**29**	8	16	5	**7**	2	5	

Total number of recommendations outstanding as of 22nd March 2022 for financial year 2021/22 is 45 (12 of which have completed) compared to the position in February 2022 when a total of 30 outstanding recommendations were noted.

Report Title:	**Draft Annual Internal Audit Plan 22-23**			Agenda Item no.	8.5
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	05/04/22
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Internal Audit				

Main Report
Background and current situation:

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

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

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

The Internal Audit Charter has been updated as at April 2022 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Following an extensive planning process and in accordance with the requirements of the Public Sector Internal Audit Standards, the Internal Audit Plan has been prepared which sets out our risk-based plan of work for the year 2022/23.

The plan covers the whole of the 2022/23 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

In addition, the Plan also includes the Internal Audit Charter which has been prepared as at April 2022.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Approve** the Internal Audit Plan for 2022/23.
- **Approve** the Internal Audit Charter for 2022/23.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X

3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The Internal Audit Plan and Charter provide the Audit Committee with a level of assurance that the work of the Internal Audit department will be based around the key risks faced by the Health Board and will be sufficient to allow for delivery of the annual Internal Audit report and Head of Internal Audit Opinion.
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Annual Internal Audit Plan: Draft Internal Audit Charter

March 2022

Cardiff and Vale University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

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

2.2 Risk based internal audit planning approach

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

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

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19 and the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the

organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit and Assurance Committee in line with the Internal Audit Charter.

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

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

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

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

2.3 Link to the Health Board's systems of assurance

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

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit and Assurance Committee and the Quality and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the Health Board Executives and

a number of Independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's Executive team and the Chair of the Board.

The draft Plan has been provided to the Health Board's Executive Management Team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

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

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

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

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

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

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

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

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit and Assurance Committee for approval.

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

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

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

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

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

In addition, capital audit work in relation to the following projects will be charged for separately on the basis of separately agreed Integrated Audit & Assurance Plans:

- Development of Genomics Partnership Wales;
- University Hospital Llandough – Endoscopy Unit; and
- University Hospital Llandough – Engineering Infrastructure.

Provisions for this work was included by the Health Board in its respective business case submissions and accordingly funded through the Welsh Government's capital project allocations.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2022/2023

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Risk Management	1	N/A	Review the on-going development and implementation of the Risk Management Strategy and Procedure.	Director of Corporate Governance	Q4
Core Financial Systems	2	BAF Risk 2	Review a selection of controls in place to manage key risk areas across the range of the main financial systems.	Executive Director of Finance	Q4
QS&E Governance (Deferred from 21/22 plan)	3	BAF Risk 4	Review the governance arrangements to support the delivery of the Quality, Safety and Experience Framework (2021 – 2026)	Executive Nurse Director / Medical Director	Q3
Management of Health Board Policies	4		Review the arrangements in place for the creation, management and review of Health Board policies.	Director of Corporate Governance	Q3/4
Assurance Mapping	5		Advisory review to support the development of assurance mapping within the Health Board.	Director of Corporate Governance	Q1
Medical & Dental Staff Bank	6	BAF Risk 1	Review the effectiveness of the processes and controls operating within the Health Board's new Medical & Dental Staff Bank managed by MEDACS.	Executive Director of People & Culture	Q1

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Staff Wellbeing – Culture & Values	7	BAF Risk 5	Review arrangements within the Health Board for developing an effective culture and values and ensuring the wellbeing of staff. Include review of Occupational Health Services.	Executive Director of People & Culture	Q2
Inclusion & Equality Team	8	BAF risk 5	Review of the structure of the Team and the plans in place to take key actions forward relating to areas such as the Welsh Government Race Equality Plan.	Executive Director of People & Culture	Q4
Implementation of People & Culture Plan	9	BAF Risk 1 & 5	Review of processes for ensuring appropriate implementation of the Plan. Specific areas of review to be agreed.	Executive Director of People & Culture	Q3
Nurse Staffing Levels Act	10	BAF Risk 4	Review of processes in place to ensure compliance with the requirements of the Act. Focus on Paediatric arrangements which is a new part of the Act.	Executive Nurse Director	Q3
Reporting of Covid Deaths	11	BAF Risk 10	Review the arrangements for monitoring, recording and reporting Covid deaths in line with Welsh Government guidance.	Executive Nurse Director	Q3
Financial Plan / Reporting (Deferred from 21/22)	12	BAF Risk 2	Review COVID and non-COVID financial planning and reporting within the Health Board and to Welsh Government.	Executive Director of Finance	Q2

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Charitable Funds	13		Review the processes in place within the Health Board to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.	Executive Director of Finance	Q3
Capital Systems	14	BAF Risk 6	The specific area(s) of coverage will be risk assessed and agreed with management during 2022/23. Areas of coverage may include: • Compliance with UHB Capital Systems/Procedures; • Capital Planning; • Equipment; • Project Audits (not progressed via integrated audit plans)	Executive Director of Finance	Q4
Estates Assurance – Decarbonisation (Deferred from 21/22)	15		To determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy, and to provide assurance on capital allocations provided by Welsh Government to address decarbonisation issues across the estate during 2021/22.	Executive Director of Finance	Q2
Medical Staff Additional Sessions	16	BAF Risk 1	Review of the new policy and procedure being developed in relation to additional sessions worked by medical staff.	Medical Director	Q3

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Clinical Audit Follow-up	17		Follow-up of 21/22 Limited Assurance report. (Planned completion date for management actions - April 2022)	Medical Director	TBC
5 Steps to Safer Surgery Follow-up	18		Follow-up of 21/22 Limited Assurance report. (Planned completion date for management actions - March 2022)	Medical Director	TBC
Performance Reporting	19	BAF Risk 7 & 8	Following on from outcome of 21/22 audit. Focus on the operation / effectiveness of the Integrated Performance Report linked to ministerial priorities.	Director of Digital & Health Intelligence	Q3
Uptake of National IT Systems	20	BAF Risk 6	Review processes in place for the implementation and use of nationally developed IT systems. Focus on the upcoming Nurse Record system.	Director of Digital & Health Intelligence	Q1
IT Strategy	21	BAF Risk 6	Review processes in place for the development and delivery of the refreshed IT strategy to ensure it meets the needs of the UHB.	Director of Digital & Health Intelligence	Q2
New IT Service Desk Tool	22	BAF Risk 6	Review the set-up and implementation of the new tool.	Director of Digital & Health Intelligence	Q3
Data Warehouse	23	BAF Risk 7 & 8	Review the effectiveness of the data warehouse. Focus on systems to handle data inputs and outputs.	Director of Digital & Health Intelligence	Q4
Cyber Security	24	BAF Risk 7 & 8	Provision and scope of audit to be agreed.	Director of Digital & Health Intelligence	TBC

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Medical Equipment & Devices (Deferred from 21/22)	25	BAF Risk 6	Review arrangements in place for recording, monitoring and replacing medical equipment and devices.	Executive Director of Therapies & Health Science	Q2
CD&T CB – Ultrasound Governance Follow-up	26		Follow-up of 21/22 Limited Assurance report. (Planned completion date for management actions - March 2022)	Executive Director of Therapies & Health Science	TBC
Recovery of Services	27	BAF Risks 7 & 8	Focus on processes in place around planned care recovery.	Chief Operating Officer	Q3
Application of Local Choices Framework	28	BAF Risks 7 & 8	Review previous application of the Framework and the governance arrangements in place to inform future use.	Chief Executive / Chief Operating Officer	Q2
Mental Health CB – Administration Services	29	Clinical Board	Review of the administration services structures, functions and roles across the Clinical Board Directorates.	Chief Operating Officer	TBC
PCIC CB – GMS Access (Deferred from 21/22 plan)	30	Clinical Board	Review the processes and procedures in place for assessing GP practices achievement against the 'Access to In-Hours GMS Services' Standards.	Chief Operating Officer	TBC
Medicine CB – QS&E Governance Framework (Deferred from 21/22 plan)	31	Clinical Board	Establish the effectiveness of the Quality and Safety Governance structures to ensure adequate identification, reporting, escalation, and monitoring of risks and issues as required.	Chief Operating Officer	TBC

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Surgery CB – Consultant Job Plans	32	Clinical Board	Detailed scope to be agreed with the Clinical Board Management. Will include focus on service lines with elective and emergency splits.	Chief Operating Officer	TBC
Specialist Services CB – Community Patient Appliances	33	Clinical Board	Audit of systems in place to monitor and manage risk of patients with specialist seating in the community who have broken or old equipment. Including how cases are managed when there are delays to equipment ordering/delivery because of supply chain issues.	Chief Operating Officer	TBC
CD&T CB – Medical Records Tracking	34	Clinical Board	To investigate the effectiveness of the mechanisms for tracking medical records both inside and outside of the medical records department.	Chief Operating Officer	TBC
Women & Children's CB – Management of Locum Junior Doctors	35	Clinical Board	To review the system for agreeing and booking locums, including appropriate use of Envoy before offer of increased rates and cross checking of shifts against claims.	Chief Operating Officer	TBC
Strategic Programmes / Recovery & Redesign Governance Arrangements	36	BAF Risk 8	Advisory review to support development of processes for bridging the gap between Strategic Programme Governance and governance of the Recovery & Redesign Portfolio.	Executive Director of Strategic Planning	Q3

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
IMTP Development Process	37	BAF Risk 7 & 8	Review of the process undertaken for development of the 22/23 IMTP to inform future processes.	Executive Director of Strategic Planning	Q1
Commissioning – IPFR Process	38	Executive	Review of processes following changes in policy and guidance. Focus on treatments for European citizens and reciprocal arrangements. Include review of processes for assuring quality of treatment.	Executive Director of Strategic Planning	Q3
Regional Planning Arrangements	39	Executive /	Review of the processes for developing regional services such as the Regional Vascular Service.	Executive Director of Strategic Planning	TBC
Shaping Our Future Hospitals Programme	40	BAF Risk 8	A provision of time is included to enable a mixed audit provision at the programme and allow for proactive input and delivery of the observer role, together with interim audits through the period including: • An evaluation of the governance arrangements implemented at the programme; • Assurance on the appointment and management of external advisers; • Business Continuity planning; • Ongoing compliance with Statutory/Mandatory requirements.	Executive Director of Strategic Planning	Q1-4

Planned output	Audit Ref	BAF Reference	Outline Scope	Executive Lead	Outline Timing
Follow-up	N/A	N/A	We will conduct follow-up work linked to the Health Board's recommendation tracker throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions.	Corporate Governance	Ongoing
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales, Welsh Health Specialised Services Committee and Emergency Ambulance Services Committee.	Director of Corporate Governance	Q4
Development of Integrated Audit & Assurance Plans	NA	BAF Risk 6	In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the UHB to "assess the risk profile of the scheme and provide appropriate levels of review". A small provision of days is included within the 2022/23 plan to enable us to work with the UHB to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.	Executive Director of Strategic Planning	Ongoing (Subject to Business cases)

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed/in draft by 30 April	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

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

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

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

2 Purpose and responsibility

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

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit and Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit and Assurance Committee on behalf of the Board. Such functional reporting includes the Audit and Assurance Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit and Assurance Committee approves all Internal Audit plans

and may review any aspect of its work. The Audit and Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit and Assurance

Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit and Assurance Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit and Assurance Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's

risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit and Assurance Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

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

Figure 1: Audit planning hierarchy

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

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national

transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

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

- the provision to the Accountable Officer and the Audit and Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit and Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit and Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit and Assurance Committee requirements; and
- The Audit and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will

include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Director of Corporate Governance 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Director of Corporate Governance and Chair of the Audit and Assurance Committee.
- If non-compliance continues, the Director of Corporate Governance and the Chair of the Audit and Assurance Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit and Assurance Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.

- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit and Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit and Assurance Committee.

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit and Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2022

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Archwilio Cymru
Audit Wales

2022 Audit Plan – Cardiff & Vale University Health Board

Audit year: 2021-22

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This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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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.

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2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations. While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

3 I am required to issue a report on the Health Board's financial statements[1] which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. I lay them before the Senedd together with any report that I make on them. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your remuneration and staff report; and
- assess whether other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

4 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

5 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit and Assurance Committee and the Board, prior to the completion of my audit.

6 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

[1] My audit examination and review cover the Health Board's Performance Report, Accountability Report and Financial Statements which, once certified, I lay before the Senedd as one document.

7 I also audit your charitable funds' accounts. I provide a separate audit plan and audit fee for this audit, which I will be presenting to the Board of Trustee Members.

8 I can confirm that to date there have been no limitations imposed on me in planning the scope my audit work.

Audit of financial statement risks

9 The following table sets out the significant risks that my planning and testing have identified, to date, for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource limit, with a limit for revenue and another limit for capital. The first three-year period ran to 31 March 2017. The Health Board has exceeded its rolling three-year revenue limit in the	I will continue to monitor the Health Board's financial position for 2021-22 and the cumulative three-year position to 31 March 2022, for the both revenue and capital-resource limits. This review will also consider the impact of any relevant uncorrected misstatements over the three years.

Financial audit risks	Proposed audit response
past five years, and I have therefore qualified my regularity opinion on the financial statements for those years. For 2021-22 and the three years to 31 March 2022, Health Board forecasts[2] to operate within its revenue and capital resource limits, subject to anticipated 2021-22 COVID-19 funding of £21.3 million from the Welsh Government. If the Health Board receives the anticipated funding, and maintains its forecast position, it would support an unqualified regularity opinion. Your current financial pressures do however increase the risk that management's judgements and estimates could be biased in an effort to achieve the financial duty.	If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2021-22 financial statements. I may also place a substantive report on the financial statements to explain the basis of the qualification and the circumstances under which it had arisen. I will focus some of my testing on areas of the financial statements which could contain reporting bias.
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an 'emphasis of matter' paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, I would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	I will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.
While COVID-19 restrictions are due to be removed in Wales on 28 March 2022, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and	I continue to discuss your closedown process and quality monitoring arrangements with the relevant officers.

[2] Based on the Month 11 year-end forecast, which the Health Board has reported to the Welsh Government.

Financial audit risks	Proposed audit response
publication of the financial statements. There is a risk that the quality of the accounts and supporting working papers may be compromised, leading to an increased incidence of errors.	
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. They could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include: fraud, error and regularity risks of additional spend; valuation (including obsolescence) of year-end inventory, including PPE; and the estimation of year-end annual leave balances.	I will identify the key issues and associated risks and plan my work to obtain the assurance needed for my audit.
I audit some of the disclosures in the remuneration report to a far lower level of materiality, such as the remuneration of senior officers and independent members. The disclosures are therefore inherently more prone to material misstatement. In past audits I have identified material misstatements in the draft remuneration report submitted for my audit, which the Health Board had to correct. I therefore judge the 2021-2022 disclosures to be at risk of misstatement.	I will examine all entries in the remuneration report to verify that it is materially accurate.
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. Last year I identified a number of material disclosures that had been omitted and had to be added.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.

Financial audit risks	Proposed audit response
Other areas of audit attention	
The introduction of IFRS 16 Leases has been deferred to 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	I will review the completeness and accuracy of the disclosures.

10 In addition to my responsibilities in respect of the audit of the Health Board's statutory financial statements, set out above, I am also required to certify a return to the Welsh Government which provides information to support its preparation of Whole of Government Accounts.

Performance audit work

11 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

12 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

13 During 2020-21, I consulted public bodies and other stakeholders on how I will approach my duties in respect of the Well-being of Future Generations (Wales) Act 2015 for the period 2020-2025. In March 2021, I wrote to the 44 public bodies designated under the Act setting out my intentions, which include:

- carrying our specific examinations of how public bodies have set their well-being objectives, and
- integrating my sustainable development principle examinations within my local audit programme

14 My auditors are liaising with the Health Board to agree the most appropriate time to examine the setting of well-being objectives.

15 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: My planned 2022 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).
All-Wales Thematic work	As part of my 2022 plan, I intend to undertake an assessment of the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. I will tailor this work to align to the responsibilities of individual NHS bodies in respect of workforce planning. I also plan to use an element of the 2022 audit fee to respond to aspects of service delivery where my insight and knowledge across Wales will provide value to NHS bodies. The exact focus of this work will be confirmed following a broader consultation on my overall programme of audit work for Audit Wales for 2022-23 and beyond (see paragraphs 18 and 19).
Locally focused work	Where appropriate, I will also undertake performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit and Assurance Committee.

Theme	Approach/key areas of focus
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

16 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

17 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

18 We will provide updates on the performance audit programme though our regular updates to the Audit and Assurance Committee.

Fee, audit team and timetable

19 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[3];

[3] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

20 As set out in the Audit Wales Fee Scheme, my fee rates for 2022-23 have increased by 3.7%, as a result of the need to continually invest in audit quality and in response to increasing cost pressures. The previous increase to our fee rates was in 2016. The estimated fee for 2022 is set out in **Exhibit 3,** alongside the previous year's actual fees. This year's estimated fee represents a 3.7% increase.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[4]	Actual fee for 2021 (£)
Audit of Financial Statements	233,503	225,000[5]
Performance audit work:		
• Structured Assessment	53,103	70,141
• All-Wales thematic review[6]	73,410	72,129
• Local projects	34,949	13,382
Performance work total	**161,462**	**155,562**
Total fee	**394,965**	**380,562**

21 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

22 Further information on my fee scales and fee setting can be found on our website.

[4] The fees shown in this document are exclusive of VAT, which is not charged to you.

[5] The actual fee marginally exceeded the fee estimate of £225,000, which we did not charge to the Health Board.

[6] As detailed in the respective audit plans.

Audit team

23 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Engagement Director (Performance Audit)	02920 320604	Dave.Thomas@audit.wales
Richard Harries	Director (Financial Audit)	029 2032 0640	Richard.harries@audit.wales
Mark Jones	Audit Manager (Financial Audit)	02920 320631	Mark.Jones@audit.wales
Darren Griffiths	Audit Manager (Performance Audit)	02920 320591	Darren.Griffiths@audit.wales
Rhodri Davies	Audit Lead (Financial Audit)	02920 320637	Rhodri.Davies@audit.wales
Urvisha Perez	Audit Lead (Performance Audit)	029 2032 0610	Urvisha.Perez@audit.wales
Angharad Clemens	Senior Auditor (Financial Audit)	02920 320500	angharad.clemens@audit.wales

24 There are two potential conflicts of interest that I need to bring to your attention, both of which relate to Mark Jones. Mark's cousin is the Health Board's new Counter Fraud Manager, who commenced the role on 1 April 2022. Also, the new

Counter Fraud Manager's wife is a Consultant in Paediatric Endocrinology and Diabetes at the Health Board.

25 We are not aware of any other potential conflicts of interest that we need to bring to your attention.

Timetable

26 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	January to April 2022	March 2022
Audit of Financial statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Audit of Financial Statements Addendum Report	January to June 2021	June 2022 June 2022 August 2022
Performance audit work: • Structured Assessment • All-Wales thematic work • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Staff secondment

27 An Audit Wales member of staff, Amy Marshall, is currently seconded to the Health Board for the period 6 December 2021 to 27 May 2022. Amy is working within the Business Partnering Teams for the:

- Primary, Community and Intermediate Care Clinical Board; and
- Mental Health Clinical Board.

28 In order to safeguard against any potential threats to auditor independence and objectivity, the following restrictions apply in line with the Financial Reporting Council's Revised Ethical Standard 2019:

- the secondee will not undertake any line management or management responsibilities; and
- the secondment is limited to no more than six months.

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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.

Report Title:	Audit enquiries to those charged with governance and management				Agenda Item no.	8.8	
Meeting:	Audit and Assurance Committee	Public	x		Meeting Date:	5.04.2022	
		Private					
Status *(please tick one only):*	Assurance	x	Approval	x	Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Deputy Director of Finance						

Main Report
Background and current situation:

Audit Wales, the UHB external auditors, are responsible for obtaining reasonable assurance that the UHB's year end financial statements, taken as a whole, are free from material misstatement, whether caused by fraud or error. As part of their audit enquiries, Audit Wales asks the UHB a series of questions and seeks a response on a number of governance areas that are relevant to their audit of the financial statements. These considerations are relevant to management, and the Board who are deemed to be those charged with governance.

Attached is the audit enquiries letter received and the response given.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The letter received from Audit Wales is part of their usual processes for gaining assurances from management and those charged with governance. The attached response has already been endorsed by the Chair, the Director of Finance and the Director of Governance.

As part of good governance this response is provided to the Audit and Assurance Committee for its support and endorsement.

Recommendation:

The Audit and Assurance Committee are requested to:

- ENDORSE the response provided to the audit enquiries to those charged with governance and management.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	x	Integration		Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
Yes, as this is part of the assurances given on the preparation of the financial statements.
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
Yes, financial misstatements could lead to reputational damage.
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Audit and Assurance Committee	5.04.2022

Mohamed,Sarah
03/28/2022 16:21:28

Archwilio Cymru
Audit Wales

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By email.

Date issued: 2 March 2022

Dear Catherine,

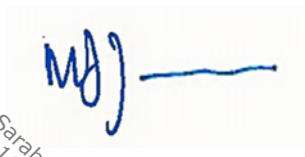
Cardiff and Vale University Health Board's 2021-22 financial statements: audit enquiries to those charged with governance and management

As your external auditors we are responsible for obtaining reasonable assurance that the financial statements, taken as a whole, are free from material misstatement, whether caused by fraud or error. This letter formally seeks responses on a number of governance areas that are relevant to our audit of the financial statements. These considerations are relevant to management, and the Board who are deemed to be those charged with governance.

I would be grateful if you could contact the relevant Health Board personnel as necessary and complete and return the attached tables in Appendices 1 to 3. Your responses should be formally considered and communicated to us on behalf of both management and those charged with governance.

I would like a reply by 8 April, but please do get in touch if you consider that date to be a problem. If you queries, please contact me via Teams, on 07748 181679, or by e-mail.

Yours sincerely,



Mark Jones

Audit Manager

Appendix 1

Matters in relation to fraud

International Standard for Auditing (UK and Ireland) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management, and 'those charged with governance', which for the Health Board is the Board itself. Management, with the Board, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by the Board.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets; or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how the Board exercises oversight of management's processes. We are also required to make enquiries of both management and the Board as to their knowledge of any actual, suspected or alleged fraud and for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

Enquiries of management - in relation to fraud	
Question	**Response**
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud and what are the principal reasons?	The assessed risk that the financial statements are materially misstated due to fraud is extremely low. Management are not aware of any fraud or potential fraud that would materially impact on the financial statements. This assessment is made on the basis of robust and comprehensive counter fraud and internal audit services. All potential fraud cases are rigorously investigated and pursued by the Health Board's counter fraud service. Internal Audit also undertake a detailed annual review of the main financial systems from which the financial statements are prepared.
2. What processes are employed to identify and respond to the risks of fraud more generally and specific risks of misstatement in the financial statements?	The Health Board has a well established year-end accounts closure process. This includes an analytical review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the fundamental financial systems upon which the financial statements are based. The risks around fraud are mitigated by a robust and well-resourced counter fraud programme. In addition there is a Post Payment Verification

	Panel which evaluates and monitor 'errors' with claims that have been submitted to Primary Care Services by the individual GP Practices and Opticians. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong codes of conduct and professional ethics. Any deliberate mis-statements would likely result in the individual being stuck off from their professional body.
3. What arrangements are in place to report fraud issues and risks to the Audit Committee?	The Audit and Assurance Committee agrees a Counter Fraud Work Plan at the start of the year. It then receives regular Counter Fraud progress reports at all of its normal business meetings. It also receives an annual counter fraud report which details the work that has been undertaken during the year under the Government Functional Standards GOVS013 Counter Fraud.
4. How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when?	All staff have access to the Standards of Behaviours Framework Policy via the Intra and Internet plus this is included upon recruitment and at induction. Consultant Medical and Dental Staff are reminded of the need to declare interests etc, when completing their job plans. Board members are made aware of the

	policy on recruitment and are also prompted to complete a declaration on an annual basis. This requires them to confirm that they have read and understood the policy. 'Declarations of Interest' is also a standing item on the agenda of all Board and Committee meetings. In addition, the Standards of Behaviours Framework policy has been circulated across the Health Board via Internet, Intranet and Email communications. These communications have highlighted the need to comply with the policy at key times of the year, including Christmas, during key sporting events and at the start of the new financial year. This has been done to make sure that expectations of ethical governance and standards of conduct and behaviour are being communicated to all professional staff and not only to Medical and Dental staff. This policy and process is being Audited by Welsh Audit Office this year and it is hoped that the assurance rating will be strengthened this year.
5. Are you aware of any instances of actual, suspected or alleged fraud since 1 April 2021?	Yes, this is fully reported to the Audit and Assurance Committee at its regular business meeting in its private session via a counter fraud progress report. Also, as part of their private meetings, the Board receives minutes from the private meeting of the Audit and Assurance Committee, which include reference

	and any significant points highlighted in the Counter Fraud Progress Reports.

Enquiries of those charged with governance – in relation to fraud	
Question	**Response**
1. How does the Board exercise oversight of management's processes for identifying and responding to the risks of fraud within the audited body and the internal control that management has established to mitigate those risks?	The Board has delegated the review and monitoring of management processes for identifying and responding to fraud risks to the Audit and Assurance Committee. This monitoring is supported by the work of the Audit and Assurance Committee and by the internal audit and counter fraud services for which the Finance Director is the lead Executive Director. The Audit and Assurance Committee receives regular reports on counter fraud matters and on the adequacy of internal controls that exist within the Health Board and on the actions being taken to mitigate these risks. The Chair of the Audit and Assurance Committee is an Independent Member of the Board and reports back to the Health Board on these matters and the minutes of both the public and private meetings of the Audit and Assurance Committee are included in the meeting papers of the Board in its open and private meetings.

2. Are you aware of any instances of actual, suspected or alleged fraud since 1 April 2021?	Yes, as part of their private meetings, the Board receives minutes from the private meeting of the Audit and Assurance Committee, which includes any significant points highlighted in the Counter Fraud Progress Reports

Appendix 2

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, (the Board), is responsible for ensuring that the Fund's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements; and
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make inquiries of management and the Board as to whether the Fund is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance, we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Enquiries of management – in relation to laws and regulations

Question	Response
1. How have you gained assurance that all relevant laws and regulations have been complied with?	Assurances are gained via the appropriate Board Committees where these issues are discussed. Where relevant these are linked to the Corporate Risk and the Health Boards, Board Assurance Framework. The Corporate Governance team have strengthened its management of Regulatory Compliance and achieved a reasonable assurance report which was an improvement following the previous years limited rating. The Health Board has continued to develop this area and has invested in staff resources to further strengthen its compliance with Laws and Regulations.
2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations since 1 April 2021, or earlier with an ongoing impact on the 2021-22 financial statements?	There is one known non-compliance in respect of a fire notice received that could result in a fine and therefore could impact upon the financial statements. This is subject to ongoing

	discussions with the South Wales Fire and Rescue Service.
3. Are there any potential litigations or claims that would affect the financial statements?	There are some Employment Tribunal cases involving the Health Board and these have been accounted for within the financial statements.
4. Have there been any reports from other regulatory bodies, such as HMRC which indicate non-compliance?	Whilst no reports have been issued, a review of the Health Board by HRMC is ongoing in respect of compliance with VAT regulations. Non compliance fines have already been levied and settled and an assessment of further liability, whilst not yet agreed, has been accounted for in the financial statements.

Enquiries of those charged with governance – in relation to laws and regulations	
Question	**Response**
1. How does the Board, in its role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	Assurances are gained via the appropriate Board Committees where these issues are discussed. Where relevant these are linked to the Corporate Risk Register and the Board Assurance Framework for the Health Board.
2. Are you aware of any instances of non-compliance with relevant laws and regulations?	Yes, we have received a fire compliance notice.

Appendix 3

Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Enquiries of management – in relation to related parties	
Question	**Response**
1. Confirm that you have disclosed to the auditor: – the identity of any related parties, including changes from the prior period; – the nature of the relationships with these related parties; and – details of any transactions with these related parties entered into during the period, including the type and purpose of the transactions.	Yes, these are all disclosed to the auditor.
2. What controls are in place to identify, authorise, approve, account for and disclose related party transactions and relationships?	Staff are required to make declarations in accordance with the Standards of Behaviour Framework Policy, incorporating Gifts, Hospitality and Sponsorship. All Board members are asked to make a declaration on an annual basis, which is then recorded and published in the Declarations of Board Members' Interests. Where a Board Member's interests change during the year, they have a personal responsibility to declare this and inform the Board Secretary.

	These related party transactions are identified in the annual accounts and their materiality quantified. For all Committees and Board meetings we have a standing agenda item at the beginning of each meeting, ‘Declaration of Interest’, in relation to items on the agenda.

Enquiries of those charged with governance – in relation to related parties	
Question	**Response**
1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	The Audit Committee receives a report at each of its meetings relating to compliance with the policy and the Gifts, Hospitality and Sponsorship Register. It also scrutinises the Annual Accounts which contain details of related party transactions. The Corporate Governance Team maintain the Gifts, Hospitality and Sponsorship Register. The Register is monitored in conjunction with the Health Board's Counter Fraud Team who flag staff members that appear on the National Fraud Database. Any adverse findings against staff members are reported to appropriate managers, executives and Board Committees as necessary.

Verification of Dialysis Sessions (Specialist Services Clinical Board)

Final Internal Audit Report

March 2022

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Review reference:	CVU-2122-26
Report status:	Final Report
Fieldwork commencement:	3 December 2021
Fieldwork completion:	21 February 2022
Debrief meeting:	25 January 2022 *(Meeting held with Directorate Manager prior to a change in role)*
Draft report issued:	25 February 2022
Management response received:	16 March 2022
Final report issued:	17 March 2022
Auditors:	Jayne Gibbon, Audit Manager Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Caroline Bird, Interim Chief Operating Officer
Distribution:	Sarah Lloyd, Acting Director of Operations, Specialist Services Clinical Board
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Nephrology and Transplant Directorate for the verification of community dialysis sessions provided by external suppliers.

Overview

Our overall rating of Substantial Assurance reflects the governance, reporting and monitoring arrangements in place for the provision of dialysis sessions.

We identified a key matter requiring management attention, which refers to the accessibility of key documents that support the monthly verification exercise.

Two further low priority recommendations of an advisory nature are within the detail of the report.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate governance arrangements in place for the provision of dialysis sessions.	Substantial
2	Procedural guidance in place	Substantial
3	Effective controls for verification of sessions and payment of invoices	Reasonable
4	Activity provided by external suppliers is monitored and reported	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matter Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2	Lack of visibility and accessibility of verification documents	3	Operation	Medium

1. Introduction

1.1 The review of Verification of Dialysis Sessions (Community Dialysis Units) within the Specialist Services Clinical Board was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the Health Board), and at the request of the Clinical Board.

1.2 The Welsh Health Specialised Services Committee (WHSSC) commissions the Health Board to provide dialysis services for South East Wales, covering the three Health Board areas of Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board, and Aneurin Bevan University Health Board.

1.3 The Nephrology and Transplant Directorate (the Directorate) at the University Hospital of Wales provides renal services to over 2.2 million people within South Wales. The Directorate offers a comprehensive range of patient services for those with renal disease, extending from early detection to the provision of maintenance programmes to treat renal failure.[1]

1.4 The Directorate is responsible for the management of the main Renal Unit in the University Hospital of Wales, Satellite Dialysis Units and the outreach Nephrology clinics in the other Health Board regions.[2]

1.5 There are six community dialysis units across the South East Wales region which are run by two external suppliers.

1.6 The executive lead for this review is the Interim Chief Operating Officer.

Audit Risks

1.7 The potential risks considered in this review were as follows:

- The Health Board is charged for services note received;
- Services are not procured in accordance with Health Board guidance; and
- Financial loss and reputational damage for the Health Board.

[1] https://cavuhb.nhs.wales/our-services/nephrology-and-transplant/
[2] https://cavuhb.nhs.wales/our-services/nephrology-and-transplant/patient-information/

2. Detailed Audit Findings

Objective 1: There are appropriate governance arrangements in place for the provision of dialysis sessions by external providers

2.1 There is a block contract in place between the Health Board and WHSSC for the provision of dialysis services for the population of South East Wales. The contract is reviewed at the end of each financial year and its value adjusted for the forthcoming year, to reflect level of dialysis activity of the previous year.

2.2 Contracts are in place with two external providers for the provision of dialysis sessions at six satellite dialysis centres in the South East Wales region. The contracts were awarded via an open tender process and in accordance with All Wales Procurement Guidance. The current contracts will expire on 31st March 2026. It is noted that due to the value of the contracts in place, approval for the awarding of the contracts was also required by Welsh Government.

2.3 Quarterly governance meetings take place with each supplier to review Clinical key performance indicators for each of the units as well as discuss any ongoing issues.

2.4 The Directorate is supported by Procurement for contract management. As part of the contractual arrangements regular meetings should take place between the providers, Procurement and the Health Board to review arrangements and note any issues. We were advised that due to the COVID-19 pandemic these meetings have lapsed but are due to resume shortly.

Conclusion 1: There are appropriate governance arrangements in place for the provision of dialysis sessions. (Substantial Assurance)

Objective 2: Procedural guidance is in place and is appropriate and up to date

2.5 We were provided with a desk instruction, 'How to Reconcile Dialysis Session Invoices against electronic data received in VitalData'. The desk instruction had been developed whilst audit fieldwork progressed, which outlines the steps of the verification process, and includes links to key schedules to be updated that can be found on the department's shared drive.

2.6 Our observations of the reconciliation process enabled us to test the desk instruction, and whilst helpful we found there are opportunities to further strengthen. The desk instructions would benefit from greater detail to provide clarity to any new members of staff. *(Matter Arising 1 – Low Priority)*

Conclusion 2: Whilst there is a desk instruction in place, further enhancements would support the resilience of the team undertaking the verification process, should there be any staff changes. (Substantial Assurance)

Objective 3: There are effective controls in place for the verification of sessions provided and payment of invoices received

2.7 There are two Data Analysts that undertake the monthly verification process, who alternate each month, to ensure resilience and continuity of the process. The end-to-end process of undertaking the verification process typically takes two working days.

2.8 The external providers submit two invoices for each satellite dialysis unit on a monthly basis, one for staff costs for delivery of the service, and a second for the number of sessions that have been delivered.

2.9 On 17th January 2022, we observed the verification process for two satellite units, for the period December 2021, overall we found that the controls in place were appropriate and effective. However, we did note a resilience risk, due to the limited accessibility of some documents, which support the verification process. *(Matter Arising 2 – Medium Priority)*

2.10 A review of a sample of invoices paid in the financial year found that the session rates charged were in accordance with the agreed contract.

2.11 A review of the confirmation orders generated to pay the dialysis invoices noted that the description line was standard and did not reflect the month the charge related to, invoice number or the number of sessions being invoiced. *(Matter Arising 3 – Low Priority)*

Conclusion 3: The controls in place for the verification of dialysis sessions and payment of invoices were found to be appropriate. However, our recommendations, once implemented, would enhance the effectiveness of controls for transparency and resilience. (Reasonable Assurance)

Objective 4: Activity provided by external suppliers is monitored and reported

2.12 Within the Specialist Services Clinical Board, a performance meeting takes place within the Nephrology and Transplant Directorate every two months. At that meeting the Directorate Manager will submit an update report on the Renal Service, which will include information on the dialysis service activity.

2.13 To note, there is no target set for the number of dialysis sessions to be delivered each year. The Health Board is required to provide a service to match demand. Any issues regarding matching demand will have to be managed by the Health Board in the short term. Longer term, issues will be escalated up through the Clinical Board and to the Welsh Renal Clinical Network (WCRN) meetings for discussion and resolution.

2.14 Monthly finance meetings also take place with the Directorate Accountant and the Directorate Manager where dialysis activity is reviewed, and any concerns noted.

2.15 The Health Board is a member of the WCRN and receives regular reports on activity for information and review.

2.16 Representatives of the Health Board also attend the meetings of the WCRN. At these meetings an update report will be submitted by the Health Board on the service and any issues regarding activity will be highlighted.

Conclusion 4: Activity of dialysis sessions is monitored and reported at a number of meetings within the Clinical Board and at all Wales meetings. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Instructions to support the verification process (Design)	**Impact**
We reviewed the desk instruction, 'How to Reconcile Dialysis Session Invoices against electronic data received in VitalData', and note the following observations: • The instruction includes links to many of the documents to be completed as part of the verification exercise, this could be strengthened by also clarifying the details of the file name and pathway of where the documents can be accessed; • Step 12 could be expanded to provide more detail on the narrative to be used for discrepancies and also reference where Unit contact details can be accessed; and • In conjunction with Matters Arising 2 and 3 of this report to expand on the information detailed for Steps 2 and 14. It is noted that current staff are very familiar with the process, but any new staff appointed would benefit from a more detailed procedure.	Lack of clear guidance could result in errors occurring during the verification process.
Recommendation 1	**Priority**
Management should review the desk instruction, 'How to Reconcile Dialysis Session Invoices against electronic data received in VitalData' with a view to expanding many of the steps detailed, for clarity on what action to take, where to access and save key documentation.	**Low**

Agreed Management Action 1	Target Date	Responsible Officer
The Renal Systems Analysts have carefully considered the Matters Arising 1 and will incorporate, expand, and add clarification to the information in "How to Reconcile Dialysis Session Invoices against electronic data received in VitalData " document based on the Audit observations. The document will be reviewed 'live' when performing reconciliation exercises for Feb and Mar session data, in Mar and Apr respectively.	1st May 2022	Renal Systems Analysts

Matter Arising 2: Lack of visibility and accessibility of verification documents (Operation)	**Impact**
Whilst observing the verification process for a sample of dialysis sessions delivered in December 2021, we noted the following: • Some supporting evidence such as the 'pivot query table' as well as 'monthly activity queries worksheets' were saved to an individual staff member's personal H Drive, rather than the department's shared drive; • Emails regarding queries on the monthly activity that are sent to the Dialysis Satellite Units and any responses are held within the email account of the Data Analyst that is undertaking the exercise. Current processes present a resilience risk, due to the lack of visibility or accessibility of information which informs the verification process, should a query arise when a member of staff is unavailable.	Resilience of the verification process and payment to providers due to the lack of visibility or accessibility of information which informs the process.

Recommendation 2		Priority
Management should ensure that all documentation / evidence that supports the monthly verification process for the provision of dialysis sessions is accessible to all members of the team, either through greater use of the department's shared drive or use of a team email account. *With reference to Recommendation 1, management should also consider this recommendation when updating the instruction to support the verification exercise.*		**Medium**
Agreed Management Action 2	**Target Date**	**Responsible Officer**
When considering the matter of lack of visibility or accessibility of information, which informs the verification process, there are 3 core areas of the process that we will review. They are: (1) Excel outputs - generating the raw data, creating a table for analyses to reconcile day-to-day comparison plus the re-runs of the output, (currently observed as held on Analysts' H:/ drive) (2) Word docs - the monthly activity queries to the six SE Wales Dialysis Units (currently created and E-mailed from Analysts' E-mail account) (3) Master workbook - the evolving Performance Monitor table (currently available on the Dept shared drive) [Note: all of the above is accessible and readily available from the source Renal Information System (VitalData) and can be extracted by running pre-defined code] With regard to (1), the raw data and any outputs will be visible on the Master workbook in addition to the Performance Monitor table – both available to view on the Dept shared drive.#	1st April 2022	Renal Systems Analysts

With regard to (2), the E-mailed activity queries will be sent from the N&T Generic Account Mailbox, which is managed by Renal T staff # Note, one of the longer-term objectives of the CAV Renal IT Team in 2022 is to migrate current shared drive information to a more user friendly, controlled platform such as CAV SharePoint.		

Matter Arising 3: Oracle confirmation order details (Operation)	**Impact**
We reviewed a sample of invoices paid during the financial year 2021/22 for the provision of dialysis sessions at the satellite dialysis centres, provided by the external providers. As part of our testing we interrogated the Oracle Financial System to review the narrative within the system, we noted that the information detailed on the confirmation orders was minimal, for example 'for the receipt of dialysis sessions provided'. The confirmation orders are raised to facilitate payment of invoices received, but there was a lack of clarity of associated invoice number, the relevant month and number of sessions delivered.	Potential incomplete audit trail.
Recommendation 3	**Priority**
Management should consider enhancing the details recorded on confirmation orders raised within Oracle to pay invoices for dialysis sessions provided. Consideration should be given to adding the following information: • Invoice Number; • The relevant month sessions were provided; and • Number of sessions delivered.	**Low**

Agreed Management Action 3	Target Date	Responsible Officer
Please note there is one Braun / Fresenius invoice per unit, per row in Oracle in relation to the number of sessions that have been delivered. Procurement have provided templates for each dialysis unit, e.g. "Invoice payment for renal dialysis unit services at Cardiff South". Once the row is selected, then the Invoice Number is evident. We can add to this narrative and continue to include the month and now introduce the number of sessions delivered, which is exactly what we would instruct payment for.	1st April 2022	Renal Systems Analysts

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Raising Staff Concerns (Whistleblowing)

Final Internal Audit Report

March 2022

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to raising staff concerns and to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the systems objectives were managed appropriately.

Overview

We have issued reasonable assurance on this area.

The matters that require management attention include:

- The Freedom to Speak Up communication campaign cannot be overestimated in value given the low number of staff concerns currently reported. The timeliness of campaigns should be improved.
- Whilst processes are in place to record staff concerns, we make a recommendation to enhance current arrangements to ensure the robustness of recorded concerns.
- The Health Board is yet to determine whether the Board or sub-committee will monitor the use of the All-Wales Procedure for Staff to Raise Concerns.

Other low priority recommendations are within the detail of the report.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Adoption of the All-Wales Procedure for NHS Staff to Raise Concerns	Substantial
2	Staff awareness of the procedure	Reasonable
3	Managers are aware of their responsibilities	Reasonable
4	Processes are in place to record, investigate and address staff concerns	Reasonable
5	Governance arrangements for the review, reporting and escalation of identified concerns and themes	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
3	Timeliness of the Freedom to Speak Up communication campaign	2 & 3	Operation	Medium
4	Greater clarity within the Freedom to Speak Up Staff Concerns Log	4	Operation	Medium
5	Compliance with the governance arrangements of the All-Wales Procedure for NHS Staff to Raise Concerns	5	Design	Medium

1. Introduction

1.1 The review of the arrangements for Raising Staff Concerns (Whistleblowing) was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board ("The Health Board").

1.2 It is vital that staff in the NHS feel empowered to speak up for patients at the earliest opportunity, whenever patient safety may be compromised, or potentially serious errors occur.

1.3 The Health Board has adopted the All-Wales Procedure for NHS staff to raise concerns and has information regarding the UHB's 'Freedom to Speak Up' process signposted on its website.

1.4 The Health Board and senior management have a duty to provide an environment which facilitates open dialogue and communication, ensuring that concerns raised by staff are dealt with as soon as possible.

1.5 Staff should have mediums where they are able to confidently speak up and report past, current or future concerns in a timely and safe way, with the assurance that these concerns will be adequately handled.

1.6 The Executive Director of People and Culture is the lead for this review.

Audit Risks

1.7 The potential risks considered in this review were as follows:

- The Health Board's processes are not in compliance with the 'All-Wales Procedure for NHS Staff to Raise Concerns';
- Staff are unaware of the procedures and are therefore unclear on how to report a concern;
- Managers and senior officers with responsibility for dealing with concerns have not received appropriate training, and concerns are not therefore dealt with consistently with the procedure;
- Concerns are not documented, investigated, or acted upon where appropriate; and
- Poor governance arrangements result in the failure to escalate and address key issues.

2. Detailed Audit Findings

Objective 1: Effective, documented and up to date procedures are in place within the Health Board to ensure that concerns are handled in line with the requirements of the 'All-Wales Procedure for NHS Staff to Raise Concerns'

2.1 In September 2021 all NHS Wales organisations received the revised All-Wales Procedure for Staff to Raise Concerns. The amended procedure was agreed by the Welsh Partnership Forum Business Committee on 8 June 2021 and subsequently ratified by the Welsh Partnership Forum on 8 July 2021. The procedure can only be amended through agreement by the Welsh Partnership Forum, and not amended locally.

2.2 The updated procedure is held on the Health Board's website, within the Workforce and Organisational Development Policies, which includes information on where matters can be raised, as follows:

- The Freedom to Speak Up helpline on F2SUCAV@wales.nhs.uk or 02921846000;
- Workforce & OD (HR) staff;
- The Director or Corporate Governance or Head of Risk and Regulation;
- Professional Heads;
- The Chief Executive or UHB Vice Chair; and
- Any concerns relating to patient safety can be raised by contacting the UHB Chair.

2.3 On 16 November 2021 the Strategy and Delivery Committee received an Employment Policies Report (item 2.1), which included reference to the revised All-Wales Procedure for NHS Staff to Raise Concerns. The context of the All-Wales Procedure was provided, and the report referred to Appendix 2 for the attached procedure. The Committee were requested to, *'Formally ADOPT the revised Procedure for NHS Staff to Raise Concerns'*. We note that although referenced, Appendix 2 was not attached to the paper. *(Matter Arising 1 – Low Priority)*

2.4 Through our audit testing we were also made aware of an historic 'Standard Operating Procedure for Managing Concerns from Staff', which was a helpful illustration of actioning a concern. A copy of the guidance had previously been held on the website but is currently held on the department's shared drive. *(Matter Arising 2 – Low Priority)*

Conclusion 1: The Health Board's approach to responding to staff concerns aligns with the All-Wales Procedure for Staff to Raise Concerns, which has been formally adopted through the Committee structure. (Substantial Assurance)

Objective 2: Effective processes are in place to ensure staff are aware of the procedures and they are made readily available to all staff with or without IT access

2.5 The 'All-Wales Procedure for NHS Staff to Raise Concerns' is available to all staff on the Health Board's Website, amongst the Workforce and Organisational Development Policies[1]. Given the procedure is available on the public facing webpages, staff can view with or without access to Health Board IT systems.

2.6 The Health Board has a process and communications campaign to highlight opportunities for staff to raise concerns called 'Freedom to Speak Up' (F2SU), which has been in existence for a number of years and was refreshed in May 2021, as noted in an update to the Management Executive on 5th July 2021. The F2SU process is promoted on the Health Board's website.

2.7 The F2SU communication campaign is accessible to staff, with or without access to a Health Board computer and includes:

- Videos and posters to target staff;
- Information on both the intranet and internet;
- Screen savers across all hospital sites;
- Messages shared via the Health Board StaffConnect App, staff are able to access this app from their personal phones;
- Presence on the Electronic Staff Record (ESR);
- Videos uploaded to twitter from the UHB chair, Executive Director of Nursing, and the Director of Corporate Governance;
- The Health Board's Trade Union page refers to F2SU; and
- An email was sent to all staff to highlight F2SU.

2.8 There are dedicated resources available to staff on the Health Board's website, within the F2SU webpages[2] and staff are reminded of how to raise a concern.

2.9 Due to staff changes, we were unable to speak with the key contact in the Communications Team, who had previously led the F2SU communications campaign. Further work is required to embed the F2SU biannual campaign, which was scheduled for December 2021 but is yet to take place. We were advised at the close of our audit fieldwork that the campaign would run in February 2022. *(Matter Arising 3 – Medium Priority)*

Conclusion 2: The Health Board have created multiple means of communicating with staff to ensure they are familiar with the F2SU process, which provides a mechanism to align with the 'All-Wales Procedure for NHS Staff to Raise Concerns'. Further work remains to embed the scheduling of the F2SU communication campaign. (Reasonable Assurance)

[1] https://cavuhb.nhs.wales/about-us/governance-and-assurance/policies-procedures-and-guidelines/workforce-and-organisational-development-policies/

[2] https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/freedom-to-speak-up/

Objective 3: Managers responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately

2.10 The Health Board's F2SU process is outlined on the website, and there are dedicated resources to support staff and managers in the handling of concerns raised. The support listed includes[3]:

- HR Operations Centre;
- Trade Unions;
- Occupational Health Service;
- Employee Health and Wellbeing;
- Supporting Policies and Procedures; and
- External Resources.

2.11 Specifically for managers is a section on responding to a concern, which provides 'top tips' to keep in mind when responding to a concern[4], as follows:

Remember that the individual speaking up is probably feeling nervous. Take this into account in how you engage with them. For example, be patient, listen respectfully and respond with sensitivity.

Listen to what they have to say and record it. Ask them to clarify any grey areas, but bear in mind that they may not know exact details. Read back what you've recorded so they knows what is being logged.

Reassure the individual that they will not suffer any disadvantages for having raised a concern. Reassure them that you will maintain their anonymity whereever possible. Provide a copy of the relevant UHB policy.

Take action towards resolving the concern. Report the logged information to a senior manager, a director and/or someone with designated "speaking up" responsibilities.

Advise the individual who raised the concern about who is looking into it, how long this might take and what is most likely to happen next.

Update the individual who raised the concern as far as confidentiality allows. This is critical. It is vital that the individual knows their decision to speak up is making a difference.

2.12 The All-Wales Procedure for NHS Staff to Raise Concerns requires formally reported concerns to be recorded. We note currently, there is no formal training available for managers to supplement the resources available on the Health Board's website. But we acknowledge, in a broader sense that training has been limited through the

[3] https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/general-health-and-wellbeing-resources/freedom-to-speak-up/resources-and-support/

[4] https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/general-health-and-wellbeing-resources/freedom-to-speak-up/responding-to-a-concern/

COVID-19 pandemic, to the extent that mandatory training is slowly being reintroduced. Given the context and timing of our review, it would not seem appropriate to add to the training burden of the Health Board, given this is not an area where training is mandated. However, maintaining momentum and continued awareness the F2SU communications campaign is key to ensuring that managers and staff are aware of the procedures and processes, so that concerns are handled appropriately. *(Matter Arising 3 – Medium Priority)*

Conclusion 3: There are several resources available to support managers responsible for handling staff concerns, however in the absence of formal training, the momentum of the F2SU communication campaign is key to signposting to available resources, which is yet to be fully embedded. (Reasonable Assurance)

Objective 4: Processes are in place to record both formal and informal staff concerns, that ensure they are promptly investigated and addressed with appropriate actions taken where required

2.13 The adopted All-Wales Procedure for NHS Staff to Raise Concerns includes details of the various routes that staff can raise concerns, as outlined within paragraph 2.2 of this report.

2.14 The 'Standard Operating Procedure for Managing Concerns from Staff' is an aid used by the Risk and Regulation Team to respond to concerns, which illustrates the process to be followed. There would be benefit in increasing the visibility of the document, to support the message that staff concerns are addressed through a confidential process. *(Matter Arising 2 – Low Priority)*

2.15 The Head of Risk and Regulation records and investigates all staff concerns that are brought to their attention under the F2SU process, which includes anonymous reports. All concerns are recorded within an Excel log and also logged in Datix to generate a unique reference number. There is controlled access to the concern log and F2SU inbox.

2.16 We reviewed a Datix report which extracted information on 'type – Freedom to Speak Up' and reviewed the concerns log held outside of Datix. We have made observations regarding the level of information and detail recorded. *(Matter Arising 4 – Medium Priority)*

2.17 We were able to verify from the minimal concerns logged that there had been appropriate investigation and follow up, having been promptly acknowledged and triaged. A report to the Management Executive in October 2021 noted, *"Since May 2021 a total of 11 matters have been referred to the F2SU team. Of these referrals 3 pre-date the re-launch of the service on 17th May 2021."*

2.18 A trade union representative has worked with the Head of Risk and Regulation during the process of investigating any anonymous staff concerns.

2.19 On a case-by-case basis, staff surveys are undertaken to determine if appropriate action has been taken to address a reported concern. This occurs where reports

have been anonymous, to ascertain the views of the relevant department or staff group, following the outcomes of an investigation.

Conclusion 4: Concerns formally raised by staff are promptly investigated and addressed with appropriate actions, however, the process of recording and updating Datix, and the Staff Concerns log requires further enhancements, particularly if the number of concerns logged increases. (Reasonable Assurance)

Objective 5: The Health Board has adequate governance arrangements in place for the review and analysis of concerns and the reporting and escalation of identified issues and themes

2.20 The Executive Director for People and Culture is the Health Board's lead for the All-Wales Procedure for NHS Staff to Raise Concerns.

2.21 In May, July and October 2021 the Director of Corporate Governance presented an update report to the Management Executive on the Health Board's F2SU and Raising Concerns processes.

2.22 The October 2021 report provided a specific update on matters that had been referred to the F2SU lead, since the relaunch of the service in May 2021, and the outcomes following investigation by the Head of Risk and Regulation.

2.23 We note there is an intention to analyse staff concerns and report on themes but given the low number of staff concerns currently reported, the detail does not provide an adequate basis for such reporting.

2.24 The All-Wales Procedure for NHS Staff to Raise Concerns, at paragraph 1.09 notes, *"The UHB will monitor the use of this procedure and report to the Board or a sub-committee, as appropriate."* The Health Board are yet to present any formal update to the Board or relevant sub-committee, but we acknowledge that the volume of concerns reported is currently low. *(Matter Arising 5 – Medium Priority)*

Conclusion 5: Whilst the Management Executive are well briefed on the F2SU arrangements and the mechanisms for staff to raise concerns, further work is required to fully satisfy the governance arrangements set out in the All-Wales Procedure for NHS Staff to Raise Concerns, by determining the assurance arrangements for reporting to the Board or a sub-committee. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Visibility of the All-Wales Procedure for NHS Staff to Raise Concerns within committee papers (Operation)	**Impact**
The Strategy and Delivery Committee on 16 November 2021[5] received an Employment Policies Report, which included reference to the revised All-Wales 'Procedure for NHS Staff to Raise Concerns'. The Committee were requested to formally adopt the revised procedure, referred to at Appendix 2 of the report, but members of the Committee did not have opportunity to view the procedure, as it was not appended as suggested.	• Lack of clarity of revised procedures
Recommendation 1	**Priority**
For future reference, sub-committees should receive a copy of the procedure they are being asked to formally adopt.	**Low**

Agreed Management Action 1	**Target Date**	**Responsible Officer**
Agreed - This was an isolated occurrence as procedures and policies are usually attached to papers where they are referred to. This will be monitored continuously moving forward.	Immediately	Head of Corporate Governance

[5] https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2021-22/2021-11-16-audit-final-papers-v4-pdf/

Matter Arising 2: Formalisation of Standard Operating Procedure for Managing Concerns from Staff (Design)		**Impact**
To inform our audit the Risk and Regulation team shared a document 'Standard Operating Procedure for Managing Concerns from Staff', which is a local document held on a shared drive. The document helpfully illustrates how concerns are handled, and although the Raising Concerns Procedure is referenced, a direct hyperlink or location of the procedure would provide further clarity. We were advised that the document had previously been held on the Health Board's website, prior to the webpages being reviewed and refreshed.		• Staff are unaware of the procedures
Recommendation 2		**Priority**
The Risk and Regulation Team should consider making the 'Standard Operating Procedure for Managing Concerns from Staff' visible to all staff via the Health Board website (as previous), with hyperlinks to the 'All-Wales Procedure for NHS Staff to Raise Concerns'.		**Low**
Agreed Management Action 2	**Target Date**	**Responsible Officer**
Agreed - The Standard Operating Procedure will be reinstated on the Health Board website.	March 2022	Head of Risk and Regulation

Matter Arising 3: Timeliness of the Freedom to Speak Up communication campaign (Operation)	**Impact**
The Health Board's communication campaign to highlight opportunities for staff to raise concerns called 'Freedom to Speak Up' was refreshed and re-launched in May 2021, with the intention of a re-run of the campaign every six months, next scheduled for December 2021. At the closure of audit fieldwork in February 2022, we noted that the campaign had not yet ran. COVID-19 demands and staffing issues have impacted the timeline of the communications campaign. The F2SU campaign is key to ensuring that managers and staff are aware of the channels available to them to raise and address staff concerns. The current low number of matters being raised, as referenced in 2.17 above, would suggest that there is scope to further increase awareness.	Staff are unaware of the procedures and are therefore unclear on how to report a concern.

Recommendation 3	**Priority**
To enhance the timeliness of the Freedom to Speak Up Communication Campaign, dedicated resources should be assigned to the campaign to ensure the biannual aspirations are achieved, which will remind staff of the channels available to them to raise concerns.	**Medium**

Agreed Management Action 3	**Target Date**	**Responsible Officer**
Agreed – The Freedom to Speak up Campaign was relaunched via internal and external communications channels the week commencing 07/02/2022. Regular biannual updates will continue to be issued in conjunction with the Health Boards communications team.	March 2022	Head of Risk and Regulation

Matter Arising 4: Greater clarity within the F2SU Staff Concerns Log (Operation)	**Impact**
We reviewed the Freedom to Speak Up Staff Concerns Log maintained by the Risk and Regulation Team. Our review focused on matters logged since the relaunch of the campaign in May 2021, and we noted the following: • Staff concerns which were closed in the log, remained open in Datix (40799, 40244, 40951, 42792, 42624,43196 & 48326); • We were unable to locate one of the Datix entries, which was marked as closed on the Risk and Regulations Team's log; • Whilst we acknowledge that concerns were followed through and investigated, the log lacked detail around the various actions and steps, in comparison to the richness of the update to the management executive in October 2021; and • Closed concerns did not have a summary to back up or explain why or how decisions were reached and closed.	• Risk of continuity due to staff absence
Recommendation 4	**Priority**
To build on existing arrangements, the following enhancements should be made to the Risk and Regulation team's Freedom to Speak Up Staff Concerns Log: • To ensure the status of Datix entries reflects the Risk and Regulation team's log; and • Greater clarity of action taken in response to a concern and the decision reached to address a concern.	**Medium**

Agreed Management Action 4	**Target Date**	**Responsible Officer**
Agreed – A cleanse of the Freedom to Speak up Log and Datix will be undertaken by the Head of Risk and Regulation.	May 2022	Head of Risk and Regulation

Matter Arising 5: Compliance with the governance arrangements of the All-Wales Procedure for NHS Staff to Raise Concerns (Design)	**Impact**
The All-Wales Procedure for NHS Staff to Raise Concerns, at paragraph 1.09 notes, *"The UHB will monitor the use of this procedure and report to the Board or a sub-committee, as appropriate."* At the time of our review we were unable to evidence any formal reports to the Board or relevant sub-committee, but we acknowledge that the volume of concerns reported is minimal. We were able to evidence regular reports to the Management Executive, but the updates did not clarify the intended reporting arrangements to the Board or sub-committee. In conjunction with matter arising two, the Standard Operating Procedure does include intended reporting to the Board, but the document currently has no status, and is held on a local drive.	• Lack of clarity of revised procedures

Recommendation 5	**Priority**
In accordance with the All-Wales Procedure for NHS Staff to Raise Concerns, the executive lead for the Procedure, in conjunction with the Director of Corporate Governance should determine the appropriate reporting arrangements to the Board or sub-committee.	**Medium**

Agreed Management Action 5	**Target Date**	**Responsible Officer**
Agreed - This will be reported into the Strategy and Delivery Committee on a Bi-Annual Basis as part of the Workforce report. Mohamed.Sarah 03/28/2022 16:21:28	May 2022	Executive Director of People and Culture, and Director of Corporate Governance.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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IT Service Management (ITIL)
Final Internal Audit Report

March 2022

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note
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 & Assurance 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 Cardiff and Vale University 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.

Executive Summary

Purpose

To provide assurance to Cardiff & Vale UHB's Audit Committee that a process is in place for ensuring IT services are provided in an efficient and secure manner and reflect the needs of the organisation.

Overview

Overall, there are poor controls in place over the IT Service Desk function. It is acknowledged that management are planning major improvements by implementing a new call handling system, restructuring the service desk department and introducing new ways of working based on the ITIL Framework. However, based on the present situation we have issued limited assurance on this area. The significant matters which require management attention include:

- Lack of an IL Framework for the delivery of services;
- Lack of documented guidance for call handlers;
- Inaccurate call classification and prioritisation of calls; and
- High levels of 'open' calls with lack of monitoring.

Additional recommendations are also made which can be found within the detail of the report.

Report Classification

		Trend
Limited 	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.	N/A No recent audit work in this area

Assurance summary[1]

Assurance objectives		Assurance
1	Service Design	Limited
2	Service Desk Operation	None
3	Operation Management	Limited
4	Knowledge Management	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Lack of an ITIL Framework	1	Design	High
2	Lack of documented guidance for call handlers	2	Design	High
3	Inaccurate call classification and prioritisation	2	Operation	High
4	High level of open calls and lack of call monitoring	2	Operation	High
5	Lack of Service Catalogue	1	Design	Medium
6	Lack of call resolution and closure targets	3	Design	Medium
7	Lack of defined problem management process	3	Design	Medium
8	Lack of knowledge management process	4	Operation	Medium

1. Introduction

1.1 In line with the 2021/22 Internal Audit Plan for Cardiff & Vale University Health Board (the Health Board) a review of IT Service Management was undertaken.

1.2 Best practice for IT service management is set out within ITIL, formally an acronym for Information Technology Infrastructure Library. This is a set of detailed practices for IT service management that focuses on aligning IT services with the needs of business. ITIL describes processes, procedures, and tasks which are not organisation-specific, but can be applied by an organisation for establishing integration with the organisation's strategy, delivering value, and maintaining a minimum level of competency.

1.3 The potential risk considered in this review was as follows:

- IT services provided do not suit the needs of the organisation.

1.4 At the time of our audit management were in the process of introducing a new call handling system and restructuring the service desk function and processes which will be geared to delivering an IT service based on the ITIL Framework.

2. Detailed Audit Findings

Objective 1: IT services are appropriately designed, provided and managed with reference to an appropriate framework (ITIL).

2.1 There are presently no ITIL accredited staff working within the IT service desk which is not geared to delivering an IT service based on the ITIL framework. There is also no defined process in place to agree services with departments. Consequently, the IT delivery and departmental expectations may not be clear which could lead to disputes. **(Matter Arising 1)**.

2.2 In addition, the current call handling system is no longer considered fit for purpose, and the on-line portal that was used by staff to raise issues is no longer functional.

2.3 However, the need for improvement has been recognised by Management who have committed to implementing a new call handling system and to restructuring its staffing and governance arrangements to better fit the needs of the organisation. This includes a commitment to aligning service provision with the ITIL Framework.

2.4 Our audit has identified that information regarding the services provided is currently held in various documents and spreadsheets, but there is no service catalogue in place. As such there is nothing that clearly sets out the services that the Digital Directorate provide together with the relevant support arrangements. We were informed that this is something that will be addressed as part of the ongoing work to develop an ITIL Framework (**Matter Arising 5**).

Conclusion:

2.5 The limitations of the IT service currently being delivered have been recognised by management, and plans have been developed to improve the service provided.

However, these are in the very early stages of implementation, and will take time to come to fruition. Accordingly, we have provided limited assurance against this objective.

Objective 2: Service desk provision is appropriate and appropriate request fulfilment management practices are followed.

2.6 Health Board staff that need help to resolve IT issues or require IT assistance are required to contact the help desk by telephone using the dedicated help desk number. However, we were informed that Health Board staff are also bypassing the help desk number and contacting IT staff directly to report issues and request services, and the online portal is no longer functional. This may be having an adverse impact on service desk delivery.

2.7 At the time of our audit there were 11 call handlers, with the aim of having at least six on duty at any one time. Opening times are officially 9 am until 5 pm, but they are currently covering from 8 am until 5:30 pm to better meet the organisation's needs. All calls are currently being recorded and managed using the HEAT system.

2.8 Our review has identified that there are no documented procedures for the operation of the service desk, and no guidance for call handlers in terms of how calls are to be logged, classified, prioritised and routed. In addition, there are no predefined calls or incident models, and there was no evidence that action taken to resolve issues or complete requests for action had been properly approved for the majority of calls reviewed (**Matter Arising 2**).

2.9 All calls received by the service desk should be classified by Call Category, Call Type and Priority. However, we were not provided with definitions for any of these fields. It was identified from testing of a sample of calls that for many calls the call category and call type had been incorrectly and inconsistently recorded, and also the majority of calls had been prioritised the same. The HEAT system allows call handlers to record free text in the call category, call type and priority field, or to leave these fields blank. Consequently the 2021/22 call log had over 400 different types of entry for each of the above fields making any analysis meaningless (**Matter Arising 3**).

2.10 From our sample of 35 calls tested, 13 were still open and one was on hold. We were not provided with any procedures or guidance for staff chasing open calls and ensuring activity on call and incidents is maintained. In addition, there is no monitoring or reporting of performance indicators for call handling.

2.11 Review of the entire call log for 2021/22 showed that there were 12,359 calls recorded in total, of which 1,223 were still open and 146 were on hold. Of the 1,223 open calls, 682 had been open for more than 30 days, the oldest calls dating back to the 01/07/2021 (**Matter Arising 4**).

Conclusion:

2.12 There were no guidance documents, Standard Operating Procedures or procedure notes for call handlers dealing with incidents and requests for action (RFA's), or for chasing open calls. Consequently, many calls reviewed had been incorrectly classified and prioritised, and there was a large number of open calls, some of

which should have been closed. The ability for call handlers to enter free text in critical fields or leave them blank has also contributed to the incorrect classification and prioritisation of calls. Accordingly, we have provided no assurance against this objective.

Objective 3: Appropriate processes are in place for incident, event and problem management in order to minimize the impact on users.

2.13 Problem management can be defined as the process of identifying and managing the causes of incidents in an IT service. However, we were not provided with any evidence that work has been begun on developing a defined problem management process that includes a record of known errors (**Matter Arising 7**).

2.14 In addition, no information has been provided in respect of target timescales for the resolution of calls. These should be specified in the service agreements that should be in place within each service area, based on the options in the service catalogue. However, as previously noted there is no service catalogue in place. We were informed that Hosting and Back-up Agreements were in in place instead of service agreements, but we were not provided with any for review during our audit (**Matter Arising 6**).

2.15 Testing of a sample of 35 calls identified that calls were not being closed down promptly. Of the 21 calls that had been closed, six had been closed within one day, 10 within five days, and five had taken more than five days. There were 14 calls still open, some of which will most certainly have been resolved.

Conclusion:

2.16 There was no defined problem management process in place, and no target timescales for the resolution and closure of calls. We have therefore provided limited assurance against this objective.

Objective 4: Processes are in place to gather, analyze, store and share knowledge and information within an organization in order to improve efficiency by reducing the need to rediscover knowledge. Appropriate processes are in place for incident, event and problem management in order to minimize the impact on users.

2.17 ITIL defines Knowledge Management as the one central process responsible for providing knowledge to all other IT Service Management processes.

2.18 Information relating to the investigation and diagnosis of incidents and problems is held in various documents and spreadsheets. However, there is no structure or process for sharing knowledge within the helpdesk or across teams, or a review process to ensure old or out of date information is removed (**Matter Arising 8**).

Conclusion:

2.19 There were no defined processes in place to gather, analyze, store and share knowledge and information gained by call handlers. We have therefore provided limited assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Service Design (Design)	**Impact**
The service desk provision currently in place is not geared to delivering an IT service based on the ITIL framework, although we were informed by senior management that the development of an ITIL framework is currently on-going, together with restructuring of the service desk / IT support team. There is also no defined process in place to agree service levels with departments. Consequently, the IT delivery and departmental expectations may not be clear which could lead to disputes. The on-line portal previously used by staff to contact the service desk was unavailable at the time of our audit. The service desk is currently using a system called HEAT to record and manage their service desk calls, but this is not considered 'fit for purpose' and is due to be replaced by a system provided by Avanti Service Management (ISM), with a target implementation date of the 30th October 2021. This will be a cloud-based service. There are currently no ITIL accredited staff within the service desk function.	IT services provided do not suit the needs of the organisation.
Recommendations	**Priority**
1.1a The re-structuring of the service desk provision should be based on the ITIL Framework. 1.1b The implementation of the new call handling system should incorporate the facility for users to raise calls via an on-line portal. 1.1c Existing and new staff should be encouraged to attain ITIL Accreditation. Mohamed,Sarah 03/28/2022 16:21:28	High

Agreed Management Action	Target Date	Responsible Officer
1.1a In conjunction with a new ITIL compliant Service Desk software solution (Ivanti Service Manager – ISM). The current limited IT support resources will be restructured to provide a skeleton framework of an ITIL service desk structure. A business case is currently under review to increase staffing within the Service Desk, to allow for separation of key tasks and address single points of knowledge. 1.1b The new Service Desk (ISM) implementation will provide a digital front door which will include incident and problem management as well as service requests, change and asset management. There will be a User Portal on all User devices. 1.1c Staff ITIL training has already started in Jan 2022. 10x members of the IT Support/Service Desk team have successfully passed the ITIL v4 Foundation course and exam to gain their accreditation. An additional 6x team members have attended the Advanced ITIL CDS course (March 2022).	September 2022	Russell Kent (Head of Digital Operations)

Matter Arising 2: Lack of Documented Guidance (Design)	**Impact**
There are no procedures for the operation of the service desk and no guidance for call handlers in terms of: • how calls are to be logged, classified, prioritised and routed; • predefined calls and no procedures for predefined calls; • incident models for most common incidents; and • how actions proposed to resolve calls should be approved. Given the limited-technical background of the call handlers this may delay the resolution of the call or result in miss-routing of calls. Actions that incur costs may also be taken without proper approval from the client resulting in disputes over payment. The organisation is not making use of the opportunity to fix calls at first contact by setting predefined calls and their resolutions.	IT services provided do not suit the needs of the organisation.
Recommendations	**Priority**
2.1a Procedures and guidelines should be developed for the Service Desk. These should clarify how to deal with incoming calls, the information to collect, the approval process for proposed resolution actions and the routing of these calls. 2.1b As part of these procedures a set of predefined calls should be developed for the most common / simple calls and incidents to enable these to be resolved on first contact.	High

Agreed Management Action	Target Date	Responsible Officer
2.1a CAVUHB have employed the services of a dedicated Ivanti ITSM Implementation Expert. As part of the deployment Standard Operating Procedure documents have been created. A standalone and dedicated automation server has been setup, this server will provide workflow with approval steps which will provide automation for numerous tasks including; New Starters, Leavers and Movers. Access Requests and general tasks. 2.1b The ISM implementation also contains an FAQ and Staff Help portal which will continue to be developed and expanded as part of the product use.	September 2022	Russell Kent (Head of Digital Operations)

Matter Arising 3: Call Classification and Prioritisation (Design)	**Impact**
Our testing identified that there were no documented definitions for call category, call type and priority, and calls and incidents are not being recorded appropriately within the HEAT system: • some incidents are being recorded as requests; • 20/35 calls sample tested were not classified correctly, with both the call category and call type being incorrectly recorded; • the field to enter the call category and call type on the HEAT system is not mandatory and is free text, resulting in over 400 different categories and call types being used so far in 2021/22. These included blanks, question marks and dates; • calls are not prioritised correctly or consistently, with 32 of the 35 calls sampled being assigned priority 3; • review of the call log for 2021/22 up to the end of October 2021 showed that the vast majority of calls had been assigned priority 3 (72%), with 20% being assigned priority 5. This field is also not mandatory and is free text resulting in the use of over 300 different priority ratings to date in 2021/22. Without classifying and prioritising calls correctly, there is a risk that resource will be expended in the wrong area, that reporting figures will be incorrect and that underlying issues may not be identified. Mohamed,Sarah 03/28/2022 16:21:28	IT services provided do not suit the needs of the organisation.

Recommendations	Priority
3.1a Procedures and guidance on the classification and prioritisation of calls should be drawn up and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents are classified and prioritised correctly in accordance with the guidance. 3.1b The planned replacement for the HEAT system should not allow free text in the call category, call type and priority fields. 3.1c The call category, type and priority fields should be mandatory to complete with call handlers selecting the appropriate entry from a drop-down menu.	High

Agreed Management Action	Target Date	Responsible Officer
3.1a Automated for call category, call type and priority fields has been implemented as standard. Exceptions can be made, although require additional approval within the Service Desk management structure. 3.1b Free Text fields for call category, call type and priority fields have been removed. 3.1c Call category, call type and priority fields are all mandatory when creating incidents and service requests.	September 2022	Russell Kent (Head of Digital Operations)

Matter Arising 4: Call Status Monitoring (Operation)	**Impact**
We were not provided with any procedures or guidance for staff for chasing open calls and ensuring activity on calls and incidents is maintained. Our testing identified calls and incidents being left with a status set to 'open' or 'on hold' and not being chased or closed. For some of these we assume that the request had been completed, but the call not closed. Sample Testing of Incidents and RFA's • Of the sample of 35 calls tested, 13 were still open and one was on hold. • There was only a record of 4/35 calls being escalated, although the escalation criteria had not been documented. • For calls that had been closed, we were unable to determine whether calls had been resolved in time as we were not provided with target resolution times. • There was no record of user sign-off for any of the calls tested. Review of the 2021/22 Call Log (up to the 20/10/2021) • There were 17,889 calls recorded within the system of which 2,473 were still open and 146 were on hold (14.6% not closed). • Of the 1,223 open calls, 682 had been open for more than 30 days, the oldest calls dating back to the 01/07/2021. If activity on calls is not maintained, users may not receive an appropriate service and if calls are not closed promptly any analysis and reporting of call statistics will not be accurate.	IT services provided do not suit the needs of the organisation.
Recommendations	**Priority**
4.1a A formal process to ensure call activity is maintained should be established, and completed calls should be closed appropriately.	High

Agreed Management Action	Target Date	Responsible Officer
4.1a A new single digital portal for staff to create, view and close incidents and service desks has been created. Accurate ISM and call metrics will be available. Calls and requests for staff will automatically be closed after multiple requests have been ignored. Cases which have not been progressed within a timely fashion will be reported automatically and flagged. Staff will also have clear visibility of their case progression via the portal.	September 2022	Russell Kent (Head of Digital Operations)

Matter Arising 5: Service Catalogue (Design)	**Impact**
During discussions with senior management, we were informed that although information regarding the services provided is held in various documents and spreadsheets, there are currently no service catalogue in place. We were further informed that this is something that will be addressed as part of the ongoing work to develop an ITIL Framework.	IT services provided do not suit the needs of the organisation.

Recommendations	**Priority**
5.1a A Service Catalogue setting out the service level that the service desk and the Digital Directorate is providing for each service should be drawn up. 5.1b The service levels provided should be formally agreed with each user department. As part of this process an agreement setting out the responsibilities and expectations of all staff should be defined.	Medium

Agreed Management Action	**Target Date**	**Responsible Officer**
5.1a A comprehensive service catalogue is being created at the moment. The highest profile requests for each of the Digital Operations teams will be available in phase one (April 2022). Work will be ongoing to further develop these in phase two and three (Q4 2022 and Q1 2023) 5.1b ISM have default Service Levels built in. SLA compliance will be reported internally initially with a view to share these figures and expectations at a later date. There are no fixed SLAs in place at the moment mainly due to current support resourcing. Further resourcing will allow us to implement reasonable SLAs and compliance reporting.	September 2022 - On-Going	Russell Kent (Head of Digital Operations)

Matter Arising 6: Call Resolution and Closure Targets (Design)	**Impact**
Our testing confirmed that incidents are being resolved and closed, but no information has been provided in respect of target timescales for resolution. These may be specified in the Hosting and Backup Agreements (HBA's), but to date we have not been provided with any HBA's for review. Of the 35 incidents and RFA's tested, only 21 had been closed. Of these, six had been closed within one day, 10 within five days, and five took more than five days. The remaining 14 calls (40%) were still open. It should be noted that when the entire call log for 2021/22 was considered, this showed that up to the 20/10/2021, 1,369 calls (11%) were either open or on hold. Of these, 682 calls had been open for more than 30 days.	IT services provided do not suit the needs of the organisation.

Recommendations	**Priority**
6.1a Target times should be set for the resolution and closure of calls in line with the timescales specified within the Hosting and Back-up Agreements. 6.1b Performance indicators should be developed based on the call resolution and closure target times, and these should be regularly monitored and reported at an appropriate level / to an appropriate forum within the Digital & Health Intelligence Directorate.	Medium

Agreed Management Action	**Target Date**	**Responsible Officer**
6.1a Target fix and resolution metrics will reported on as part of the ISM implementation. 6.1b KPIs will be created and reported on as part of the ISM implementation.	September 2022	Russell Kent (Head of Digital Operations)

Matter Arising 7: Problem Management (Design)	**Impact**
Problem management can be defined as the process of identifying and managing the causes of incidents in an IT service. However, the IT service desk function does not at present include a defined problem management process, and problems are not being identified and recorded as such on the HEAT system. An effective problem management process can help ensure incidents are resolved quickly and efficiently, and the root cause of incidents is identified. We would expect the problem management process to incorporate a number of stages including: • identification and classification; • investigation, diagnosis and resolution; • creation of known errors; and • proactive problem management.	IT services provided do not suit the needs of the organisation.

Recommendations	**Priority**
7.1a A Problem Management process should be fully defined together with an associated SOP and guidance for staff.	Medium

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1a Problem Management is included within the new ISM implementation.	September 2022	Russell Kent (Head of Digital Operations)

Matter Arising 8: Knowledge Management (Design / Operation)		**Impact**
Information relating to the investigation and diagnosis of incidents and problems is held in various documents and spreadsheets, but there is no structure or process for sharing knowledge within the helpdesk or across teams, or a review process to ensure old or out of date information is removed.		IT services provided do not suit the needs of the organisation.
Recommendations		**Priority**
8.1a Service management should consider defining a standard mechanism and process for operational knowledge management.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
8.1a The new implementation of ISM contains a repository of knowledge management. FAQ and case resolutions will also be captured within the solution.	September 2022 - On-Going	Russell Kent (Head of Digital Operations)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Arrangements to support the delivery of Mental Health Services

(Mental Health Clinical Board)

Final Internal Audit Report (Advisory)

March 2022

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of this advisory review was to evaluate and support the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges.

Overview

This is an advisory review to support management, rather than an assurance report, we therefore offer no assurance rating.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Clinical Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will enable the Clinical Board to enhance the arrangements to support the delivery of Mental Health Services.

Management within the Clinical Board have a good understanding of the risks and challenges facing mental health services, but now need to look for solutions, at a time when there is a heightened demand on services, which is only likely to increase as the impact of COVID-19 reduces.

Report Classification

Assurance not applicable

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate:

1	The services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them;
2	The means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities; and
3	The potential service delivery risks and challenges which limit the effective operation of mental health services.

Opportunities

		Audit Objective
1	Maintain a 'live' tool of documented Mental Health Services	1
2	Undertake an informed update of the Health Board's Mental Health webpages	1
3	Consider the response to issues which hamper staff efficiency and effectiveness	2
4	Undertake a review of the Clinical Board's Risk Management arrangements	3
5	Explore solutions to address the key risks and challenges identified	3

1. Introduction and background

1.1 Our advisory review of 'Arrangements to support the delivery of Mental Health Services' was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board') and at the request of the Clinical Board.

1.2 The Mental Health Clinical Board works in collaboration with local authority colleagues, charities and third sector agencies in a variety of locations to co-create services, the majority of which are provided closer to home, supporting people within the local community.[1]

1.3 The staff and service users have a long-term vision for increasing community care and shared care models. There are community teams, primary mental health services and inpatient services, as well as managing specialist services, which includes neuropsychiatry, addictions, low secure and younger onset dementia care.[1]

1.4 The executive lead for the review is the Interim Chief Operating Officer.

Audit Risks

1.5 The potential risks considered in this review were as follows:

- Lack of public awareness of mental health services delivered by the Health Board;
- Inefficient ways of working due to not having the right people in the right place at the right time; and
- Inadequate facilities to deliver mental health services.

Advisory Audit Objectives

1.6 The overall objective of this advisory review was to evaluate and support the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges.

1.7 Our review sought to ascertain and evaluate:

- The services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them;
- The means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities; and
- The potential service delivery risks and challenges which limit the effective operation of mental health services.

[1] https://cavuhb.nhs.wales/about-us/our-health-board-structure/mental-health-clinical-board/

2. Detailed Audit Findings

Objective 1: To ascertain and evaluate the services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them

Clinical Board Structure

2.1 The Mental Health Clinical Board operates via three directorates, each of which has a Directorate Manager who is responsible for overseeing all administrative matters:

- Adult Mental Health[2] - A range of outpatient and inpatient services including general and specialist community mental health services, addiction services, low secure and crisis and liaison services.
- Mental Health Services for Older People (MHSOP)[3] - A range of outpatient, day care and inpatient services for patients with a dementia and / or functional mental illness, including liaison teams, care home support, crisis support and support to carers. The directorate also supports the Welsh Neuropsychiatry Service, a Welsh Health Specialised Services Committee (WHSSC) funded specialist service providing neuropsychiatric rehabilitation for people with an acquired brain injury; and
- Psychology & Psychological Therapies[4] - The Psychology and Psychological Therapies Directorate provides adult counselling and psychology services throughout the Health Board, including Primary Care, which is organised into a number of specialties.

2.2 Initial audit planning with management highlighted that there is no formal documentation held by the Clinical Board to capture all services. Neither were we able to take assurance from the Health Board's Mental Health webpages, which either lack detail or require review.

2.3 Working with the Interim Director of Operations and the Directorate Managers we developed a data collection template for completion by each Directorate Manager, which summarised the following information, for each team or service within the directorate:

- Team / Service name, description and location;
- Establishment number of staff;
- Base - Health Board facilities or Charities / Local Authority / Third sector;
- The means of delivery of the service e.g. face-to-face / virtually;

[2] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/community-mental-health-teams/adult-mental-health-specialty/
[3] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/mental-health-services-for-older-people1/
[4] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/psychology-and-psychological-therapies-directorate/

- Accessible IT infrastructure, printing and telephones; and
- Risks which limit the effective operation of Mental Health services and the challenges which exist.

2.4 Key findings identified through the data collection process are highlighted within this report. The complete data collection templates, which were populated through this review have been provided to Clinical Board management separately, and are a key output of the review.

2.5 It was evident from discussions with each of the Directorate Managers that a vast amount of information was available, in various locations and formats, which facilitated the timely completion of the data collection templates.

Opportunities for further development:

2.6 The collaborative exercise to populate the data collection template has provided the Clinical Board with a record of key information on the size and shape of the Clinical Board, which will be a useful baseline tool to inform future planning of services, whilst recovering from the pandemic. Looking ahead, the Clinical Board should attempt to hold the data collection tool as a live document, which will provide a concise and accurate overview of arrangements within the Mental Health Clinical Board. *(Opportunity 1)*

2.7 At the outset of the review, we discussed with management the public information held on the Health Board's website, regarding mental health services. It was acknowledged that work is needed to enhance the website and this exercise will assist in informing future updates of the website. *(Opportunity 2)*

Conclusion 1: Following the completion of this review, management are now enabled to collectively evaluate the services which make up the Mental Health Clinical Board, informed by the collaboratively delivered data collection tool that documents services.

Objective 2: To ascertain and evaluate the means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities.

2.8 As noted within paragraph 2.3 of this report, the data collection tool to document services incorporated the means of delivering services and the support arrangements in place. Establishment numbers populated in the template were provided by management. The below provides a summary of our findings across the three directorates, with further granular detail provided to management.

Adult Mental Health:

2.9 Adult Mental Health employs approximately 760 staff spread across multiple locations (Hafan Y Coed and Llanfair Unit at Llandough Hospital, Cardiff Royal Infirmary, and a variety of Health Centres / Clinics) with teams ranging in size according to the service. Staff are accommodated in Health Board facilities, in addition to a small number of rented facilities.

2.10 Services are mainly delivered face-to-face despite restrictions due to COVID-19.

2.11 Facilities such as telephones, IT and printing are generally available. However, intermittent IT networking issues, in addition to limited wi-fi or telephone issues were noted by some services / teams, which are expanded upon within the data collection template.

Mental Health Services for Older People (MHSOP):

2.12 MHSOP employs approximately 365 staff who are mainly based in Hafan Y Coed and the Llanfair Unit at Llandough Hospital, but other locations are also used (Park Road, Whitchurch, Monmouth House - UHW, Grand Avenue, Ely and Barry) with teams ranging in size according to the service. The locations are predominantly Health Board facilities, with the exception of Grand Avenue, Ely, which is owned by Cardiff Council.

2.13 A significant proportion of services are delivered face-to-face with a lesser amount delivered virtually.

2.14 Similar to paragraph 2.10, IT infrastructure, telephones and printing are generally available. However we noted limited access to adequate numbers of working mobile equipment (netbooks / laptops) and a need for further computers to support nursing staff within their offices.

Psychology & Psychological Therapies:

2.15 Psychology and Psychological Therapies employs approximately 110 staff who are spread across multiple locations, with a predominant presence at the Cardiff Royal Infirmary, but also Hamadryad Centre, Cardiff University's Hadyn Ellis Building and Avon House, Penarth. Prior to suspension of some services at the start of the pandemic, St David's Hospital was utilised.

2.16 Some staff have been working from home since the start of the pandemic. Services are delivered via a mixture of virtual and face to face working, with the split varying according to the service. However, rooms are also hired at church halls and other Local Authority, or third sector venues as required and, prior to the pandemic, staff were also based in GP surgeries on a peripatetic basis.

2.17 Additional laptops for home working were made available through the pandemic, in addition to mobile phones provided to some staff.

Opportunities for further development:

2.18 The data collection exercise has highlighted some localised challenges which hamper the efficiency and effectiveness of staff, which relate to intermittent IT network issues, inadequate wi-fi provision, telephone issues and an inadequate number of computers and mobile devices. This exercise has provided the means of evaluating and documenting specific issues at a granular level, by service. Management should consider the means of responding to, and addressing the issues presented within the Clinical Board. *(Opportunity 3)*

Conclusion 2: The data collection exercise has provided a sound evidence base to evaluate the means of delivering each mental health service and has highlighted associated issues. The Clinical Board will need to reflect upon such issues and determine if they are able to resolve them, or where they might look for support.

Objective 3: To ascertain and evaluate the potential service delivery risks and challenges which limit the effective operation of mental health services

Clinical Board Risk Register

2.19 At the time of our review the Mental Health Clinical Board risk register held four risks:

- MHSOP Nursing Staff Recruitment;
- Poor Clinical Environment;
- Violence and Aggression; and
- Young Person in Adult Mental Health Placement*.

2.20 *This risk refers to a one-off incident, rather than the wider scope of how services, procedures and staff were organised.

2.21 The Clinical Board Risk Register was held in the corporate template.

Directorate Risk Registers

2.22 Each of the three directorates maintain their own risk register, which the Directorate Managers consider of value, to keep directorate risks in mind. However, despite this, the risk registers have not always been kept up to date, detailed or comprehensive. The risk management process appears to have slipped to varying degrees. We note that the directorate risk registers were held in outdated templates. There is a corporate expectation in the Health Board that all risk registers will align with the corporate template, currently being used to hold the Clinical Board risks.

2.23 The risk registers include a significant number of historic risks which have not moved on and the existing controls are rated inadequate. This is largely due to the directorate being unable to define controls to reduce the risks. This is generally because they are outside the control of the directorate and possibly the Clinical Board, for example, national risks or where significant investment is required to resolve them.

2.24 There is a need to rejuvenate discussion and communication from individual staff and teams, through directorates and on to the Clinical Board, so that all risks are adequately escalated upwards and feedback on progress, including timescales for resolution, is subsequently disseminated back to staff. We understand that greater emphasis is now being given to the risk management process, which should help identify and address the current position.

Key mental health service risks

2.25 The most common risk identified by service teams was staffing. This relates to both the numbers of staff and their skill level, both newly qualified and experienced staff, and covers both nursing and medicine. We acknowledge that staffing is a national issue. Particular issues relate to the number of nurses per patient, leading to a nursing gap and increasing waiting lists, where Welsh Government targets are being exceeded.

2.26 The next most common risk relates to inadequate accommodation and covers both the quality and extent of premises. We were advised that the worst cases of poor quality accommodation relate to four community services bases, which are in a very poor state of repair and are deteriorating further. Management advised that this has been the case for around 10 years and despite raising outside of the Clinical Board for support, no solution has been identified. We were informed by management that any proposed improvements had been impacted by various wider proposals, which have impeded moving forward.

2.27 Space in some premises is inadequate for service needs, for example, 96 staff are currently based in one ward, there is an insufficient team base, and there is a lack of space for some group activities. This can adversely impact the quality of care provided, create inefficiencies due to travel between locations, and in some cases prevent the expansion of services to address lengthening waiting lists.

2.28 It may be possible to address these risks via Community Hubs, locality bases or use of partner organisation premises. However, care would be needed regarding information governance arrangements, for example, confidentiality of telephone calls and ensuring the sole use of NHS devices by NHS staff for data security.

2.29 In alignment with the findings under objective 2 of this report, collective risks have been identified which relate to ineffective IT systems and technology. Our discussions with Directorate Managers and a review of their risk registers has highlighted directorate specific risks, for example, three different IT systems are being used by MHSOP Community Locality Teams, which presents risks associated with accessibility and patient information gathering and sharing.

Summary of the greatest risks and challenges to the Mental Health Clinical Board:

2.30 From our discussions with the Directorate Managers and reviews of the Clinical Board Risk Register and Directorate Risk Registers, we have summarised the most reoccurring risks and challenges:

- The need to re-evaluate service delivery models. Significant changes were made at the start of the pandemic and as we move out of the pandemic, following the relaxation of COVID rules, it is unlikely that the pre-pandemic model will be re-established;
- Recruitment of sufficient and suitably skilled staff when there is limited national availability, which is not improving;

- The wellbeing of existing staff to deliver services when demands are heightened, and the facilities or IT equipment do not facilitate efficient and effective working;
- Ensuring staff continuity of care for patients;
- Adequacy or availability of suitable accommodation for services, particularly for those who have faced long term issues;
- The ability to meet the growing demand for services;
- Resolving significant IT issues which have been identified; and
- Pressures caused by rises in Delayed Transfer of Care.

2.31 We discussed with management the extent to which the Integrated Medium Term Planning process would address the risks and challenges, which have been identified and it was concluded that the planning process would only address them to a very limited extent, rather than addressing the root-causes.

Opportunities for further development:

Risk Management processes

2.32 Further work is needed to enhance the risk management processes, to facilitate the escalation of risks from Directorate Risk Registers, through to the Clinical Board Risk Register, particularly where collective and reoccurring themes are evident across all three Directorates.

2.33 It is questionable whether the Clinical Board Risk Register is truly reflective of the current risks, given there are only four risks held on the register. The register will benefit from clarification of the risk escalation process noted in paragraph 2.32, which may see an increase in the number of risks captured on the Clinical Board Risk Register. *(Opportunity 4)*

Addressing service risks and challenges

2.34 The outcome of this review has highlighted the extent of risks and challenges facing the Clinical Board, a refresh of the risk management arrangements will prompt a review of the mitigating controls, to present a current risk position, which can be used to facilitate discussions with representatives outside of the Clinical Board for support, such as the Operations department, the Estates department, IM&T Services and Digital Health and Care Wales. *(Opportunity 5)*

Conclusion 3: This review has highlighted that there is a clear understanding of the risks and challenges facing the Clinical Board, which impact the efficient and effective operation of mental health services. However, the Clinical Board needs to undertake an exercise to document and articulate their risks through the corporate process, which facilitates the escalation and moderation of risks. The Clinical Board will also need to consider how they may look to create solutions to mitigate their risks, or where they may look inwardly within the Health Board or externally to partners for support.

Appendix A: Opportunities for improvement

Finding 1: Maintain a 'live' tool of documented Mental Health Services	**Impact**
We collaboratively worked with management to develop a tool to enable the Clinical Board to collectively map and evaluate their services, which was absent at the commencement of the review. Whilst information was held within the directorates, in varying forms, there was no overarching position available. The data collection tool, developed through this review, now sits with management to take forward and maintain.	Inadequate collective oversight of risks and challenges facing the Clinical Board.
Opportunity 1	**Priority**
Looking ahead, the Mental Health Clinical Board should attempt to maintain the data collection tool as a 'live' document, as a means of holding a concise and accurate overview of services, which can inform future planning of services.	**N/A – Advisory Review**

Agreed Management Action	**Target Date**	**Responsible Officer**
…	…	…

Finding 2: Undertake an informed update of the Health Board's Mental Health webpages		Impact
Whilst we noted the Health Board's Mental Health webpages, we were advised by management that they are in need of a review and update, as an example, we noted that the 'A- Z of Mental Health Services'[5] only lists four services. The data collection tool provides a means of informing an update of the Health Board's Mental Health webpages, which are a key mechanism for communicating the services offered to the public.		Lack of public awareness of mental health services delivered by the Health Board
Opportunity 2		**Priority**
Management should utilise the information collated through this review to inform an update of the Health Board's Mental Health webpages, to better inform members of the public of the services offered to support mental health.		**N/A – Advisory Review**
Agreed Management Action	**Target Date**	**Responsible Officer**
...	...	...

[5] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/ (accessed 21/01/2022)

Finding 3: Consider the response to issues which hamper staff efficiency and effectiveness	Impact
This review has provided the means of breaking down the varying Directorates by locations, the facilities available to support staff, and any known issues. Through the data collection exercise, Directorate Managers have provided in granular detail the arrangements in place to support staff to undertake their roles, highlighting any known issues. Issues highlighted through this review include intermittent IT network access, inadequate wi-fi provision, telephone issues and an inadequate number of computers and mobile devices. As the Health Board progresses out of the pandemic, the Clinical Board will be in an opportune position to reflect on current services and the know issues currently presented, to build stronger services, which will better equip staff to respond to the demands placed upon services.	Inadequate facilities to deliver mental health services.
Opportunity 3	**Priority**
Management should consider the means of responding to, and addressing the issues highlighted through the data collection exercise. This may involve consideration of: • Quick wins which can be addressed at speed; • To seek support from the Health Board's IM&T Service and Digital Health and Care Wales; • The physical location of teams if IT issues cannot be resolved; • The impact on staff wellbeing when IT equipment is prohibiting efficient and effective working, at a time of heightened demand; • Alternative ways of working resulting from the impact of the pandemic; • The barriers prohibiting solutions and how these might be addressed; and • If the issues cannot be addressed within the Clinical Board, how these might be escalated within the Health Board.	**N/A – Advisory Review**

Agreed Management Action	Target Date	Responsible Officer
...	...	...

Finding 4: Undertake a review of the Clinical Board's Risk Management arrangements	Impact
Whilst the Clinical Board has a good understanding of the risks facing mental health services, we note the following which could be improved: • The directorate risk registers require review and aligning with the corporate risk register template (currently being used to document the Clinical Board risks); • The process of escalating risks within the Clinical Board requires clarification, to better inform the Clinical Board Risk Register, particularly where risks are relevant to all three directorates, for example highlighting emerging themes; and • Following the above, the Clinical Board Risk Register would benefit from review, which may be impacted by the review of Directorate Risk Registers and associated themes.	Inadequate collective oversight of risks and challenges facing the Clinical Board.
Opportunity 4	**Priority**
The Mental Health Clinical Board would benefit from reviewing their risk management arrangements, particularly the Clinical Board and Directorate risk registers, and the mechanisms of escalation associated with the risks. *The Clinical Board may wish to seek support from the Risk and Regulation Team to undertake the review.*	**N/A – Advisory Review**

Agreed Management Action	Target Date	Responsible Officer
…	…	…

Finding 5: Explore solutions to address the key risks and challenges identified	Impact
The outcome of this review has highlighted the extent of risks and challenges facing the Clinical Board. On completion of opportunity 4, the Clinical Board will be in an informed position of having updated their risk registers. The next step would be to evaluate the risks and challenges, particularly the gaps in controls or assurances, to consider what further solutions can be sought within the Clinical Board, more widely within the Health Board, or externally through working with partners.	Potential risk of key risks and challenges not being adequately addressed.
Opportunity 5	**Priority**
The risk and challenges identified in this review should be further explored for solutions, to consider how to further address the gaps in controls or assurance and whether these may look inwardly within the Health Board or externally to partners for support.	**N/A – Advisory Review**

Agreed Management Action	Target Date	Responsible Officer
…	…	…

Appendix B: Assurance opinion rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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