Public Audit Committee Meeting

Tue 06 September 2022, 09:30 - 13:00

Agenda

09:30 - 09:30
0 min

1. Welcome and Introductions

John Union

09:30 - 09:30
0 min

2. Apologies for Absence

John Union

09:30 - 09:30
0 min

3. Declarations of Interest

John Union

09:30 - 09:30
0 min

4. Minutes of the Committee meeting held on 5 July 2022

John Union

04 Draft Public Audit Minutes 5.7.22MD.NF.pdf (15 pages)

09:30 - 09:30
0 min

5. Action log following meeting held on 5 July 2022

John Union

05 Draft Public Action Log - SeptemberMD.NF.pdf (3 pages)

09:30 - 09:30
0 min

6. Any other urgent business: To agree any additional items of urgent business that may need to be considered during the meeting

John Union

09:30 - 09:30
0 min

7. Items for Review and Assurance

7.1. Internal Audit Progress Report

Ian Virgil

7.1 Internal Audit Progress Report cover September 22.pdf (3 pages)
7.1a Internal Audit Progress Report cover September 22.pdf (18 pages)

7.2. IT Service Management Verbal Update

David Thomas

7.3. ChemoCare IT System – Verbal

David Thomas

7.3 Chemo Care System Final Report.pdf (23 pages)

7.4. Audit Wales Update to include:

Audit Wales

7.4 C&VUHB AC Update (September 2022).pdf (12 pages)

7.4.1. Audit of Accounts' Addendum Report

7.4a Audit of Accounts Addendum Report.pdf (16 pages)

7.4.2. Estates Follow Up Review

7.4b Estates Review Follow-up Report.pdf (19 pages)

7.5. Declarations of Interest, Gifts and Hospitality Report

Nicola Foreman

7.5 Declarations of Interest Gifts and Hospitality Tracking Report September 2022.pdf (4 pages)
7.5a - Declarations of Interest Register.pdf (5 pages)

7.6. Internal Audit Tracking Report

Nicola Foreman

7.6 Internal Audit Tracking Report - September 2022.pdf (4 pages)
7.6a Appendix 1- Internal Audit Tracker Sept 2022 v2.pdf (17 pages)
7.6b Appendix 2 - Internal Audit Summary Tables - September 2022.pdf (3 pages)

7.7. Audit Wales Tracking Report

Nicola Foreman

7.7 Audit Wales Tracking report covering report - Sept 2022 v2.pdf (3 pages)
7.7a - Appendix 1 - Audit Wales Tracking Report Summary Table - Sept 2022.pdf (1 pages)
7.7b - AW Tracker Sept 2022.pdf (10 pages)

7.8. Assurance Mapping

Nicola Foreman

7.8 Assurance Mapping Update.pdf (3 pages)

7.9. Regulatory Compliance Tracking Report

Nicola Foreman

7.9 Regulatory Compliance Tracking Report July 2022.pdf (4 pages)
7.9a Regulatory Tracker - September 2022.pdf (2 pages)

7.10. Procurement Compliance Report

Catherine Phillips Claire Salisbury

7.10 Procurement Compliance Report.pdf (7 pages)

7.11. Counter Fraud Progress Report

Gareth Lavington

7.11 Counter Fraud Progress Report.pdf (2 pages)
7.11a CAV Period 2 - 2022 Progress Report.pdf (12 pages)

7.12. Procedure for Internal and External Tracking Reports Update

Nicola Foreman

7.12 Procedure for Internal and External Tracking Reports Updates.pdf (3 pages)

09:30 - 09:30
0 min

8. Items for Approval / Ratification

No Items

09:30 - 09:30
0 min

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgil

9.1 Internal Audit Reports for Information cover.pdf (2 pages)

9.1.1. Monitoring and Reporting of Staff Sickness Absence

9.1.1 Audit Report_Monitoring and Reporting of Staff Sickness Absence.pdf (14 pages)

9.1.2. Ultrasound Governance Follow-up (CD&T CB)

9.1.2 Internal Audit Follow Up Report_Ultrasound Governance.pdf (8 pages)

9.1.3. Integrated Medium Term Plan 2022 – 2025: Development Process

9.1.3a Internal Audit Report_IMTP Development Process (002).pdf (13 pages)

9.1.4. Stock Management – Neuromodulation Service (Specialist Services CB)

9.1.4 Neuromodulation Stock-SS CB.pdf (15 pages)

9.1.5. Waste Management

9.1.5 Waste Management Audit Report.pdf (25 pages)
9.1.5a Cardiff UHB Waste Management Audit Report (final issued) doc.pdf (25 pages)

09:30 - 09:30
0 min

10. Agenda for Private Audit and Assurance Committee

John Union

10.1. Private Audit Minutes – 14 June 2022 and 5 July 2022

10.2. Counter Fraud Progress Report (Verbal)

10.3. Workforce and Organisational Development Compliance Report

10.4. Overpayment of Health Board Salaries (Verbal)

10.5. Procurement Influenceable Spend Report and Improvements

09:30 - 09:30
0 min

11. Any Other Business

John Union

09:30 - 09:30
0 min

12. Review and Final Closure

John Union

12.1. Items to be deferred to Board / Committee

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

Thursday 8 November 2022 at 9:30am via MS Teams

09:30 - 09:30
0 min

13. Declaration

John Union

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

Draft Minutes of the Public Audit & Assurance Committee Meeting
Held On 5 July 2022 at 9am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union and Committee Chair
Ceri Phillips	CP	UHB Vice Chair
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Rachel Gidman	RG	Executive Director of People & Culture
Ian Virgil	IV	Head of Internal Audit
Wendy Wright-Davies	WW	Deputy Head of Internal Audit
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Paul Rogers	PR	Interim Assistant Director for Therapies and Health Science
Aaron Fowler	AF	Head of Risk and Regulation
Tim Davies	TD	Head of Corporate Business
Jonathan Pritchard	JP	Assistant Director of People Resourcing
Urvisha Perez	UP	Audit Wales
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Fiona Jenkins	FJ	Executive Director for Therapies Health Science
Meriel Jenney	MJ	Executive Medical Director

Item No	Agenda Item	Action
AAC 5/7/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 5/7/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 5/7/22 003	**Declarations of Interest** **The Committee resolved that:**	

	a) No Declarations of Interest were noted.	
AAC 5/7/22 004	**Minutes of the Meeting Held on 12th May 2022 and 14th June 2022** The Minutes were received. **The Committee resolved that:** a) The draft minutes of the meetings held on the 12th May 2022 and 14th June 2022 were a true and accurate record of the meetings.	
AAC 5/7/22 005	**Action Log – Following Meeting held on 14 June 2022** • AAC 22/5/4/007 – The update on the IT service Management Report actions would be provided at the September meeting. • AAC 22/2/8/023 - Independent Members would meet with Audit Wales and Internal Audit virtually in September. • AAC 5/4/22 010 – The high-level assurance map would be presented at the September meeting. • AAC 14/6/22 008 – would be added to the Action Log for the September Committee meeting. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 5/7/22 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 5/7/22 007	**Internal Audit Progress Report** Ian Virgil (IV) presented the Internal Audit Progress Report (the Report) and highlighted the following – • The Report provided information on the delivery of the 22/23 plan. • The report also discussed the remaining progress reports from 21/22. <u>Section 2</u> • 4 audits had been finalised. They were from the 21/22 plan and had fed into the Head of Internal Audit (HIA) Annual Opinion for 21/22. • The table highlighted the outcome - 1 report received substantial assurance, 2 reports received reasonable assurance and 1 report received limited assurance.	

	• 1 report in relation to waste management was still to be completed. <u>Section 3</u> • Against the 41 reviews scheduled for 22/23, 4 audits were a work in progress and 6 were in the planning stage. • The team were still in the early stages and the audits would be progressed and finalised in due course. <u>Section 4</u> • There have been changes to the timings for the planned audits for 22/23. • Following a more detailed review of the availability of Internal Audit resources and discussions with relevant lead contacts, adjustments have since been proposed to the planned timings for the following audits: – Medical & Dental Staff Bank – Moved from Q1 to Q2 – Reporting of Covid Deaths – Moved from Q3 to Q2 – Financial Plan / Reporting – Moved from Q2 to Q3 – Performance Reporting – Moved from Q3 to Q4 • Following discussions with management, there was one audit that had been proposed in addition to the progress plan for this year requested by Specialist Services. • Internal Audit had been requested by the Clinical Services Board to complete a report within their area. • Following discussions with the Medicine Clinical Board, they would also like Internal Audit to focus on the outsourcing of Endoscopy. The Executive Director of Finance (EDF) commented that Quality and Safety Governance had been invested in for two years. It would be useful to see the outcome of the investment within the Clinical Boards. IV responded that within the 22/23 plan, there was a piece of work looking at the quality and safety governance at a Corporate level and a piece of work within the Medicine Clinical Board. IV added that he had a meeting with the END that week to discuss the timings of that piece of work. The Deputy Head of Internal Audit (DHIA) advised the Committee on the following: • Internal Audit had looked through a sample of the closed audits for 21/22. The outcome of the review was in Appendix B of the Report. • 11 of the sample were noted as complete.	

	• It was difficult to get an update on some reviews because of a change in resource throughout the year. • There were 3 recommendations that could not be fully validated because information was outstanding. • The exercise highlighted reasonable assurance. The Committee Chair (CC) queried the 3 recommendations that could not be validated. The DHIA responded that they were included in Appendix B. One was with Finance and the other two were in an area where there had been a change in resource. The Director of Corporate Governance (DCG) stated that they would be opened and added back onto the Tracker. The HIA advised that the exercise had highlighted that the Audit Committee could be reasonably assured that the progress information detailed within the Tracker for 21/22 was accurate, although further efforts were required to obtain complete assurance from management. <u>Section 6 – Final report summaries</u> a) Recovery of services and Delivery of the Annual Plan 21-22 • Substantial assurance was issued. • The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Recovery of Services and Delivery of the Annual Plan 21/22. • Two priority recommendations were made. That included - The transparency of reprofiling recovery funding; and - The timeliness of information contained within the Board Assurance Framework. • It was noted that this was not a surprise to management. They had been completed close to year end and they already started to revise the arrangements for 22-23. b) Risk Management • Reasonable assurance was issued. • The purpose was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the risk management arrangements. • It was a key piece of work and had informed the HIA opinion.	

	• Greater efforts were required in the Clinical Boards and the Corporate departments to enhance the risk registers. • Given the size of the Health Board, the tools available for management to record that were not ideal. • Risk registers sat within spreadsheets with limited transparency. • The Health Board hoped to move to the Once for Wales Solution in 22/23. That would help move the Health Board forward in terms of risk management maturity. The DCG advised that recording the risks on an Excel spreadsheet was a good place to start. However, there were a number of project management tools that could help with risk management in the organisation. The CC queried if the tools were already available to the Health Board or would be developed. The DCG responded that they were already available. The risks were currently on an Excel spreadsheet and could not be easily interrogated. c) Performance Reporting (Data Quality) • Reasonable assurance was given. • 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 Performance Reporting (Data Quality). • Two medium priority recommendations were made which required management attention. Both focused on the robustness of systems and processes to capture and validate the data within the Integrated Performance Report, specifically the Balanced Scorecard. • The recommendations proposed, once implemented would enhance the clarity and completeness of the report. The UHB VC stated that he did not see any comment in the Report on the timeliness of the data. The DHIA responded that the scope had related to the data quality. Within the 22/23 plan they would review performance reporting. d) ChemoCare IT System • Limited assurance was given. • Neither the DDHI nor the IT Audit Manager could attend to give an update on the actions. • The purpose was to provide assurance that data held within the Chemocare IT System was accurate,	

	secure from unauthorised access and loss, and that the system was used fully. • 7 medium priorities and 1 key priority were highlighted. • The high priority recommendation related to the database security. • An action plan had been agreed by management to approve the issues. The DCG confirmed that the Director of Digital Health and Intelligence (DDHI) had been invited to the September meeting to give a detailed report. The CC queried what stage of the 22/23 plan would the follow up reports be brought. The HIA responded that the majority were included in the plan. This limited assurance report and the Nurse Bank report were identified as limited assurance after the plan was agreed. Additional time would need to be built into the plan. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports, were considered. b) The proposed adjustments to the planned timings for the identified 2022/23 audits were approved.	
AAC 5/7/22 008	**Temporary Staffing Department (Nurse Bank) Internal Audit Report Update** The Executive Director of People & Culture (EDPC) introduced the item and highlighted that she had requested that Workforce and OD took over the temporary staff from Director of Nursing. They had also requested an audit to be completed. The results were disappointing but they wanted to proactively get the actions in place. The Assistant Director of People Resourcing (ADPR) advised the Committee on the following: 3 recommendations were rated as a high priority. 1. Inadequate structure within the TSD (design) • There was no deputy in place for the Senior Nurse. The Professional Standard Nurse would also be retiring soon. • There would also be a lead for recruitment. That would involve upgrading one of the existing staff. • A lack of resilience in staff was noted and the inability to undertake each other's roles.	

	• The function was changing, with the introduction of the health roster, the focus would be to make it more automated. • The focus would also be on recruitment. • The processes had also been reviewed and an organisation chart had been set up to allow people to cover each other. 2. Lack of resilience of the TSD (operation) • It was evident that staff were not able to undertake each other's roles when one of the managers was absent due to long term sickness last year. • With the introduction of the health roster, the focus was that there was an automated system where wards could request shifts. • Billing would also be done as self-billing on the ward. • The focus was on recruitment in the Bank and to have a range of professions. • They were also implementing a rotation within the department so that people could cover each other when off. 3. Range of agency usage (operation) • 36 agencies were being used. • Meetings have taken place with several agencies to see if they could provide supplied staff. • Ideally, they would like to use less agencies and increase staff on the Bank. • However, it was useful to have a wide selection of agencies to provide staff. • The ADPR was keen to set up a good management performance framework. • The ADPR would also be introducing KPIs and reporting on a monthly basis. • The Healthcare Support Worker job adverts had received 120 applications, of which 98 people were interviewed and 65 people were appointed. • Ideally, the aim was to get staff in place ready for the Autumn and Winter pressures. **The Committee resolved that:** a) The contents of the report were noted.	
AAC 5/7/22 009	**IT Service Management Report** **The Committee resolved that:** a) The Update would be brought back to the September meeting.	**DDHI**

AAC 5/7/22 009	**Audit Wales Update** Urvisha Perez (UV) presented the update and highlighted the following: • The Auditor General had certified the 21-22 Performance Report, Accountability Report, and Financial Statements on 17 June 2022. • The review of Quality Governance Arrangements was completed. • Appendix 3 showed work that was underway. • The Orthopaedic Services Follow up audit and the Review of Estates audit were in the draft stage. They were aiming to present this to the September Audit Committee Meeting. • The field work for the Structured Assessments was underway and interviews were taking place. Internal Audit colleagues would also join in the interviews. • Exhibit 5 highlighted recently published NHS national reports. <u>Quality governance report</u> • The report looked at the Health Board governance arrangements in relation to Quality Governance. • The Health Board had effective arrangements to monitor and track progress with complaints, where it consistently achieved performance targets, and arrangements to capture patient experience were reasonably effective. • The Health Board had a well-established values and behaviour framework which was embedded in workforce processes. • Agendas for corporate and operational quality and safety meetings provided a wide coverage of quality and safety issues for discussion and there was sufficient information for scrutiny and assurance at both a Corporate and at Clinical Board levels and the Health Board's use of quality data was maturing. • The agendas could be more dynamic to reflect new and emerging risks and issues. • 7 recommendations were made. The Health Board Management response had also been included. • UP thanked everyone at the Health Board for supporting the review. The CC queried whether the recommendations were on the Tracker. The DCG responded that the recommendations would be added to the tracker after the meeting. **The Committee resolved that:** a) The Audit Wales Update was noted.	**Audit Wales**

AAC 5/7/22 010	**Ultrasound Clinical Governance Position** The Interim Assistant Director of Therapies and Health Science (IADTHS) presented the paper and highlighted the following: • The Ultrasound Governance Arrangement audit had received 'Limited Assurance'. • Since then they have set up the Ultrasound Clinical Governance Group. • Terms of Reference for that Group had also been written. That would provide assurance regarding proper communication pathways and reporting maps. • A lot of work had been undertaken in relation to the membership of the Ultrasound Group. • The policies and procedures had also been updated and were now published under "U" of the policies webpage instead of under "T" on the Health Board website. • An abridged version of policies and procedures had been completed and that would be shared with Members. • The aim was to have the Ultrasound Clinical Governance meetings prior to the medical equipment meetings. • There were a few outstanding actions regarding training. The team was putting together a training pack in relation to Ultrasound use which would be uploaded onto ESR in 6 to 12 months' time. • The team was also working on an electronic audit tracker to improve governance and audit the quality of ultrasound images. WW commented that in the 22/23 Internal Audit Plan there was a follow up to the Ultrasound limited assurance report. The EDPC queried the six months wait for ESR and whether that was due to an internal or external issue. The IADTHS would get confirmation and contact the EDPC offline. **The Committee resolved that:** a) The actions being taken (as set out in this report) to address the recommendations made by Internal Audit in the Ultrasound Governance audit report dated August 2021 were noted.	**IADTHS** **IADTHS**
AAC 5/7/22 011	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the report and highlighted the following:	

	• The report set out where the Health Board was in terms of compliance, standards of behaviour and procedures. • There was an 11.2% increase in declarations of interest submissions since the April Committee. • 77.7% of staff at Band 8 and above had declared an interest. That included: - 97.33% of Declarations received are rated Green (328 Declarations). - 2.66% of Declarations received are rated Orange (8 Declarations). - 0.01% of Declarations are rated Red (1 Declaration).1 interest declared as red. • The HRR gave assurance around the 1 interest that was declared as red and stated that there was continuing dialogue with colleagues. • The team continued to work with colleagues from Communications to ensure regular contact and to keep staff engaged in the process. • An email had been issued last week as part of "Staff Connects". Another drop-in session for staff was proposed for later in the year. • Overall it showed a positive trend and more staff had declared interests through ESR. The CC queried how often were updates seen. The HRR responded that this was part of the communication. Twice a year staff were reminded to update their declarations when there was a material change. There were instances of duplications but these could be fished out. The Independent Member for Trade Union (IMTU) queried whether a senior management staff member at Band 8 and upwards who retired and returned to work needed to declare again. The HRR responded that they would. The DCG stated that it was built into the policy. If there were any change in a staff member's circumstances they would need to let the Risk and Regulation Team know. **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 approved.	
AAC 5/7/22 012	**Internal Audit Tracking Report** The HRR presented the report and highlighted the following:	

	• The Regulation and Risk Team had continued to have regular meetings with Internal Audit to discuss the process. • There had been an increase in 7 recorded entries that month. • 37 were added in the April update. • The overall number of outstanding recommendations had increased from 84 individual recommendations to 91 during the period April 2022 to July 2022. • The change could be attributed to the following: - 14 entries reported as complete at the April Committee were removed from the Tracker - 16 Entries related to the Advisory IM&T Control and Risk Assessment Audit had been removed from the Tracker to be monitored offline. - At the time of reporting all 16 advisory recommendations remained recorded as partially complete. - A further 37 entries had been added to the Tracker since April 2022. - Of the 91 recommendations listed within the Tracker, 25 were recorded as completed, 56 were listed as partially complete and 10 were listed as having no action taken or reported since the April Committee meeting. Following discussions with Internal Audit, the Team would focus on the entries that had been on the Tracker for a while. The CC stated it would be useful to know the status of the recommendations from March 2020 to understand why they were outstanding. IV responded that there had been really good work undertaken to develop the Tracker in relation to accuracy and information and the next step would be how the Committees could use this information. The DCG stated that there was no formal tracking in place when she first started with the Health Board and it was therefore agreed to look back during the past 3 years. **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 April 2022 was noted.	
AAC 5/7/22 013	**Audit Wales Tracking Report** The HRR presented the report and highlighted the following:	

	• 20 entries were recorded on the Tracker at present. • Of the 20 recommendations recorded on the Tracker, 3 were recorded as complete, the remaining 17 were recorded as partially complete. • 5 were overdue. • Audit Wales continued to meet with recommendation owners. • The team would focus on the older entries. **The Committee resolved that:** a) The progress which had been made in relation to the completion of Audit Wales recommendations was noted. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	
AAC 5/7/22 014	**Regulatory Compliance Tracking Report** The HRR presented the report and highlighted the following: • There were growing recommendations from legislative bodies and Welsh Government. • Welsh Health Circular (WHC) updates were regularly provided at ME. The next update would be shared on Monday. • Since the report had been prepared there have been 2 additional WHCs that had been circulated. • Following April's Committee Meeting a total of 2 completed entries were removed from the register. • A further 3 entries have been reported as complete since April's meeting and were recorded on the attached Tracker. The EDF commented that she was working with the EDPC in relation to Capital, Estate and Facilities. That was mainly for the Health and Safety Committee and may filter its way onto this tracker. The DCG stated individual recommendations needed to be tracked. **The Committee resolved that:** a) The assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations was approved. b) The continuing development of the Legislative and Regulatory Compliance was noted.	
AAC 5/7/22 015	**Review Risk Management** The DCG presented the report and highlighted the following:	

	• The report looked at the requirements of the Standing Orders to review the Risk Management Policy and Strategy on an annual basis. • No changes were required to the Strategy and procedure, although the processes should be tightened. • The Risk Management Review was scheduled to go to Board at the end of July to state no changes were made to the Strategy and procedure. **The Committee resolved that:** a) The contents of this Risk Management Review update were noted. b) Assurance that the Health Board's Risk Management processes and procedures had received Reasonable Assurance from Internal Audit, was received. c) Agreed that the Health Board's Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register) did not, at the time of the Committee meeting, require updating.	**DCG**
AAC 5/7/22 016	**Procurement Compliance Report - Single Tender Actions** The EDF presented the report and highlighted the following: • It was the standard compliance report which detailed breaches of the procurement policy. • A more detailed report on the improvement work being undertaken would be presented to the Committee at its September meeting. **The Committee resolved that:** a) The contents of the Report were noted. b) The contents of the Report were approved.	**EDF**
AAC 5/7/22 017	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LCFS) presented the Report and highlighted the following: • Up to 85 days of Counter Fraud work had been completed. • Counter Fraud had very little presence digitally within the Health Board. • The team had managed to create a fit for purpose site that was available on SharePoint. • An e-learning package was being developed and the aim was to have it completed in the next quarter. • 4 fraud alerts had been issued. • 1 awareness session was delivered within the Child Health department. The team would continue to deliver more sessions.	

	• The team had published a fraud newsletter which was included in Appendix 4. • A new referral line had been set up and 17 referrals had been received so far, of which 8 had been informally resolved, 5 had been promoted to investigation and 4 remained open. • 9 were open at the start of the year and 7 had been closed. One referral had led to criminal conviction. The CC queried whether the volume was getting lower in terms of ongoing cases. The LCFS responded that the team had been trying to develop the infrastructure and open as many referrals as possible. **The Committee resolved that:** a) The contents of the report were noted.	
	Items for Approval / Ratification	
AAC 5/7/22 018	**Draft Management of Policies, Procedures and Other Written Control Documents Policy** The Head of Corporate Business (HCB) presented the report and highlighted the following: • The Corporate Governance department had a responsibility to coordinate and control the production of the publication and archiving of policies and controlled documents. • There were two documents that provide mechanisms for that. - UHB 001 which was the policy on policies and - UHB 242 which was the more detailed procedure. • Both documents were due for a bi-annual review. UHB 001 required minor amendments. UHB 242 did have some changes to provide a clearer definition of the type of control documents to be used in Health Board. **The Committee resolved that:** a) The adoption of the amendments to UHB 001 (Management of Policies, Procedure and other Written Control Documents Policy) and UHB 242 (Written Control Documents – Development and Approval Procedure) was approved.	
AAC 5/7/22 019	**Internal Audit reports for information:** (i) Recovery of services and Delivery of the Annual Pla 2021 – 2022 Final Report – Substantial Assurance	

	(ii) Risk Management Final Internal Audit Report – Reasonable assurance (iii) Performance Reporting (Data Quality) Final Report - Reasonable Assurance (iv) ChemoCare IT System Final Report – Limited Assurance	
AAC 5/7/22 020	**Agenda for Private Audit and Assurance Committee** i. Counter Fraud Progress Report (Verbal) ii. Workforce and Organisational Development Compliance Report	
AAC 5/7/22 021	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
AAC 5/7/22 022	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
	Date and time of next committee meeting Tuesday 6 September 2022 at 9am via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
5th July 2022
(For the Meeting 6 September 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
Actions in Progress					
AAC 22/5/4/007	IT Service Management Report	David Thomas to provide an update on the IT service Management Report actions.	David Thomas	6/9/2022	**Update on 6 September 2022** On September agenda – item 7.2
AAC 22/2/8/023	Meeting with Audit Wales	Independent Members to meet with Audit Wales virtually.	Nicola Foreman	6/9/2022	**Update on 6 September 2022** Meeting between the Committee IMs and Audit Wales scheduled to take place before Audit meeting starting in September.
AAC 22/2/8/009	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	30/09/2022	**Update by 30 September 2022** These will be removed at the end of September after a final check with the EDPC.
AAC 22/5/4/013	Procurement Audit Influenceable Spend Report	Procurement will complete a deep dive analysis on the potential opportunities to increase procurement influence within non-	Claire Salisbury/Catherine Phillips	6/9/2022	**Update on 6 September 2022** On September agenda – item 7.10

		pay expenditure and return to the Audit Committee in September 2022 with a further update.			
AAC 22/5/4/013	Procurement Audit Influenceable Spend Report	The Procurement team could look at whether the Primary Care spend could be influenced.	Claire Salisbury	6/9/2022	**Update on 6 September 2022** On September agenda – item 7.10
AAC 5/4/22 010	Review System of Assurance	A high- level assurance map to be provided to Board.	Nicola Foreman	6/9/2022	**Update on 6 September 2022** On September agenda – item 7.8
AAC 14/6/22 008	Audit Wales ISO 260 Report	A follow up report would go to the September meeting.	Audit Wales	6/9/2022	**Update on 6 September 2022** On September agenda – item 7.4 (Audit of Accounts' Addendum Report)
AAC 5/7/22 009	The Estates Review audit	Aiming to present these in September meeting.	Audit Wales	6/9/2022	**Update on 6 September 2022** On September agenda – item 7.4 (Estates Follow up Review)
AAC 5/7/22 009	The Orthopaedic Services: Follow up	Aiming to present these in September meeting.	Audit Wales	6/9/2022	**Update on 6 September 2022.** A quick progress update will be included in the Audit Wales Update report to September's Committee (agenda item 7.4), with the full Orthopaedic Services Follow Up report to be presented to the Committee at a later date.
Actions referred to Board / Committees					

AAC 5/4/22 010	Review System of Assurance	A high- level assurance map to be provided to Board.	Nicola Foreman	29/9/2022	An update to be shared at the Board meeting in September 2022.
AAC 5/7/22 015	Risk Management Review	An update report relating to the Risk Management Review is scheduled to go to Board in July 2022.	Nicola Foreman	28/7/2022	Completed This Matter was considered and agreed by Board at its July meeting.

Report Title:	**Internal Audit Progress Report**				Agenda Item no.	7.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	06/09/22	
			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 2022/23 plan was formally approved by the Audit Committee at its April 22 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 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 Waste Management report from the 2021/22 plan has now been finalised. Although this report was not finalised in time for submission to the May Committee, the outcome was included within the Head of Internal Audit Opinion and Annual Report for 2021/22.

The following reports from the 2022/23 plan have been finalized since the July 22 meeting:

- Integrated Medium Term Plan 2022-2025: Development Process – Substantial Assurance
- Monitoring and Reporting of Staff Sickness Absence – Reasonable Assurance
- Follow-up: Ultrasound Governance – Reasonable Assurance
- Stock Management – Neuromodulation Service (Specialist Services CB) - Reasonable Assurance

The progress report also includes details of proposed additions to the 2022/23 plan and amendments to the planned timings for a number of audits.

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 additions and adjustments to the planned timings for the identified 2022/23 audits.

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 September 2022

NWSSP Audit and Assurance Services

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

Contents

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 2022/23 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 2022/23 was agreed by the Audit & Assurance Committee in April 2022 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 September Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
5 Steps to Safer Surgery Follow-up	WiP		Delay in agreeing brief and availability of Internal Audit resource.
Uptake of National IT Systems	WiP		Delay in obtaining information from the operational lead.

3. Outcomes from Completed Audit Reviews

A total of five audit reports from the 2021/22 plan were not finalised in time for submission to the Audit Committee in May 22, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2021/22. Four of these were reported to the July meeting and the last, the audit of Waste Management, has now also been finalised, as detailed in the table below.

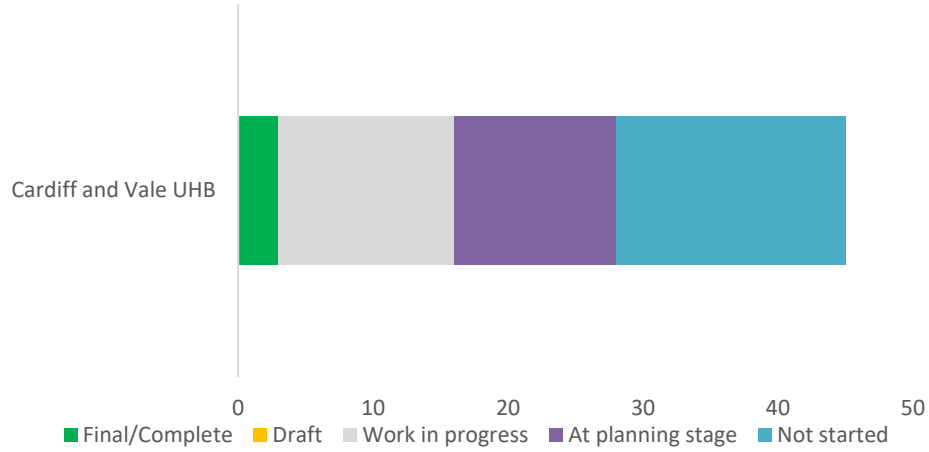
Four assignments from the 2022/23 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS (2021/22 Opinion)	ASSURANCE RATING	
Waste Management	Reasonable	
FINALISED AUDIT REPORTS (2022/23 Opinion)	**ASSURANCE RATING**	
Integrated Medium Term Plan 2022-2025: Development Process	Substantial	
Monitoring and Reporting of Staff Sickness Absence	Reasonable	
Follow-up: Ultrasound Governance		
Stock Management – Neuromodulation Service (Specialist Services CB)		

4. Delivery of the 2022/23 Internal Audit Plan

There are a total of 45 reviews within the 2022/23 Internal Audit Plan (including the proposed additions highlighted within section 5 below), and overall progress is summarised below.



From the illustration above it can be seen that three audits have been finalised since the Committee met last.

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

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

Appendix A also includes details of the three audits from the 2021/22 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2021/22. The outcomes from these audits will feed into the 2022/23 Opinion.

5. Changes to the 2022/23 Plan

Three follow-up audits have been proposed for addition to the 22/23 plan, as the original audits were completed with Limited assurance after the plan was agreed:

- ChemoCare IT System Follow-up;
- Network & Information Systems (NIS) Directive Follow-up; and
- Nurse Bank (Temporary Staffing Department) Follow-up.

It is also noted for completeness that the audit of Stock Management within the Neuromodulation Service was added to the plan following agreement by the Committee at the May 22 meeting.

Adjustments have been proposed to the planned timings for the following audits:

- Assurance Mapping – Move from Q1 to Q2 following agreement to complete the audit in 2 parts;
- Charitable Funds – Move from Q3 to Q2 to avoid overlap with Audit Wales work;
- Core Financials – Move from Q4 to Q2 due to availability of IA resource;
- Clinical Audit Follow-up – Move from Q2 to Q4 at request of Asst Dir of Nursing; and
- Management of Locum Junior Doctors (Women & Children's CB) – Move from Q3 to Q4 to allow for Internal Audit resourcing.

The following audits have been identified for completion during 2022/23 as part of the work around the Development of Integrated Audit Plans:

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

The Committee will receive the final reports to provide assurance on the developments and the outcomes will feed into the Head of Internal Audit opinion for the year. However, the audits have been commissioned in accordance with the agreed Audit Plans provided within the approved Business Justification Cases for the projects.

6. Final Report Summaries

6.1 Waste Management

Purpose

The audit was undertaken to assess the UHB's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Reasonable assurance has been issued in this area.

A number of areas of good practice were evidenced during the audit, noting particularly the development and implementation of an internal audit management system for the planning, delivering, and monitoring of a range of estates compliance audits, including waste.

The significant challenges faced by Estates & Facilities in the last two years in responding to the Covid pandemic are recognised (e.g., increased volumes of clinical waste from testing centres).

The matters requiring management attention include:

- the need to review and update the existing waste management policy and associated procedural guidance;
- the preparation of a training needs assessments:
- the need to address operational issues identified at site testing, particularly the adequacy of bin signage and cleanliness of site compounds; and
- Other recommendations are within the detail of the report;

Positive action in addressing the matters arising was being demonstrated at the time of the issue of this final 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	Policy & Procedures	Reasonable
2	Governance & Management	Reasonable
3	Contractual Arrangements	Reasonable
4	Operational Practice	Reasonable
5	Monitoring & Reporting	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
1	Policy & Procedures should be appropriately updated	1	Design	Medium
3	Risk escalation processes should be defined (actioned since audit fieldwork)	2	Design	Medium

4	Training requirements should be needs focussed (actioned since audit fieldwork)	2	Design	Medium
5	Key Performance Indicators should be applied to contractual arrangements	3	Design	Medium
6	Operational issues should be effectively addressed including enhanced signage and waste storage within main yards	4	Operation	Medium

6.2 Integrated Medium Term Plan 2022-2025: Development Process

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the 'Integrated Medium Term Plan 2022 - 2025 Development Process'.

Overview

We have issued substantial assurance on this area.

The Health Board's Integrated Medium Term Plan aligns with the requirements of the NHS Wales Planning Framework 2022 – 2025. The initial deadline for submission to Welsh Government by 31 March 2022 was achieved, but subsequent actions were required as a result of the financial deficit underpinning the Plan.

The Health Board has good governance arrangements in place to oversee the development of the Integrated Medium Term Plan, although we have made a medium priority recommendation to enhance accessibility and transparency.

We have made two further low priority recommendations / advisory points which are in the detail of the report.

Report Classification

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	⇔ Annual Planning Process 2021-22 (May 2021)

Assurance summary[1]

Assurance objectives		Assurance
1	Appropriate governance arrangements are in place.	Reasonable
2	Lessons learnt are identified as part of the planning cycle.	Substantial
3	The planning process is aligned to the NHS Wales Planning Framework 2022 – 2025.	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Accessibility and transparency of governance arrangements	1	Operation	Medium

6.3 Monitoring and Reporting of Staff Sickness Absence

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 Monitoring and Reporting of Staff Sickness Absence.

Overview

We have issued reasonable assurance on this area.

We have made two medium priority recommendations, which look ahead, to support the Health Board's recovery from the pandemic. We have suggested that reporting on sickness absence within the Clinical Boards and Corporate Departments looks beyond the high level sickness rates, and provides greater analysis of sickness absence.

In response to the pandemic the role of the HR Advisors has moved away from traditional relationships focused within the Clinical Boards, to locating to specialist teams such as the Managing Attendance at Work Team. There is opportunity to clarify the People and Culture Operating Model with regards to roles and responsibilities for sickness absence.

A further low priority recommendation is within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Review and reporting of staff sickness absence rates at a Health Board wide level	Substantial
2	Systems and processes in place to review and report on Clinical Boards and Corporate Departments sickness absence	Reasonable
3	Appropriate actions are put in place to further analyse and support poor performing areas identified through the review and reporting of sickness absence	Reasonable
4	The Board Assurance Framework adequately highlights the risk of staff sickness	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Enhanced reporting of sickness absence within the Clinical Boards	2	Design	Medium
2	Clarification of roles and responsibilities	2	Design	Medium

6.4 Follow-up: Ultrasound Governance

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Ultrasound Governance (CVU 2122-27) review that was reported as part of our 2021/22 work programme, which provided 'Limited' assurance.

Overview of findings

Management have made good progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

The two high priority recommendations raised are now complete, and moves the overall rating from a 'Limited' to 'Reasonable' Assurance, given the mitigation in risk.

Of the five recommendations made, only one medium priority remains incomplete and is work in progress. Whilst we were able to evidence progress of recommendation two being taken forward, the recommendation remains at medium priority, given the importance of the exercise to provide complete assurance to the Executive Director of Therapies and Health Science. The recommendation will remain on the Audit Committee's Tracker of Internal Audit Recommendations until fully complete.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1	Lack of communication of the revised Policy and Procedure	High	Complete
2	Absence of Clinical Board assurance	Medium	Medium
3	Design and feedback of the Ultrasound Risk Management Procedure	Medium	Complete
4	Ultrasound governance arrangements	High	Complete
5	Roles and responsibilities outlined by procedure	Medium	Complete

6.5 Stock Management – Neuromodulation Service (Specialist Services CB)

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Neurosciences Directorate in relation to neuromodulation equipment stock management.

Overview

We have issued reasonable assurance on this area.

The outcome of our review builds on the improvements instigated by management, working with finance, to strengthen the stock management arrangements within the Neurosciences Directorate.

We have made recommendations under each of the five objectives of our review, the most notable, is a high priority recommendation to address missing stock, to the value of £75,000.

At the time of closing our audit fieldwork, the stock remained unaccounted for. The implementation of the recommendations from this review will strengthen the control environment, which should mitigate the risk of future financial losses due to missing stock.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Neuromodulation stock procedures	Reasonable
2	Security and accessibility of stock	Reasonable
3	Stock records and reconciliations	Reasonable
4	Ordering and receipt of stock	Reasonable
5	Management information of stock	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Standard Operating Procedures	1	Design	Medium
2	Storage and Security of Stock	2	Operation	Medium
3	Outcome of June 2022 Stock Count	3	Operation	Medium
4	Goods Receipting Process	4	Operation	Medium
5	Missing Stock	5	Operation	High

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2021/22 Plan							
Monitoring and Reporting of Staff Sickness Absence		*People & Culture*			*Final*	*Reasonable*	*September*
Capital Systems Management		*Finance*			*Work In Progress*		*November*
Post Contract Audit of DHH Costs		*Finance*			*Work In Progress*		*November*
2022/23 Plan							
IMTP 2022-25: Development Process	37	Strategic Planning	Q1		Final	Substantial	September
Follow-up: Ultrasound Governance	26	Therapies & Health Science	Q1		Final	Reasonable	September
Stock Management – Neuromodulation Service (Specialist Services CB)	42	COO	Q1		Final	Reasonable	September
Staff Wellbeing – Culture & Values	07	People & Culture	Q1		Work in Progress		November
5 Steps to Safer Surgery (Follow-up)	18	Medical	Q1		Work in Progress		November
Uptake of National IT Systems	20	Digital & Health Intelligence	Q1		Work in Progress		November
Core Financial Systems	02	Finance	~~Q4~~	Q2	Work in Progress		February
Assurance Mapping	05	Corporate Governance	~~Q1~~	Q2	Work in Progress		November
Medical & Dental Staff Bank	06	People & Culture	~~Q1~~	Q2	Work in Progress		November

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reporting of Covid Deaths	11	Nursing	~~Q3~~	Q2	Planning		November
Charitable Funds	13	Finance	~~Q3~~	Q2	Work in Progress		February
Estates Assurance – Decarbonisation (Deferred from 21/22)	15	Finance	Q2		Planning		February
IT Strategy	21	Digital & Health Intelligence	Q2		Work in Progress		November
Medical Equipment & Devices (Deferred from 21/22)	25	Therapies & Health Science	Q2		Work in Progress		November
Application of Local Choices Framework	28	Chief Executive / COO	Q2		Planning		November
Administration Services (Mental Health CB)	29	Chief Operating Officer	Q2		Planning		November
Endoscopy Insourcing (Medicine CB)	31	Chief Operating Officer	~~Q3~~	Q2	Work in Progress		November
Community Patient Appliances (Specialist Services CB)	33	Chief Operating Officer	Q2		Planning		February
– Medical Records Tracking (CD&T CB)	34	Chief Operating Officer	Q2		Work in Progress		November
QS&E Governance (Deferred from 21/22 plan)	03	Nursing / Medical	Q3				February
Implementation of People & Culture Plan	09	People & Culture	Q3				February
Nurse Staffing Levels Act	10	Nursing	Q3		Planning		April
Financial Plan / Reporting (Deferred from 21/22)	12	Finance	~~Q2~~	Q3	Planning		February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Medical Staff Additional Sessions	16	Medical	Q3				February
New IT Service Desk Tool	22	Digital & Health Intelligence	Q3		Planning		February
Cyber Security	24	Digital & Health Intelligence	~~TBC~~	Q3	Planning		February
PCIC CB – GMS Access (Deferred from 21/22 plan)	30	Chief Operating Officer	Q3		Planning		February
Management of Locum Junior Doctors (Women & Children's CB)	35	Chief Operating Officer	~~Q4~~	Q3			April
Strategic Programmes / Recovery & Redesign Governance Arrangements	36	Strategic Planning	Q3				February
Commissioning – IPFR Process	38	Strategic Planning	Q3				April
Regional Planning Arrangements	39	Strategic Planning	Q3		Planning		February
Risk Management	01	Corporate Governance	Q4				April
Management of Health Board Policies	04	Corporate governance	Q4				May
Inclusion & Equality Team	08	People & Culture	Q4				April
Capital Systems	14	Finance	Q4				April
Clinical Audit (Follow-up)	17	Medical Director	~~Q2~~	Q4	Planning		April
Performance Reporting	19	Digital & Health Intelligence	~~Q3~~	Q4			April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Data Warehouse	23	Digital & Health Intelligence	Q4				April
Recovery of Services	27	Chief Operating Officer	~~Q3~~	Q4			May
Consultant Job Plans (Surgery CB)	32	Chief Operating Officer	Q4				April
ChemoCare IT System Follow-up	43	Digital & Health Intelligence	TBC				TBC
Network & Information Systems (NIS) Directive Follow-up	44	Digital & Health Intelligence	TBC				TBC
Nurse Bank (Temporary Staffing Department) Follow-up	45	People & Culture	TBC				TBC
Shaping Our Future Hospitals Programme	40	Strategic Planning	Q1-4		Work in Progress		n/a
Development of Integrated Audit Plans:	*41*	*Strategic Planning*					
• *Development of Genomics Partnership Wales*			*Q3*		*Planning*		*February*
• *University Hospital Llandough – Endoscopy Unit Development*			*Q2*		*Work in Progress*		*November*
• *University Hospital Llandough – Engineering Infrastructure*			*Q2*		*Work in Progress*		*November*

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
IMTP 2022-25: Development Process	Substantial	Final	20/07/22	10/08/22	26/07/22	27/07/22	G
Follow-up: Ultrasound Governance	Reasonable	Final	03/08/22	24/08/22	18/08/22	18/08/22	G
Stock Management – Neuromodulation Service (Specialist Services CB)	Reasonable	Final	02/08/22	23/08/22	19/08/22	19/08/22	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	April 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2022/23	G	100% 3 from 3	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 3 from 3	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	100% 3 from 3	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 3 from 3	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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ChemoCare IT System
Final Internal Audit Report

May 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

Contents

Review reference:	C&VUHB-2122-21
Report status:	Final
Fieldwork commencement:	26th January 2022
Fieldwork completion:	31st March 2022
Debrief meeting:	29th March 2022
Draft report issued:	19th April 2022
Management response received:	19th May 2022
Final report issued:	19th May 2022
Auditors:	Syed Shah, Bank Principal Auditor Martyn Lewis, IT Audit Manager
Executive sign-off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	David Trigg, Lead for Implementation of ChemoCare (Adult) Kerry Crompton, Lead for Implementation of ChemoCare (Paediatric) Sandra Whitney, IT Programme Manager
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.

Executive Summary

Purpose

To provide assurance that data held within the ChemoCare IT System is accurate, secure from unauthorised access and loss, and that the system is used fully.

Overview

There is a framework for control over the ChemoCare system and there were areas of good practice. However, the controls have not been fully enacted. The significant matters which require management attention include:

- Out of date versions of Windows server and SQL Server database in use.
- Generic accounts exist with system administrator privileges.
- Lack of formal supplier's performance monitoring mechanism.
- Weaknesses within the Business Continuity Plan and Hosting and Backup arrangements.
- Weaknesses in password policy and current configuration settings.
- No automatic alerts configured to notify in the event of interface failures.

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

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Governance Process	Reasonable
2	Database Control	None
3	Input Controls	Substantial
4	Application Access	Limited
5	Outputs and Interfaces	Reasonable
6	Audit Log	Substantial
7	Continuity	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	Performance Monitoring Mechanism.	1	Design	Medium
2	Database Security	2	Operation	High
4	User Management	4	Operation	Medium
5	Password Controls	4	Operation	Medium
6	Interface Failure Alerts	5	Design	Medium
7	Hosting and Backup Agreements	7	Operation	Medium
8	Business Continuity	7	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 the ChemoCare IT system was undertaken.

1.2 The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the ChemoCare IT System, to provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

1.3 The ChemoCare system provides an integrated prescribing solution for Paediatric Oncology and Adult Haematology patients within Cardiff & Vale UHB, Cwm Taf Morgannwg UHB and Aneurin Bevan UHB.

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

- inappropriate access to system / data.
- inaccurate data held in system.
- inaccurate data reported from system.
- loss of processing / data; and
- the Health Board may not maximise the benefits from the system.

1.5 At the time of our audit, management is in the process of upgrading the system from version 5 to the new version 6.

2. Detailed Audit Findings

Objective 1: an appropriate governance process is in place for the system.

2.1 The ChemoCare system was bought from CIS in 2018 and a contract is in place for the provision of the system. The system was implemented in different phases. Currently version 5 is being used and the plan is to move to version 6 within six months, for which necessary administration work is being done. All the maintenance support is provided by CIS Oncology (Via accounts managed by Boxxe), with an appropriate contract in place.

2.2 The contract provides a clear requirement and specification for the system, and also covers confidentiality, data protection, intellectual property, indemnity, limitation of liability, dispute resolution, force majeure, records retention and right of audits.

2.3 There is an agreed SLA with the service provider, which states different incident severity levels and the vendor's response and fixing time. In addition, the service agreement also requires a periodic review meeting to assess the performance of the supplier. We also note that the NWSSP Procurement manual also requires monitoring of the contracted Key Performance Indicators and requires that the contract owner should keep the procurement services advised on supplier performance.

2.4 However, we note that the system administrators for ChemoCare were not aware of the agreed SLAs and requirement for supplier performance review. Hence there is no mechanism in place for performance monitoring for ChemoCare and no process to record the supplier's compliance with the agreed SLAs or to carry-out a periodic performance assessment to highlight any significant or frequent breeches (if any). **(Matter Arising 1).**

2.5 In addition, we note that there are no agreed penalty clauses in the contract to protect and compensate the NHS in the event of the supplier frequently breeching the agreed SLA.

2.6 We further note however, that from discussion with the system administrators, the supplier's performance in providing system support is satisfactory and there have been no major performance issues.

2.7 There are named system administrators in place for both South East Wales Haematology (SEWHN) and Paediatrics with good knowledge of the system and of the role. We note that the role of the system administrator has been defined within a document.

2.8 User groups are in place within both SEWHN and Paediatrics for users to feed their concerns into, although we note that the pandemic has impacted on the operation of these. However, both the system administrators are based within the respective departments and are therefore accessible.

Conclusion:

2.9 There is a governance process in place for the system, with named system administrators who understand the role and the system, and a contract is in place for maintenance and support, although we note that the performance is not currently being monitored. Accordingly, we have provided reasonable assurance over this objective.

Objective 2: appropriate control is maintained over the database.

2.10 The current version of Chemocare is installed on Windows Server 2008, support for which ended in 2020 and which contains vulnerabilities, including some significant vulnerabilities. The current system is based on SQL Server 2008, support for which ended in 2019. The use of these out-of-date components leads to an increased security risk for the Health Board. (**Matter Arising 2**)

2.11 We do note the ongoing work to move to a later version of ChemoCare and that this is based on more up to date versions of server and SQL server.

2.12 The system is securely hosted by IT, however our review of the access controls over the database identified further security weaknesses: (**Matter Arising 2**)

- database access is via SQL authentication and not windows, which is a less secure methodology;
- application users access the database using a single database user with the database Owner role. This role provides complete access to the database and so introduces a security risk; and

- user passwords are stored in clear text within the database and are not encrypted.

2.13 We further note that there is no process to ensure ongoing database management actions such as integrity checks or table optimisation is undertaken. Testing of the database noted that the errors table had a very large number of errors logged within it. These are not reviewed and the table is not periodically cleared out. (**Matter Arising 2**)

Conclusion:

2.14 Although the system is securely hosted, it is based on out-of-date components for which vulnerabilities exist. In addition, security is weakened by the authentication method, lack of encryption and provision of database owner to all users. There is no established process for database maintenance and there are a significant number of errors within the database errors table. Accordingly, we have provided no assurance against this objective.

Objective 3: all input is authorised, complete, accurate, timely and input once only.

2.15 Data entry into the Chemocare system is by a mixture of free text and selecting from drop down menus.

2.16 The standing data which supports the drop down lists within Chemocare was defined during the system set up of the system, with different values in place for adults and paediatrics. There was a structured process in place for this with a peer review process to ensure that all minor and major changes in the input parameters were independently reviewed by another member of staff and the results are archived to retain a record.

2.17 We tested a sample of entry fields within the system to establish if there were controls in place to enforce data quality on entry. This testing demonstrated that there are input controls in place and they are being managed, for example:

- There are established ranges for adult and paediatric patients. The age limit has been set as > 18 = Adult and < 12 as Paediatric, with the option to treat as either if aged between these;
- There is a warning triggered if abnormal weight is entered for a patient to ensure the user checks the entry values;
- The format is enforced for Adult GFR and Paediatric Calculation; and
- There are restrictions in place to prevent users modifying a prescription, with the system only allowing modification to drugs i.e. changes within agreed set parameters set in the drug file.

2.18 There is a user guide available for users in the form of a quick reference guide, there are also a comprehensive set of Standard Operating Procedures (SOPs) in place and a basic task guide is also available for nursing staff. We note that the user guide was last updated in 2013, and there is an intent to review and update after the move to version 6.

2.19 Training is provided to users prior to them being granted full access to the system to ensure that they understand how to use the system. We did note however that within Adult Haematology individual training logs are not signed off and archived for the records purpose. In addition, there is no centralised training record maintained to track whether training has been provided to all users. We have been informed that this is being currently worked on and will be completed before the launch of version 6. (**Matter Arising 3**)

Conclusion:

2.20 There is extensive use of drop-down lists, the maintenance of these is controlled. There are data input restrictions in place and a set of user guides for staff to ensure they understand how to use the system. Accordingly, we have provided substantial assurance against this objective.

Objective 4: proper control is exercised over access to application systems.

2.21 User access is managed by the system administrators for both Adult and Paediatrics. Access to users is based on roles and our testing confirmed that the concept of least privilege is being maintained and that the roles given to users were appropriate. We also note that there are a number of staff with read only access to the system that facilitates the sharing of information without a risk of erroneous data entry.

2.22 There is a SOP that sets out the process for providing access to new users and is accompanied by a new user request form to enable approval and tracking of user creation. We note however that this is not generally followed. User access is mostly granted by an email (or sometimes) verbal request and not the form provided. In addition, we note that the user request form is not up to date and does not include all the current roles in use within the system. (**Matter Arising 4**)

2.23 Users are given usernames for individual access to ensure that actions can be tracked within the system. However, there are generic accounts within both Adult Haematology and Paediatric Services. These include system manager level access and so remove accountability and traceability for actions undertaken using these accounts.

2.24 Our testing identified staff who have left the Health Board, or who have transferred and whose accounts were still active. We note that accounts are automatically archived if not used for 180 days, however this does not fully manage the risk associated with inappropriate access. (**Matter Arising 4**)

2.25 Access to the system is controlled via username and password and the SOP sets out the requirements for the password. We note however, that the SOP governing password setting is outdated and does not reflect the Health Board the IT Security policy. In addition, there were variations in practice between the services. (**Matter Arising 5**)

- There are different length requirements for passwords between the systems. For adult it is 8 and Paediatric it is only 6: and

- There are differences in the password re-use times between systems. Passwords are archived for 365 days in Adult Haematology; however, it is archived for only 200 days in paediatric.

2.26 We further note that there are weaknesses in password management, with no forced requirement for passwords to contain a mixture of uppercase, lowercase and numbers despite the SOP stating this. Furthermore, the current version in use (v5) does not has the ability to lock-out an account after a set number of attempts using an incorrect password. (**Matter Arising 5**)

2.27 Our testing also identified that there are few user accounts (including system admin) where the password change policy is different from the current practice and SOP. For instance, on 3rd March 2022 next password due for System Manager accounts were appearing as 10th March 2027 and 5th September 2024. (**Matter Arising 5**)

Conclusion:

2.28 Although there is an SOP that sets out the requirements for the provision of user access, this is not always complied with and there are both generic users and leavers still active within the system. In addition, the password controls are not currently set at the level required by the security policy. Accordingly, we have provided limited assurance against this objective.

Objective 5: controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports, and interfaces.

2.29 There is a reporting module and reports are created through Crystal (Licensed), with a set of reports in place which were created by the system administrator. We note that the Health Board has paid for the auto reporting module, through a grant provided by the Welsh Cancer Network who are provided with updates. However this is not currently active and so reports are manually produced. However, we were informed that work is ongoing to enable the automation functionality.

2.30 There are inbound real time interfaces for Paediatric services with LIMS and RPMS and for Haematology Adults with LIMS and EMPI to enable the transfer of patient demographics and of results. However, there is no auto alert mechanism to notify the system administrators for the failure in the interfaces with reliance currently placed on end-users identifying missing information, or pathology daily checks identifying failed delivery, these are then escalated to CIS oncology and relevant internal forums.

2.31 On our inquiry, the CIS project manager explained that ChemoCare can email warnings should errors grow or no inbound messages be received in certain minutes, but access to SMTP server is required to enable this functionality. (**Matter Arising 6**)

2.32 Conversely, we note that outbound interfaces generate errors when not successful. This is displayed to the users who will then report it to system administrators who then escalate the matter to the CIS help desk.

2.33 There are restrictions in place to prevent loss of data via USB transfer, with the USB ports having been locked down within the Health Board. We further noted during our access management testing that separate profiles for Read Only - With Printing has been created for a few users having service printing requirement. This also prevents data loss as normal Read Only users don't have printing rights.

Conclusion:

2.34 Reports are in place and the creation of these are controlled by the system administrator, although we note the current lack of the automation functionality. There are interfaces in place, although failure notification is not automatic and relies on users. There are restrictions in place to prevent data loss through USB and unauthorised printing. Accordingly, we have provided reasonable assurance against this objective.

Objective 6: a complete audit log is maintained which enables data items item to be tracked

2.35 Audit logging is available within the system, although we note that the current functionality is limited in version 5, with the full functionality available in Version 6.

2.36 The system does track creation, deletion and changes to data items and the system administrators have access to limited log records. For example, front-end user activities are logged and accessible to the system administrators such as for day-to-day patient treatment they can see modification to a treatment, or to particular patient records.

2.37 We note however that more detailed audit log records can be accessed by the supplier and they will provide these when asked if it is necessary.

2.38 Security log information such as logins and failed logins are recorded and stored within the database, although as there is no active database management as noted previously, there is no review of this information.

Conclusion:

2.39 Audit logging is available within the system. We note the current limited access, However, as the system will be upgraded to version 6 by summer, which will provide full audit functionality, and as the current version is meeting the service requirements for day-to-day user activities, we have provided substantial assurance over this objective.

Objective 7: appropriate business continuity arrangements are in place with include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure.

2.40 The ChemoCare system has a resilient architecture and is installed on virtual servers with the physical servers hosted within the Health Boards SAC. The hosting is within the Digital Directorate and so is protected to the same level as other core Health Board systems.

2.41 The hosting arrangement is set out with Hosting and Backup Agreements (HBAs) which set out the responsibilities and the systems covered, together with the backup regimen. However, we note that the HBAs are in draft stage and have not been signed by the system owners since March 2018. Moreover, 7 out of 12 servers in place are not included in the draft HBAs. (**Matter Arising 7**)

2.42 The HBAs state that regular backups will be taken and monthly backup reports provided to the service, however the system administrators have not been provided with these reports, and despite several reminders the information relating to confirmation of backups (logs) and testing of these for validity was not made available during our fieldwork. As such we could not confirm the successful backup for ChemoCare. In addition, information related to a Disaster Recovery (DR) plan and its periodic testing was also not shared during our fieldwork. (**Matter Arising 7**)

2.43 There is a Business Continuity Plan (BCP) in place for the ChemoCare system to enable patient care to continue in the event of a system interruption and this was prepared in the year 2016.

2.44 We noted that the current BCP is not periodically tested and has not been updated for a substantial time. We were informed by the system administrators that the current BCP will be updated once the version 6 goes live. In addition, we also noted that the criticality of the system and reliance on other systems and key IT infrastructure have not been formally established. Also, there is no evidence that a Business Impact Analysis was performed to assess the extent of losses in the event of any failure (**Matter Arising 8**).

Conclusion:

2.45 The system is resiliently hosted and there is a departmental continuity plan in place, although we note that this does contain weaknesses. There is a backup regimen in place, which is the Health Board standard process. However, we were not able to confirm the operation of this or the testing of backups and disaster recovery. Accordingly, we have providedlimited assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Performance Monitoring mechanism (Design)	**Impact**
The system administrators for ChemoCare were not aware of the agreed SLAs and requirement for supplier performance review. Hence there is no mechanism in place for performance monitoring for ChemoCare and no process to record the supplier's compliance with the agreed SLAs or to carry-out a periodic performance assessment to highlight any significant or frequent breeches (if any). In addition, we note that there are no agreed penalty clauses in the contract to protect and compensate the NHS in the event of the supplier frequently breeching the agreed SLA.	Absence of formal supplier performance mechanism could lead to unidentified breeches of agreed SLA.
Recommendations	**Priority**
1.1 A formal supplier's performance monitoring mechanism should be established within both Adult Haematology and Paediatric services to ascertain that there are no frequent and significant breeches of SLA. 1.2 Outcome of the performance review should be periodically shared with the Shared Services Procurement team, as required by the procurement manual. 1.3 If possible, penalty clauses should be agreed with the supplier during the subsequent contract renewal process.	Medium

Agreed Management Action	Target Date	Responsible Officer
1.1 Create SLA breech log with annual review of this. 1.2 Annual review can be shared with Shared Services Procurement team. Will commence post-implementation of Version 6. 1.3 Penalty clauses will be discussed at next contract renewal (there is a national procurement process underway)	Start log July 2022 with first annual review July 2023	Kerry Crompton (Paeds)

Matter Arising 2: Database (operation)	**Impact**
We noted weaknesses in the control and security over the database: • The current version of ChemoCare is installed on Windows Server 2008, support for which ended in 2020 and which contains vulnerabilities, including some significant vulnerabilities. The current system is based on SQL Server 2008, support for which ended in 2019. The use of these out-of-date components leads to an increase security risk for the Health Board; • User access is via SQL authentication and not windows, which is less secure; • Application users access the database using a single database user with the dbo role. This role provides complete access to the database and so introduces a security risk; • User passwords are stored in clear text within the database and are not encrypted. This introduced a security risk; • There is no process to ensure ongoing database management actions such as integrity checks or table optimisation is undertaken; and • Testing of the database noted that the errors table had a very large number of errors logged within it. These are not reviewed and the table is not periodically cleared out.	There is a cyber security risk of inappropriate access and loss of data.
Recommendations	**Priority**
2.1 Windows servers should be upgraded to versions for which support is available; 2.2 SQL Server 2008 R2 should also be replaced with new versions for which support is available; 2.3 Database authentication should be moved to Windows authentication;	High

2.4 User passwords should be encrypted within the database; 2.5 The core user account should have the dba role removed and a more appropriate user access role defined; and 2.6 Database management tasks should be defined and regularly undertaken, this should include review and clear out of the error table.		
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 As part of the chemocare upgrade to version 6 Windows servers OSrs have been replaced with a version which is supported i.e Windows 2016	Complete in UAT go live July 2022	Gareth Richards (Server Manager)
2.2 As part of the Chemocare upgrade to version 6, SQL Server 2008R2 has been replaced with a version which is supported. i.e. SQL Server 2019.	Complete in UAT go live July 2022	Gareth Richards (Server Manager)
2.3 Discussion with the supplier and service will take place post upgrade to understand if this is doable.	September 2022	Kerry Crompton, David Trigg / CIS
2.4 Not required if using Windows Authentication (as suggested in 2.3).		
2.5 Discussion required with the service and supplier.	September 2022	Kerry Crompton, David Trigg / CIS
2.6 Discussion required with the service and supplier.	September 2022	Kerry Crompton, David Trigg / CIS

Matter Arising 3: User Training Logs (Operations)	**Impact**
The SOP governing the new Chemo Care user account requires that nursing lead or system manager should contact the new user to organise a date for training. Once the new user has received training and is signed off to use the system, their access should be upgraded to their agreed level. On our inquiry, the Lead for Implementation of Chemo care (Adult Haematology) has informed that training is provided to every new user however, individual training logs are not signed off and archived for the record purpose. In addition, there is no centralised training record maintained to track whether training has been provided to all users. We have been informed that this is being currently worked on and will be completed before the launch of version 6.	In absence of a proper training record there is a probability the few users might not get the training.

Recommendations	**Priority**
3.1 Individual user training logs should be signed off and archived for record purpose.	Low

Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Electronic training log to be completed for all current users and updated training logs to be signed reflecting appropriate training for current users. Reporting module to be used to establish current list of active users. Discussions with system managers at both CTM and AB UHB's to ensure training logs completed locally and fed into central database of active users.	July 2022 (Allowing 2 months of user groups to discuss, agree and implement)	David Trigg (Adult Haematology)

Matter Arising 4: User Management (operations)	**Impact**
There are weaknesses in the processes for user management: • Although there is a SOP that sets out the process for providing access to new users, this is not generally followed. User access is mostly granted by an email (or sometimes) verbal request and not the form provided. In addition, we note that the user request form is not up to data and does not include all the current roles; • There are generic accounts within both Adult Haematology and Paediatric Services. These include system manager level access; and • Our testing identified staff who have left the Health Board, or who have transferred and whose accounts were still active. We note that accounts are automatically archived if not used for 180 days, however this does not fully manage the risk associated with inappropriate access.	There is a risk of inappropriate access to the system / data.
Recommendations	**Priority**
4.1 The new user form should be updated to reflect the current roles, and the process as set out in the SOP should be followed for new user accounts; 4.2 Generic accounts must not be used and identified accounts must be replaced with unique users. If any account is not required, then it should be deleted; and 4.3 A process for periodic reconciliation of staff leavers to users should be established to ensure that accounts are deactivated on a timely basis.	Medium

Agreed Management Action	Target Date	Responsible Officer
4.1 Update SOP to reflect all current roles. This will need to be done separately for adults and paediatrics as the roles differ slightly.	May 2022	Kerry Crompton (for paediatric system)
4.2 All generic accounts archived on the paediatric system.	April 2022	David Trigg (Adult Haematology)
4.2 Time to archive user accounts will be reduced from 180 days to 90 days within the paediatric system to reduce the risk of staff who have moved on still having access to the system.	April 2022	

Matter Arising 5: Password Controls (Operation)	**Impact**
There were weaknesses in user access controls: • There is no forced requirement for passwords to contain a mixture of uppercase, lowercase and numbers; • There are different length requirements for passwords between the systems. For adult it is 8 and Paediatric it is only 6; • There are different account archive settings in both Adult Haematology and Paeds systems that is, 365 days and 200 days respectively. In case any account is not active for the defined number of days than the account is automatically archived and become inactive;	There is a risk of inappropriate access to the system / data.

• The password change settings in both Adult Haematology and Paeds systems are 90 days; • There are a few user accounts (including system admin) where the password change policy is different from the current practice and SOP. For instance, on 3rd March 2022 the next password due for the System Manager accounts were appearing as 10th March 2027 and 5th September 2024; and • The current version in use (v5) does not has the ability to lock-out an account after a set number of attempts using an incorrect password. In addition, the new user form contains out of date information relating to password length and change requirements.	

Recommendations	Priority
5.1 Password controls should be set to enforce a level of complexity, with a minimum length of 8 and with a standard use and re-use time.	Medium

Agreed Management Action	Target Date	Responsible Officer
5.1 Paediatric system updated to reflect practice of adult system. Minimum of 8 characters.	April 2022	Kerry Crompton (for paediatric system)

Matter Arising 6: Interface Failure Alerts (design)		**Impact**
There are inbound real time interfaces for Paediatric services with LIMS and RPMS and Haematology Adults with LIMS and EMPI. However, there is no auto alert mechanism to notify the system administrators for any failure in the interfaces. Currently reliance is on the feedback received from end-users which is then escalated to CIS oncology and relevant internal forums. On our inquiry, the CIS project manager has informed that ChemoCare can email warnings should errors grow or no inbound messages be received in certain minutes but access to SMTP server is required to enable this functionality.		Frequent interface failures might not be identified leading to service disruptions and manual work for the staff.
Recommendations		**Priority**
6.1 System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
6.1 Will look at this as part of the V6 upgrade and ensure an auto alert system is in place.	July 2022	Kerry Crompton (paeds system) David Trigg (Adult Haematology)

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Matter Arising 7: Hosting and Back-up Agreements (Operations)	**Impact**
We reviewed the Hosting and Back-up agreements (HBA) for both Adult Haematology and Paediatric Services and noted the below weaknesses: • Both HBAs are in draft stage and have not been signed by the system owners since March 2018; • 7 out of 12 servers are not included in the HBAs; and • As per the HBA, IM&T is required to provide monthly backup reports to the Dept/Directorate however, we were informed by the Lead for Implementation of Chemo care (Adult Haematology) he has not received any such monthly reports in past. **Scope Limitation:** Backup logs and evidence to confirm the backup testing were requested from the IM&T Department however, despite several reminders the information was not made available during our fieldwork.	Absence of correct information related to servers could result in omitting such servers during the back-up process.

Recommendations	**Priority**
7.1 HBAs should be updated and signed by the relevant department. Also, monthly back-up report should be sent to the relevant department; and 7.2 A schedule for testing the backups to restore should be established.	Medium

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 BCP will be reviewed as recommended.As part of the ChemoCare upgrade all HBAs will be updated to reflect the new infrastructure and signed by all relevant parties.	July 2022	Gareth Richards (Server Manager)
7.2 As part of the HBAs review, a backup regime will be agreed and a plan to restore agreed.	July 2022	Gareth Richards (Server Manager)

Matter Arising 8: Business Continuity Plan (Operation)	Impact
While reviewing the Business Continuity plan for the Chemo Care system, the below weaknesses were noted: • The BCP is not periodically tested and has not been updated for a substantial time. As per the system owner the BCP will be updated once the version 6 goes live; • Criticality of the Chemo Care system has not been formally established; • There is no evidence that a formal risk assessment was carried-out to identify all significant events or vulnerabilities to the system; • The document does not outline dependencies on any other application, information system / IT infrastructure; and • No Business Impact Analysis were performed to assess the extent of losses in the event of any failure.	Noncomprehensive BCP can limit the ability to continue the business in case of system unavailability due to any adverse event.

Recommendations	Priority
8.1 The identified gaps should be taken into consideration at the time of the next BCP update once the version 6 goes live.	Medium

Agreed Management Action	Target Date	Responsible Officer
8.1 BCP will be reviewed as recommended.	August 2022	Kerry Crompton (paeds system) David Trigg (Adult Haematology)

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

Date issued: September 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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Contents

Audit and Assurance Committee Update

About this document

1 This document provides the Audit and Assurance 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	The Auditor General certified the document on 17 June, and it was laid on the Senedd's website later that day. We have issued our Audit of Accounts Addendum Report, which is on today's agenda.
Audit of the Health Board's 2021-22 Charitable Financial Statements	We have issued the 2022 Audit Plan, which the Charity's Trustee Members will consider at their next meeting. We are looking to commence the audit in late October, pending receipt of the draft financial statements. The Charity Commission's deadline for the certified financial statements is 31 January 2023.

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 July 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 and Assurance Committee
Review of Estates: Follow-up of Recommendations	Report to be considered in September 2022. Management response to be considered in November 2022.

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
NHS Structured Assessment Executive Lead – Director of Corporate Governance	The Structured Assessment examines the existence of proper arrangements for the efficient, effective, and economical use of resources. The 2022 Structured Assessment will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Managing the workforce, digital resources, the estate, and other physical assets	Current status: Fieldwork in progress Planned date for consideration: November 2022
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	Current status: Report drafting Planned date for consideration: TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
	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.	
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. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.	Blog and data tool published in April 2022 Project brief issued in August 2022, with fieldwork planned to start in September 2022. Planned date for consideration: TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
All-Wales thematic on workforce planning arrangements	This work will examine 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.	We are currently scoping this work. We will update the committee as work progresses.
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 **Exhibit 5** outlines the Good Practice Exchange (GPX) events which have been held recently. Materials are available via the link below. Details of future events are available on the GPX website.

Event	Details
Responding to the Climate Emergency in Wales Please see **Appendix 1**	This webinar focussed on sharing the Auditor General's emerging findings on public sector action to decarbonise.

NHS-related national studies and related products

6 The Audit and Assurance 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.

7 **Exhibit 6** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

8 The Audit and Assurance Committee might also wish to be sighted of the recently published Audit Wales Strategy - **Assure, Explain, Inspire: Our Strategy 2022-27**. This strategy sets out our 5-year vision to drive improvement and support Welsh public Services as they adapt to the challenges and opportunities of a changing world.

9 The Audit and Assurance Committee might also wish to be sighted of the current consultation on our **Fee Scales for 2023-24**. This consultation invites views and comments on our proposals for fee rates and other aspects of the statutory fee regime for our audit work. The closing date for responding to the consultation is **16 September 2022**.

Exhibit 6 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report Please see **Appendix 1**	August 2022
Public Sector Readiness for Net Zero Carbon by 2030 Please see **Appendix 1**	July 2022
The Welsh Community Care Information System update	July 2022

Appendix 1 – key messages from recent national publications

Public Sector Readiness for Net Zero Carbon by 2030

10 The Auditor General has committed to a long-term programme of work on climate change. Our baseline review asks: 'How is the public sector preparing to achieve the Welsh Government's collective ambition for a net zero public sector by 2030?'

11 We have now published two reports to share the findings from the baseline review:

- Key findings report: (published 14 July 2022) this report targets senior leaders and those with scrutiny roles, with the aim of inspiring them to increase the pace of their work on achieving the 2030 collective ambition. We set out an overall conclusion and 5 calls for action. The calls for action are not strictly recommendations. However, we encourage public bodies to consider the report, and through their internal governance structures, set out publicly how they intend to respond to the calls for action.
- An evidence report: (published 10 August 2022) this report supplements the key findings report by providing more detailed findings and data. It does not make a separate overall conclusion, or separate calls for action.

12 We have also published blogs and run a successful webinar:

- Responding to the Climate Emergency in Wales (webinar)
- Call for clearer information on climate change spending (blog)
- COP26: Shining a light on the Welsh response to climate change (blog)
- How we'll support Wales in rising to the climate change challenge (blog)
- Heat is on to tackle climate change (blog)

13 The **overall conclusion** from our baseline review is:

14 "There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions. Organisations need to be bold and innovative and share experiences of their successes and failures. The Auditor General will not criticise organisations for taking well-managed risks to address this unprecedented challenge."

15 The **5 calls for action** are:

1 Strengthen your leadership and demonstrate your collective responsibility through effective collaboration

2 Clarify your strategic direction and increase your pace of implementation

3 Get to grips with the finances you need

4 Know your skills gaps and increase your capacity

5 Improve data quality and monitoring to support your decision making

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Audit of Accounts Report Addendum – Cardiff and Vale University Health Board

Audit year: 2021-22

Date issued: August 2022

Document reference: 3092A2022

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

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.

Contents

Audit of accounts report addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to you on 14 June 2022. It sets out the recommendations arising from our audit of the 2021-22 accounts; and provides an update on the progress you have made against previous recommendations.

Recommendations from this year's audit

2 **Exhibits 1 to 8** set out eight audit findings and recommendations, together with the management responses to each of them.

Exhibit 1

Matter arising 1 – weaknesses in the stocktaking arrangements	
Findings	We attended two of the Health Board's year-end stock-takes: • for theatres stock at the University Hospital Wales site; and • for wheelchair and spart parts stock at the ALAS Posture and Mobility Service Centre in Treforest (ALAS). We identified the following weaknesses in the procedures being applied: • While the Health Board has guidance in place for counting and checking theatre stock, it has no guidance for counting the stock held at the ALAS site. • For the sites we attended, stock sheets were not sequentially numbered, which could result in sheets being misplaced or lost, but not being identified as such, and important details therefore being overlooked and not accounted for. • Stock was counted by only one officer, rather than the required two officers as the counter and the verifier. Also, we identified a number of differences between our (sample-based) stock count and the counts undertaken by officers, which they amended. We are satisfied that the differences did not represent a risk of material misstatement with the financial statements.

Matter arising 1 – weaknesses in the stocktaking arrangements	
Recommendation	The Health Board should strengthen its stocktaking procedures. In doing so the Health Board should introduce a corporate set of stocktaking procedures for all its stock sites. As part of the process the Health Board should use sequentially numbered stock-count sheets.
Accepted in full by management	Yes
Management response	Whilst the Health Board has robust stock procedures documented, it is accepted that these need to be reinforced and recommunicated to the relevant stock take teams and accountants. Training sessions will be held to ensure guidance is followed and understood. If any additional steps are required due to specialised stock being held (i.e. ALAS) additional specific guidance will be issued.
Implementation date	Year end 2022/23

Exhibit 2

Matter arising 2 – weaknesses in the processing of a retire and return application and an underpayment to an employee	
Findings	We examined the retirement and return of the Executive Director of Therapies and Health Sciences, who retired on 31 March 2022 and returned on 2 April. We found that the Executive Director's line manager, in this case the former Chief Executive, had not signed their approval of the application form, as required by paragraphs 2.2 and 3.1 of the retire and return policy. The Remuneration and Terms of Service Committee did retrospectively note the retirement and return, in May 2022.

Matter arising 2 – weaknesses in the processing of a retire and return application and an underpayment to an employee	
	On a separate finding, for an employee's exit the Health Board needs to take account of their undertaken leave, by paying the balance due or ensuring that the employee takes the leave before their last day. The Executive Director of Therapies and Health Sciences had a leave balance of 10 days, and had applied for payment for those days. However, we found that the Health Board had incorrectly based the payment on 10 hours, rather than 10 days, and that the Health Board had therefore underpaid the Executive Director by £4550.62. We understand that the Health Board paid the £4550.62 in June 2022.
Recommendation	The Health Board should ensure that line managers always evidence their approval, and that such approval is verified by another officer before an application is processed. Also, the Health Board should review its procedures for the payment of untaken leave, to establish how the underpayment had first occurred, and, how it had not been picked up as an error. The Health Board should then strengthen its controls where necessary.
Accepted in full by management	Yes
Management response	Procedures are being reviewed and any identified additional controls will be implemented in 2022/23.
Implementation date	Year end 2022/23

Exhibit 3

Matter arising 3 – delays in receiving working papers and supporting evidence	
Findings	Each year we agree an Audit Deliverables Document with the relevant senior officers. The document helps to ensure that we receive the required records to support the draft annual report and accounts, by the specified dates. We did not receive all the agreed records by the agreed dates. The most significant delay related to the records to support year-end debtors and creditors. An impact of these delays was that we were unable to select our audit samples and issued them to officers. We also experienced delays during the first couple of weeks of the audit in respect of some of the samples that we had issued, such as those for payroll, inventory and fixed assets. Given the relatively short time span of the audit, it is important that we receive the agreed records on time.
Recommendation	For 2022-23 the Health Board should provide us with all the relevant records, per the agreed Audit Deliverables document in place for that year. Also, the Health Board should ensure that all supporting records are provided in a timely manner, particularly during the first couple of weeks of the 2022-23 audit.
Accepted in full by management	Yes
Management response	The main working papers were delivered as per the deliverables document however some additional supporting papers were provided in week 2 (following the additional WG reporting deadlines which fall in week 1 of the annual audit). A review of all working papers and deliverable dates will be carried out to help ensure audit have all the information they require in the first week of audit to prevent delays going forwards. A review of working paper formats for debtors and creditors will also be carried out to identify improvements to minimise the need for multiple files/supporting papers.

Matter arising 3 – delays in receiving working papers and supporting evidence	
Implementation date	Year end 2022/23

Exhibit 4

Matter arising 4 - lack of detailed instructions to the valuers	
Findings	We found that the Health Board does not provide a formal instruction to its external valuers, the Valuation Office Agency. A formal instruction is an important communication that conveys a clear understanding of the Health Board's valuation requirements, so that its valuer understands, agrees, and adheres to them.
Recommendation	Prior to a valuation being undertaken, the Health Board should issue and agree a formal instruction to its valuers.
Accepted in full by management	Yes
Management response	A full specification has been issues in relation to the quinquennial view by Welsh Government. In relation to our ad hoc valuations throughout the year, we will agree formal instructions to the District Valuer by valuation type going forward.
Implementation date	Year end 2022/23

Exhibit 5

Matter arising 5 - assets not being depreciated when brought into use	
Findings	When the Health Board brings a fixed asset into use, in accordance with its accounting policy it should commence depreciation in that financial year. We found that the Health Board had not depreciated some assets that had been brought into use during 2021-22, and we calculated that depreciation was understated by £348,000 for 2021-22. This error resulted in the overstatement of the net book value of fixed assets and the understatement of the revenue costs. The Health Board corrected the misstatements. While this amount was trivial to our true and fair opinion, it was potentially material to the Health Board's outturn against its three-year revenue resource limit and to our regularity opinion.
Recommendation	The Health Board should accurately apply its accounting policy and depreciate all assets when they are brought into use.
Accepted in full by management	Yes
Management response	Additional controls have been added to the year-end procedures to ensure assets are depreciated correctly.
Implementation date	Year end 2022/23

Exhibit 6

Matter arising 6 – some working papers were not referenced to the agreed Audit Deliverables Document	
Findings	The Audit Deliverables document (see matters arising 3) sets out our information requirements and the officer responsible for each item. We agree with officers that all information uploaded for the audit should be clearly referenced to the Audit Deliverables document. This enables our work to be more efficient and reduce any queries to officers. We found that while some working papers had been clearly referenced to the Deliverables Document (such as primary care and continuing healthcare), other were not referenced (such as debtors and creditors). The lack of clear referencing made it difficult for us to establish whether we had received all the appropriate working papers, prior to commencing our audit testing.
Recommendation	For 2022-23 the Health Board should reference all its information to the agreed Audit Deliverables Document.
Accepted in full by management	Yes
Management response	To ensure satisfactory naming and sharing of documents in 22/23 a premeeting would be advisable to get agreement on titles and distribution list. Working paper titles where amended in 21/22 to aid understanding of contents but this was based on accounts notes not deliverables – will update further in 22/23 based on Audit Wales guidance.
Implementation date	Year end 2022/23

Exhibit 7

Matter arising 7 – weaknesses in network security vulnerability assessments	
Findings	For several years the Health Board has not completed an external penetration test or security-vulnerability assessment on the network perimeter, (ie. via an external third-party accredited company). Such assessments are considered to be good practice to help address security vulnerabilities and avoid malicious and unauthorised access to the Health Board's network. Internal network vulnerability assessments are completed using the Nessus software to scan in real time to identify and analyse any security vulnerabilities. However, the outputs from Nessus assessments are not actively monitored.
Recommendation	The Health Board should strengthen its assessment of network security vulnerability by: • completing regular external penetration testing on the network perimeter, including at least annually by an accredited third party; and • actively monitoring the internal network-penetration testing to promptly identify and address any weakness.
Accepted in full by management	Yes
Management response	The UHB is currently in the process of appointing a dedicated cyber team. Two positions have been filled and we are recruiting a further two posts. An externally performed penetration test is being scheduled for Q4 of 2022/23. Once the cyber posts are in place, we will be in a position to proactively use a number of cyber tools at our disposal. This includes: SIEM, which is currently operational and staff are in the process of being trained. Defender for Endpoint, currently in the process of being onboarded and, Nessus, operated by the server team but will be supported by the cyber department. We anticipate that all roles will be appointed to by Q3 of 2022/23.

Matter arising 7 – weaknesses in network security vulnerability assessments	
Implementation date	We anticipate that all roles will be appointed to by Q3 of 2022/23.

Exhibit 8

Matter arising 8 – monitoring and review of user access to the WellSky Hospital Pharmacy system can be strengthened	
Findings	The Health Board implemented the WellSky hospital pharmacy IT system in August 2021. WellSky is centrally managed by Digital Health and Care Wales (DHCW) and user access is based on standard role profiles within the system, to access a menu of projects, programs and reports. While DHCW processes user access requests that have been authorised by the WellSky systems management team, there is no document that maps all access profiles granted to the Health Board's users. We understand that such a document is the Health Board's responsibility. We consider it good practice to record and frequently update a summary document of all user profiles, to enable the regular review of access rights and that they remain appropriate.
Recommendation	The Health Board should strengthen its formal monitoring of user access rights to the WellSky system. Also, the Health Board should ensure that its monitoring is based on regular reviews, and a clear and up-to-date record (retaining historic details) of all users, and confirmation that each user's access is appropriate.
Accepted in full by management	Yes
Management response	The WellSky system management team will review user access profiles by the end of March 2023, this

Matter arising 8 – monitoring and review of user access to the WellSky Hospital Pharmacy system can be strengthened	
	will also include putting in place a regular annual review process.
Implementation date	31 March 2023

Recommendations from previous years' audit

3 We raised six recommendations last year, all of which the Health Board's management fully accepted. We are satisfied that one of the recommendations has been addressed. **Exhibit 9** sets out the other five recommendations, which management are addressing.

Exhibit 9: progress against previous years' recommendations

Audit Year	Recommendation	Progress
2019-20	**The quality of some of the Health Board's underlying working papers requires further improvement** The Health Board should review and simplify its supporting records for certain areas of its annual financial statements, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand how some of the documentation affects our audit.	The Health Board improved some of its processes and records for 2021-22 and we understand that it plans more improvements for 2022-23. We will continue to liaise with the finance team on the improvements.
2020-21	The Health Board should replace its unsupported Windows 2008 servers and W7 devices.	The Health Board has an ongoing programme in place to replace or upgrade all affected devices.
2020-21	The Health Board should update and test its IT Disaster Recovery Plan (DRP) to gain assurance that IT systems can be restored if needed.	The Health Board is reviewing and updating its IT DRP as part of a programme to refresh its IT security documentation.
2020-21	The Health Board should update its IT change-control policy and procedure.	The Health Board is updating its change-control policy as part of its new helpdesk system.

2020-21	The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls.	The Health Board is currently reviewing its data centre rooms and is considering whether to decommission some of them.

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Estates Follow Up Review – Cardiff and Vale University Health Board

Audit year: 2021

Date issued: August 2022

Document reference: 3083A2022

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

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Summary report

Introduction

1 Our 2017 Review of Estates found that Cardiff and Vale University Health Board was taking positive steps to improve estate management but would benefit from introducing a strategic plan to direct activities. We found that while the strategic approach to estates management was improving, there was no overall estates strategy in place. We also found that performance management and staff engagement were improving, but the service was under-resourced compared to the size and condition of the estate.

2 We made several recommendations for the Health Board to address to improve its strategic approach to estate management, and ensure an economical, efficient, and effective estates service.

3 Since our 2017 review, several drivers for change strengthen the need to redevelop the Health Board's estate to support future models of care and new ways of working. These include:

- the risks to patient and staff safety arising from an aging estate;
- the need to achieve carbon reduction and sustainability ambitions; and
- addressing the legacy and ongoing impact of Covid-19.

4 The Health Board has an estates investment programme, which includes plans to replace the University Hospital of Wales (UHW), refurbish the University Hospital Llandough (UHL), and invest in Wellbeing Centres and Hubs. Parts of this programme is underway, and some investment was expedited during the pandemic to maintain safety and support new models of care and new ways of working. The Health Board's main challenge, therefore, is managing new developments alongside maintaining the safety of the existing estate.

5 Our review considered how the Health Board has addressed our recommendations in the context of the drivers for change described above. We undertook a high-level assessment of the progress made by the Health Board to address our 2017 recommendations. In conducting this work, we:

- asked the Health Board to complete a self-assessment of progress;
- reviewed documentary evidence to support the self-assessment, as well as Board and Committee papers; and
- interviewed Board members and several Health Board officers to discuss progress, current issues, and future challenges.

6 A summary of our findings is set out in the following section with more detailed information provided in **Appendix 1**.

Our findings

7 Our overall conclusion is **that the Health Board has increased its strategic focus on the future estate but there is insufficient Board-level visibility of the condition of the existing estate. Work has commenced to develop a new estate strategy, which will be linked to the Health Board's ten-year strategy and capital plan. While there have been structural and process changes to enable more effective estate service delivery, local and national workforce shortages and pay differentials present significant and immediate risks to maintaining a safe and effective service. In the longer-term, this presents potential risks to the Health Board's ability to sustain its existing estate while it delivers on its programme of replacement and redevelopment.**

8 In summary, the status of progress against each of the previous recommendations is set out in **Exhibit 1**.

Exhibit 1: status of 2017 recommendations

Implemented	Ongoing	No action	Superseded	Total
2	1	2	2	7

R1	An Independent Member for capital and estates was appointed to the Board in February 2020.
R2	The Health Board has migrated from Backtraq estates management system to MiCAD FM[1] software to better manage planned and reactive maintenance.
R3	The Health Board reported that it developed and agreed an estates management strategy in 2017, but despite several requests they were not able to provide us with a copy. However, at the time of this review, the Health Board was in the early stages of developing a new strategy for estates.
R4	Whilst adopting zero-based budgeting was an ambition for the Health Board, it has since determined that it is unfeasible with the current funding regime.
R5	The Health Board has not implemented a system to inspect a percentage of repairs each month. This means the Health Board has no arrangements in place to provide assurance that work carried out is of a good quality and complies with relevant safety standards.
R6	Further work is needed to provide clear key performance indicators (KPI) for use by the Estate and Facilities Service Board and to provide Board level assurance.
R7	The Health Board migrated its estate management system from Backtraq to MiCAD FM. MiCAD includes a portal for staff to request repairs and relevant staff have received training on the new system.

[1] Micad FM software enables users to manage planned and reactive estate maintenance.

Recommendations

9 In undertaking this work we have made three recommendations (see **Exhibit 2**), which have been designed to enable the Health Board to address outstanding issues. They also reflect drivers for change since our 2017 review. The Health Board's management response to these recommendations is summarised in **Appendix 2**. [Appendix 2 will be completed once the report and management response have been considered by the relevant committee.]

Exhibit 2: recommendations

Recommendations
Develop a fully-costed Estates Management Strategy R1 The Health Board could not provide a copy of its estate management strategy, which it reported was agreed in 2017. However, the Health Board is currently in the early stages of developing a new estates strategy. The new strategy should clearly set out: • a baseline assessment of the condition of the current estate and the total resources (including workforce) needed to maintain it against available resources; • how the estate will be maintained and resourced to the required standard in the short- and medium-term; and • plans for maintaining and investing in the current estate whilst implementing its estates investment programme.
Introduce a system to inspect a percentage of repairs each month R2 We found that the Health Board is yet to develop a system to inspect a percentage of repairs each month. This is an essential element for any estate maintenance service, providing vital assurance that work is being carried out in compliance with the relevant safety and quality standards. The Health Board should introduce a monthly inspection regime by March 2023.
Strengthen performance management R3 We found that the Health Board is continuing to develop KPIs for its estates and facilities services but is yet to establish a suitable format to report the information internally and up to the Board for assurance. By March 2023, the Health Board should ensure that: • relevant estates and facilities KPIs are included in the integrated performance report which is received by the Board; and

Recommendations

- the KPIs are linked to the new estates strategy.

Appendix 1

Progress to address our 2017 recommendations

Exhibit 3: assessment of progress

Original recommendation to be addressed	Status[2]	Summary of progress
R1. Ensure the estates service is represented at Board level, prioritise recruiting an independent Board Member for estates.	**Implemented**	The Health Board appointed an Independent Member for Capital and Estates (IMCE) in February 2020. The IMCE has also been appointed as the Chair of the Finance Committee and Chair of the Shaping Our Future Hospitals Committee (SOFHC). The IMCE is further informed by: • the Strategy and Delivery Committee, for briefings on capital allocation; • the Board for details of capital programmes which are signed-off before going to Welsh Government for approval; and • Board member patient safety visits. Through this combination of roles, there is scope to enhance the role of the IMCE to maintain a perspective of short-, medium-. and long-term estates strategy and operation. There is also potential to develop appropriate engagement opportunities between the IMCE and the Capital, Estates and Facilities Team. While the IMCE's role is not an operational one, she recognises the importance of ensuring there is clear alignment between estate and facilities plans and

[2] Green indicates that the recommendation has been implemented; Amber indicates ongoing action to address the recommendation; Red indicates that insufficient or no action has been taken; and Blue indicates that the recommendation has been superseded.

Original recommendation to be addressed	Status[2]	Summary of progress
		priorities over the short-, medium- and long-term. The Health Board will need to be highly adept at responding to the short and long-term planning implications arising out of issues during the programme of work. The SOFHC met for the first time in July 2021 with a specific remit to oversee the Health Board's Shaping Our Future Hospitals Programme with its focus on shaping major future capital developments. SOFHC meetings have been paused pending a response from Welsh Government on the Health Board's Outline Business Case, although the work of the SOFH Programme Board is ongoing.
R2. Create a central log of estates related issues and actions resulting from Clinical Board meetings.	**Implemented**	We previously reported that the Health Board's Backtraq estates management system recorded repairs and maintenance jobs as well as generating performance data and reports. Data quality was poor and a KPI for Backtraq compliance had been included on the estates and facilities dashboard to help drive improvement. The Health Board subsequently moved from the Backtraq system to its MiCAD FM system in 2021. The MiCAD FM system manages planned and reactive maintenance requests and is aligned with asbestos location information held on MiCAD IPR, which meant that this data could be aligned with compliance information already on the system, primarily the asbestos risk register. As a result, staff are readily able to identify any asbestos risk that may be present in an area where a repair or maintenance is needed. The MiCAD IPR system is also being used to hold the Health Board's existing building plans.

Original recommendation to be addressed	Status[2]	Summary of progress
R3. Develop a fully-costed Estates Management Strategy.	**No action**	The Health Board reported that it agreed a strategy for estates in 2017; however, it has not been able to produce a copy. Therefore, we have not been able to see evidence of strategic planning for the short and medium-term. The Health Board reported that it has started to develop a new strategy for estates, which it plans to tie in with its capital plan and ten-year strategy - 'Shaping Our Future Wellbeing' - which is also being refreshed [see **Recommendation 1**]. The existing approach to planning is driven mainly by the prioritisation of expenditure on maintenance, equipment replacement, and the need for new equipment. There are several pressing reasons why a clear strategic plan for estates should be developed and approved. While the work of the SOFH programme is in its early stages, there is a need to understand what the complex relationship between shorter and longer-term strategy and plans will look like. For example, changing timeframes for the delivery of new facilities will require the ongoing review of plans for the maintenance and utilisation of existing facilities and equipment. All partners will need to be fully engaged in that activity over a period of years to ensure effective decision-making. The Health Board will need robust governance arrangements to ensure oversight of the potential risks to the quality and safety of patient care, as well as the inherent financial risks, arising out of its ambitious development programme. Operational managers are concerned about the existing shortfall in workforce capacity, which is largely due to difficulties in recruiting and retaining staff, and rates of staff sickness. They expect that this situation will become even more pronounced. The age profile of the Health Board's estates and facilities workforce is skewed towards those approaching retirement. Succession planning into senior roles is made more difficult because middle-grade staff have been leaving. There are recruitment and retention difficulties across Wales in this aspect of the

Original recommendation to be addressed	Status[2]	Summary of progress
		public sector, with better remuneration in, and accessibility to, jobs in the private sector. There is competition for staff within the NHS as well, particularly in South-East Wales where several health bodies are in close geographic proximity. We understand that at least one health body has adjusted its pay rates to attract and retain staff. The restructuring of the estates and facilities services into a single Service Board has enabled a more efficient approach to service provision across the Health Board. The Director of Finance recognised the historical reliance on bank and agency staff and is confident that down-stream work within the estates and facilities function to improve operational processes will be vital to addressing the situation. While agency staff are prohibitively expensive, they have become less readily available. However, when recruitment and development of apprentices and junior staff takes place, existing staff find it difficult to spend time providing the necessary support. This situation will be made more difficult with the end of the Recruit and Retention Payment (RRP) in October 2022, having been temporarily extended in March 2022. The RRP is an incentive payment for mechanical and electrical maintenance staff. The RRP was required and implemented by Cardiff and Vale, Aneurin Bevan, and Cwm Taf Morgannwg University Health Boards. Operational managers are less optimistic about the extent to which workforce issues can be addressed. The Director of Capital, Estates and Facilities is seeking to escalate a risk to the Corporate Risk Register which relates to the impact of workforce shortages on maintaining safety and compliance. He has also presented a paper to the Management Executive

Original recommendation to be addressed	Status[2]	Summary of progress
		Committee which outlines the current situation, the impact of losing the RRP, and costed options to help address the situation. The Health Board should ensure that these workforce challenges are considered and addressed as part of developing its new estate strategy [see **Recommendation 1**]
R4. Develop a zero-based estates budget that makes provision for likely revenue costs arising from changes to the Health Board estate, such as new buildings.	**Superseded**	Our recommendation to develop a zero-based estates budget to make provision for likely revenue costs arising from changes to the Health Board estate has not been implemented. Zero-based budgeting was an ambition for the Health Board, but it has since determined that it is unfeasible with the current funding regime. However, as part of developing its new estate strategy the Health Board should have a baseline understanding of the condition of the current estate and the total resources needed to maintain it against available resources [see **Recommendation 1**]. The Health Board provided us with comparative estates maintenance budget allocation data from ERIC[3] reports in England which we used in our original report. The data showed that the financial allocation for estates maintenance at the Health Board was significantly less than the amounts allocated to comparator sites in England. Data from more recent ERIC reports and EFPMS[4] reports is set out in **Exhibit 4**. They show that the budget allocation per square metre

[3] Estates Returns Information Collection, NHS Digital

[4] NHS Wales's Estates and Facilities Performance Management System - Welsh Health Estates

Original recommendation to be addressed	Status[2]	Summary of progress

remains significantly less than any comparator site in England and any other health board in Wales.

Exhibit 4: Benchmarking estates maintenance budget allocation 2020-21

Health boards	Budget allocation		
	£	m^2	£ / m^2
Cardiff and Vale University Health Board [excluding St David's Hospital]	**5,262,710 [4,752,186]**	**388,109 [377,466]**	**14 [13]**
Betsi Cadwaladr University Health Board	14,425,312	389,717	37
Cwm Taf University Health Board	9,743,035	292,882	33
Hywel Dda University Health Board	5,489,526	189,613	29
Aneurin Bevan University Health Board	7,339,506	260,068	28
Swansea Bay University Health Board	6,236,423	248,387	25
		Average £ / m^2	31
English comparator NHS trusts	**Estates Maintenance £**	**m^2**	**£ / m^2**
Barts Health NHS Trust	19,255,105	445,498	43
Oxford University Hospitals NHS Trust	13,219,199	329,095	40
Nottingham University NHS Trust	12,997,316	327,446	40
Imperial College Healthcare NHS Trust	10,899,836	286,323	38

Original recommendation to be addressed	Status[2]	Summary of progress
		University Hospitals of Leicester NHS Trust 8,493,708 303,124 28 Leeds Teaching Hospitals NHS Trust 12,773,621 509,226 25 Average £ / m^2 36 Source: The Health Board from EFPMS reports for 2020-21 and English site data taken from ERIC reports for 2020-21. Square meterage represents the gross internal floor-area and it is assumed that the areas and costs are net of shared site users.
R5. Introduce a system to inspect a percentage of repairs each month.	**No action**	Having a system for random inspection of repairs and maintenance is an essential element for any estates maintenance service, providing vital assurance that work is being carried out in compliance with the relevant safety and quality standards. However, the Health Board has still not implemented such a system [see **Recommendation 2**]. The Health Board intends to use the MiCAD FM system as a means of addressing the situation. The system can produce reports that show the number and rate of completed works per week. Senior managers would be able to use the reports to make a random selection of jobs to be inspected by supervisors. The data captured could be included in KPI reports. However, we understand that the main barrier to the implementation of this approach is the lack of supervisory staff at operational level. It is an example of how staff shortages compromise the Health Board's ability to ensure the safety and quality of its facilities and equipment.

Original recommendation to be addressed	Status[2]	Summary of progress
R6. Strengthen performance management by: • extending the new performance dashboard to include KPIs for the other services covered by the Service Board, and • making greater use of the data captured through the Backtraq repairs maintenance system.	Ongoing	The Capital, Estates and Facilities Service Board is continuing to develop KPI and performance reports. For example, the Estates and Facilities Report and a dashboard supporting the Estates and Facilities People, Risk, Opportunities and People (PROP) Programme. But the Health Board acknowledges that further work is needed to develop these reports and measures further. At Board level, aside from periodic reporting of maintenance requests and resolution KPIs, it receives little information about estates maintenance. Estates management reporting is ad-hoc and split between committees. For example, the Health and Safety Committee receives assurance on statuary compliance and the Finance Committee receives assurance on capital spend. Given the condition of the current estate and potential risks to patient and staff safety, it is important that the Board receives regular assurance on estates maintenance. The Health Board, therefore, should identify key measures to routinely include in its integrated performance report, which is received at each Board meeting [see **Recommendation 3**].
R7. To ensure repairs are correctly prioritised: • run Backtraq refresher training for help-desk staff; and • review questions on call-handler's scripts.	Superseded	Recommendation 7 was superseded following the Health Board's migration from Backtraq estates management system to MiCAD FM. Training was provided by MiCAD FM to help desk staff following the migration. As a result of the pandemic, it was agreed that the training sessions would be provided remotely over a three-day period in August 2020. The sessions were split into two categories, one for the 'superusers' who are the members of staff who would delegate work and create reports, and 'helpdesk' which was an entry level training sessions for staff required to request maintenance jobs to familiarise themselves with the new system. The MiCAD FM system provides direct access through the customer portal to register jobs. A confirmation email is sent to confirm registration and completion of jobs.

Appendix 2

Management response to audit recommendations

Exhibit 5: management response [This table will be completed once the report and detailed management response have been considered by the relevant committee(s).]

Recommendation	Management response	Completion date	Responsible officer
Develop a fully-costed Estates Management Strategy R1 The Health Board could not provide a copy of its estate management strategy, which it reported was agreed in 2017. However, the Health Board is currently in the early stages of developing a new estates strategy. The new strategy should clearly set out: • a baseline assessment of the condition of the current estate and the total resources (including workforce) needed to maintain it against available resources;			

Recommendation	Management response	Completion date	Responsible officer
• how the estate will be maintained and resourced to the required standard in the short- and medium-term; and • plans for maintaining and investing in the current estate whilst implementing its estates investment programme.			
Introduce a system to inspect a percentage of repairs each month R2 We found that the Health Board is yet to develop a system to inspect a percentage of repairs each month. This is an essential element for any estate maintenance service, providing vital assurance that work is being carried out in compliance with the relevant safety and quality standards. The Health Board should introduce a monthly inspection regime by March 2023.			

Recommendation	Management response	Completion date	Responsible officer
Strengthen performance management R3 We found that the Health Board is continuing to develop KPIs for its estates and facilities services but is yet to establish a suitable format to report the information internally and up to the Board for assurance. By March 2023, the Health Board should ensure that: • relevant estates and facilities KPIs are included in the integrated performance report which is received by the Board; and • the KPIs are linked to the new estates strategy.			

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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:	Declarations of Interest, Gifts and Hospitality Tracking Report			Agenda Item no.	7.5
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	05.07.2022
		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

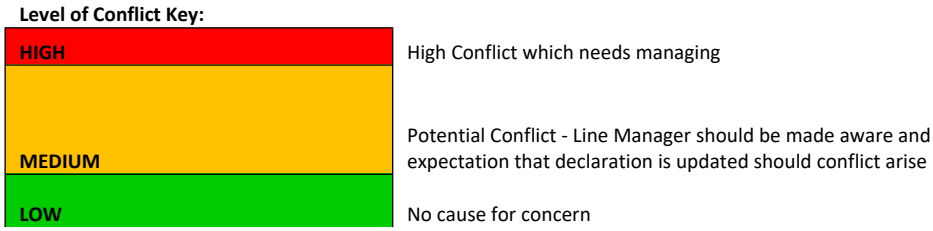
It is hoped that the number of declarations returned will increase significantly by enhancing visibility of the process, and the ease by which declarations can be recorded via ESR.

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 25 August 2022:

- 1,693 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms have been recorded on the register. This represents a 1.3% increase in submissions following the July 2022 Committee Meeting.

- 78.4% of staff banded 8a and above have returned their declaration forms.
- 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:



- 97.33% of Declarations received are rated **Green** (337 Declarations).
- 2.66% of Declarations received are rated **Orange** (8 Declarations).
- 0.01% of Declarations are rated **Red** (1 Declaration).

The 9 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 be 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 to access): 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' albeit the frequency with which declarations have been received has slowed over the summer months.

The Health Board has agreed to participate in a national Pilot with Welsh Government to improve the way in which Declarations of Interest are recorded to enable patients to be better informed about the care that they receive following the recommendations contained within The Cumberlege Report "First do no harm", specifically recommendation 8, '*'Expand the GMC register to capture financial and non-pecuniary interests for all doctors, with mandatory reporting of payments made to hospitals, research institutions and individual clinicians made by the pharmaceutical and medical devices industry'*.

The government partially accepted this recommendation although it was felt that the GMC register was not the place to hold this information. It is intended that it becomes a regulatory requirement that all registered healthcare professionals (i.e. not just doctors) should declare their relevant interests to be published locally at employer level. For us this will mean undertaking a targeted push to secure Declarations of Interest from all registered doctors (in the first instance) employed by the Health Board. As part of this process a revised communications campaign and a cleanse of the Health Board's

Declarations of Interest register will be undertaken to ensure that the most up to date information is held for all staff.

It is hoped that this process will encourage more staff to engage and submit declarations over the coming months.

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

There is a risk that non-declaration of an interest by staff members could result in breaches of legal and/or regulatory requirements, specifically in a procurement context. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.

Safety: Yes/No

N/A

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No

N/A

Reputational: Yes

Should staff members fail to comply with the Health Board's Standards of Behaviour Policy and examples of this are made public, there is a possibility that this could have an adverse reputational impact on the Health Board and its staff body. The ongoing management and development of the Health Board's Standards of

Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.
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	

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

Level of Conflict	First Name	Surname	Position held in UHB	Directorate / Speciality	Interests to Declare (Yes/No)	Third Party Declaration eg Spouse/Partner (Yes/No)	UHB Address:	Confirmed read & understood Standards of Behaviour Framework 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 part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB	Start - End Date	Financial / Other Benefits	c) A personal or departmental interest in any part of the pharmaceutical, healthcare industry, diagnostic or personalised health industry likely to 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/subsidiary	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, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Start - End Date	Financial / Other Benefits	g) Employment/self employment by any other body where there could be a perceived or actual 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 which may occur within four weeks from the date of this declaration and I understand that I can contact the Governance Office. Please return completed forms to cav.declarations@wales.nhs.uk	i) I confirm that the information accurately reflects my interests and that of my family and understand that I am responsible for ensuring I am included in the Register which is available for public inspection
Low	Ejiah	Attorney	Consultant Transplant and General Surgeon	Nephrology and Transplant	Yes	Yes	UHW	Yes	Medlap Ltd, E&G Senior Care Ltd Spouse: Medlap Ltd, E&G Senior Care Ltd	MedLap 20/01/2012; E&G SC ltd. 22/1/2016 MedLap 20/01/2012; E&G SC ltd. 22/1/2016		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	FP - Spine Cardiff			Yes	Yes	Yes
Low	Alaina	Adams	Principal Pharmacist	Pharmacy	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Attended two meetings as a Specialist Pharmacist in consultancy role for Pharmaceutical Industry and Marketing company	07.09.20 - 10.09.20	Honorarium received	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 - 11.11.20	Payment received	Yes	Yes	Yes
Low	Charlotte	Addy	Consultant	Cystic Fibrosis Unit	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Support for educational lectures/activities from GlaxoSmithKline	2022	No personal gain	Member of British Thoracic Society Board	2022	No personal gain	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Sanjeev	Agarwal	Consultant Orthopaedic Surgeon	Orthopaedics	Yes	No	LHL	Not Ticked	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	Yes	Yes	Yes
Low	Kashin	Ahuja	Consultant	Trauma and Orthopaedics	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Fellowship posts funded by Depuy Synthes, Nuvasive and Globus Medical LTD	Jun 21- Ongoing	None	No	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Yes
Low	Rania	Aldridge	Clinical Psychologist / Clinical Lead of the Integrated Autism Service	Psychology and Psychological Therapies / Autism	Yes	No	Aven 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	I do some private work in my capacity as a psychologist - autism assessments, sometimes interventions and court reports. I do not assess anyone who is known to the UHB professionally.	2012 - current	Financial	Yes	Yes	Yes
Low	Kathryn	Allen	Community Pharmacy Advisor	Pharmacy	Yes	No	Woodland House	Yes	Davies Homes Ltd	2010 - 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	Policy and planning manager Company Chemists' Association	2015 - to date	Yes salaried 7.5 hours per week	Yes	Yes	Yes
Low	Louise	Allen	Pharmacist	Primary Care Prescribing Advisers	Yes	No	Woodland House	Yes	Directorship of Davies Homes Ltd - a family building business unconnected with healthcare	ongoing	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	N/A	N/A	Yes	Yes
Low	Callum-Charles	Allen-Ridge	Senior Manager	Innovation and Improvements Team	Yes	No	Woodland House	Yes	Director for Lean in Health Ltd	2020-ongoing	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	Bank work for North Bristol NHS Trust, clinical work and also consultancy around performance management and quality improvement.	2022-Ongoing	Financial	Yes	Yes	Yes
Low	Charlie	Al-Rajwadi	Pediatrist	Podiatry	Yes	No	UHL	Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	Nil	No	N/A	Nil	No	N/A	Nil	I work 7 hours per week as a Podiatrist for Murray Medical.	2021-ongoing	Fees	Yes	Yes	Yes
Low	Raveen	Anand	Consultant	Neurophysiology	Yes	No	LHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Astra Zeneca sponsored research in UHW- performing tests out of hospital hours. 6 patients maximum.	2022	Directorate will receive remuneration for the study	N/A	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	Yes
Low	Richard	Anderson	Consultant Cardiologist	Cardiothoracic	Yes	No	UHW	Yes	Shareholder of Richard Anthony Anderson Ltd	1.08.15 - ongoing		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	01/01/2022 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Angela	Andrenelis	Consultant Transplant Surgeon	Nephrology and Transplant	Yes	No	UHW	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	01/10/2013 - 01.10.2016	Funding for an MD research project	01/10/2013 - 01.10.2015	30k provided for departmental research	Sanofi-Frances, Novartis	Kidney Wales Trustee	01.02.2021 - ongoing	Board of Trustees and its HR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Basil	Asteranis	Consultant	Anaesthetics	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 at Spire Hospital Cardiff		Fees per session	Yes	Yes	Yes
Low	Philip	Atkin	Consultant in Oral Medicine	Dental	Yes	No	UHW	Yes	1. Tautvern Medical Aesthetics Ltd (aesthetic medicine) 2. Spouse 3. Spouse and colleagues	2014 - current 2020 - current	expenses 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	N/A	Yes	Yes	Yes
Low	Kim	Atterson	Strategic Lead Occupational Therapist	Therapies / Occupational Therapy	Yes	No	LHL	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	Vice Chair of Royal College of Occupational Therapists	2018 - 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Julia	Attwell	Senior Manager	Innovation and Improvement Team	Yes	No	Woodland House	Yes	Non-Executive director Linc Cymru Housing Association	2022	Annual Payment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of the Board for Cardiff YMCA Housing Association	2022	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Maguire	Baba	Consultant Paediatric Palliative Care	Child Health	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	I have an honorary cotract with Ty Hafan Children's Hospice as their consultant	21.06.16 - ongoing	0.5WTE invoice part of my salary (1 session) per week	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Sue	Bailey	Lead Quality and Safety	QS&T	Yes	No	Woodland House	Yes	Director of dormant registered 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	N/A	N/A	N/A	N/A	N/A	N/A
Low	Sarah	Bailey	Senior Specialist Speech & Language Therapist	Neurosrsychiatry Service	Yes	No	Hafan y Coed	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	I occasionally provide independent speech and language therapy assessment for case managers in 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
Low	Phillip	Ball	Mental Health Nurse	CHAT	Yes	No	No	Yes	No	N/A	Nil	No	N/A	Nil	I have accepted an offer to join an All Wales Excel for Life Programme Implementation Group. This is a group designed to help network best practice and will be useful for myself and other senior nurses to network and share our practice. There is one paid event scheduled for the 30th April 2021, But all other work is non paid	Feb 21 - Ongoing	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Yes	Yes
Low	Timothy	Banner	Pharmacist	Pharmacy UHL	Yes	Yes	UHL	Yes	No	N/A	Nil	No	Apr-19	N/A	N/A	N/A	No	N/A	N/A	No	N/A	No	N/A	No	N/A	No	N/A	No	N/A	N/A	N/A	Yes	Yes
Low	Mirander	Barber	Consultant Clinical Psychologist	MHOOP	Yes	No	UHL	Yes	I am the Director of a Ltd company which has not traded for 18 months	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	Yes	Yes
Low	Ruth	Barratt-Naylor	Principal Practitioner Psychotherapy	Psychotherapy	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	Clinical Private Practice		Cheques	N/A	N/A	N/A	N/A
Low	Robert	Bauld	Principle Clinical Engineer / Design & Development Team Leader / Health and Safety Coordinator	Artificial Limb and Appliance Service	Yes	No	Tredweid	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	Rehabilitation Engineer Associate Lecturer	21/09/2020 - 31/08/21	Yes	Yes	Yes	Yes	Yes
Low	Sally	Bayley	Independent Member of the Board	Executives / Corporate	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member, Governance Board ACCELERATE (Life Sciences Hub)	2019 - ongoing		N/A	N/A	N/A	N/A	N/A	Cardiff University	2007 - ongoing	Salary	Yes	Yes	Yes	Yes
Low	Andrew	Beamish	ST8 General Surgery	General Surgery	Yes	No	UHW	Yes	Director and Trustee of Limited Company "AST Exams"	2014 - ongoing	Nil (Voluntary)	N/A	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 "AST Exams" 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	yes
Low	Melissa	Beard	High Intensity Psychological Practitioner	Psychology & Psychological Therapies	Yes	No	Cardiff Royal Infirmary	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	I work on the bank of primary mental health	2017 - ongoing	Average £100 a month	Yes	Yes	Yes
Low	Robert (Bryan)	Beattie	Consultant Obs & Gynae	Fetal Medicine	Yes	No	UHW	Yes	Working Director of Strategic Service Ltd trading as Innermost Healthcare	15+ years - current	financial	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 MEDSERVE Wales, an Immediate Care Charity based in South Wales Supporting Practitioners in Intensive Learning - Registered Charity		Medical Advisor to the Mysteric Dystrophy Support Group Shareholder in Time for Medicine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Lorna	Bennett	Director of Public Health	Corporate Executives	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	Honorary Contract with Public Health Wales for out-of hours on call.	2022-ongoing	Nil	Yes	Yes	Yes	Yes
Low	Claire	Beynon	Deputy Director of Public Health	Corporate Executives	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	Employment with Cardiff University, Swansea University, Cardiff Metropolitan University and the Faculty of Public Health for teaching and research duties	2016-Ongoing	Payment for teaching duties	Yes	Yes	Yes
Low	Freedmon	Bhat	Consultant Gynaecologist	Gynaecology	Yes	No	UHW	Not Ticked	HHHI 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	Yes	Yes	Yes
Low	Vijayaparamahl	Biju	Consultant	Elderly Care Medicine	Yes	No	UHW	Not Ticked	Medic Training Limited - private work from publication of articles, attending ad - board	1.03.17 - 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	Yes	Yes	Yes
Low	Robert	Blashen	Medical Consultant	Consultant Radiologist	Yes	Yes	LHL	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	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)	N/A	N/A	N/A	Yes	Yes
Low	Charlotte	Blodgworth	Advanced Nurse Practitioner	Haematology	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	N/A	Member of medical advisory group for Lymphoma Action Charity	2022	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Mike	Bourne	Consultant Radiologist	Radiology	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	UKAS	Now 16 - ongoing	Nil	N/A	N/A	Jan 18 - ongoing	Contractor	Yes	Yes	Yes
Low	Ian	Bowler	Consultant Anaesthetist	Anaesthetics	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	Chairman of MEDSERVE Wales, an Immediate Care Charity based in South Wales		Medical Advisor to the Mysteric Dystrophy Support Group			Private Practice with admitting rights at Spire Cardiff Hospital and Vale Hospital Hensol	N/A	N/A	Yes	Yes	Yes
Low	Matthew	Boyd-Anderson	Physiotherapy Technical Instructor	Therapies	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	Support Worker - Prospero Health and Social Care - Casual Fleet Hours	13/05/2020	Salary	Yes	Yes	Yes	Yes
Low	Paul	Brackpitlle	Senior Projects & Deputy Directorate Manager	Dental/Ophthalmology	Yes	No	UHW	Yes	Active Director at I'm Ode Court Management Ltd, Companies House Reference Number 08965309	1.10.17	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	Yes	Yes	Yes
Low	Eileen	Brandreth	Independent Member of the Board	Executive / Corporate	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	Employee of Cardiff University	December 2008 ongoing		Yes	Yes	Yes	Yes
Low	Carwyn	Bridges	Physiotherapist	Specialty Medicine	Yes	No	LHL	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	Limited Consultancy Chess Ltd	June 20 - Oct 20	Honorarium	Yes	Yes	Yes	Yes
Low	Francis	Brooks	Consultant	Trauma and Orthopaedics	Yes	No	UHW	Yes	Yes	Nov-21	Yes	Yes	Nov-21	Yes	No	N/A	N/A	Consultant for Sonyker	Nov 21- Ongoing	Salary	No	N/A	N/A	No	N/A	N/A	Clinical Advisor for EDO (Medical IT Company) Advisor for Doctor care Anywhere	Nov 21-Ongoing	Fees	Yes	Yes	Yes	Yes
Low	Rachael	Broome	Assistant Business Partner	Finance Business Team	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	My partner works in the Primary Care Team	Ongoing	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Kate (Catherine)	Bryant	Consultant Clinical Scientist	Ultrasound Services	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	Yes - Clinical Private Practice as a Doppler at St Joseph's Hospital		Onesime	Salary	Yes	Yes	Yes
Low	Anne	Burgess	Pharmacist Team Leader	Pharmacy	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	The Neonatal and Paediatric Pharmacists Group (NPPG) have corporate partners (pharmaceutical companies) who pay the organisation for benefits such as access to professionals for advisory meetings. I attend these as an NPPG executive committee member. Conference attendance fee for the EuPFI conference 2020 paid for by Provexa Ltd	N/A	N/A	N/A	N/A	2018 - Ongoing Sep 20 - Sep 20 Conference fee paid	Sponsorship to NPPG Annual attendance at Neonatal and Paediatric Pharmacists Group (NPPG) Conference - this is an event sponsored by multiple pharmaceutical companies	Nov 12 Ongoing	Delegate fees are reduced thanks to the sponsorship received	Member of the Neonatal and Paediatric Pharmacists Group (NPPG) executive committee and their Information Officer	Nov 11 - ongoing	SLA in place with WMIC to fund this position which is 0.2 WTE of my role. Personal expenses paid for attending meeting	N/A	N/A	Presented healthcare professional educational sessions on excipients in medicines for children at events sponsored by Dentsin Pharma Ltd and Provexa Ltd	July 20 - Nov 20	Honoraria received		Yes	Yes
Low	Tanya	Burton	Myeloma Clinical Nurse Specialist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	We use some of the pharma drugs in our health board	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Janssen/Takeda/Celgene Sanofi	2017 - Ongoing 2020 - Ongoing	One off payment	Yes	Yes	Yes
Low	Adam Joshua	Cann	Trainee Clinical Psychologist	Clinical Psychology	Yes	Yes		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	Self employment as CBT therapist working with Cruse Ltd	16/09/20 - ongoing	Yes	Yes	Yes	Yes	Yes
Low	Sophia	Chakraborty	Consultant	Senior Medical MHOOP	Yes	No		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 assessments through Clinical Partners outside my working hours	Ongoing	Fees	Yes	Yes	Yes	Yes
Low	Agnes	Chaves	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics, Spines	Yes	Yes	UHW	Yes	Director 1. Tanman Consultancy Ltd 2. Tanman Investments Ltd Spouse Director 1. Tanman Consultancy Ltd 2. Tanman Investments Ltd	2008 - ongoing 2015 - ongoing 2008 - ongoing 2015 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spread Ltd, Director	Dec-19	N/A	N/A	N/A	N/A	Practice privileges at Nuffield Vale Hospital and Spire Cardiff Hospital	2008		Yes	Yes	Yes
Low	Mohammed	Chowdhury	Consultant Dermatologist	Dermatology	Yes	No	UHW	Yes	Director of Dr MMJ Chowdhury Ltd (private dermatology work)	2012 - ongoing	Dividends, no salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	President-Elect, British Association of Dermatologists, Executive Officer of Charitable organisation (unpaid role)	July 21 - July 22	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Adam	Chrobak	Consultant Pathologist	Cellular Pathology	Yes	No	UHW	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	I report (consult for external companies, this is: Roche/Ventana, Leica and Agilent/Dako) in pathology. This is usually reporting of backlog cases sent from NHS Labs in England to a central hub for distribution.	Oct-2019 - Ongoing	Yes	Yes	Yes
Low	Yu-Tai Daniel (Daniel)	Chung	Consultant	Radiology	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	Independent Contractor at the Spire Hospital	2019 - Ongoing	Fees	Yes	Yes	Yes	Yes
Low	Gail	Clacher	Lead Clinical Nurse Specialist in MS	Neurosciences	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	Member of UKMSINA Committee		Sponsorship for overnight	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Dennis Llewellyn	Corbin	Locum Consultant Radiologist	Radiology	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	Medical and scientific advisor to Intelligent Ultrasound (formally MediaPro (Simulations and artificial intelligence in ultrasound)	2010	Consultancy Fees	Yes	Yes	Yes
Low	Declan	Coleman	Clinical Scientist	Medical Physics	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	I do some practice ultrasound scans for a private hospital in Newport.	current	Honoraria	Yes	Yes	Yes	Yes
Low	Sandra	Coles	Senior Nurse	Workforce	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	N/A	Additional agency work outside of working hours	March 2021 - present	Hourly salary	Yes	Yes	Yes	Yes
Low	Philip	Connor	Consultant	Paediatric Oncology	Yes	No	UHW	Yes	N/A	N/A	N/A	No	N/A	N/A	I have no conflicts of interest. There was a planned advisory board with a company called Sobi but this fell through. I sit on an advisory board for Chiesgas.	N/A	N/A	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	Yes	Yes	Yes
Low	Sara	Cook	Consultant	Critical Care	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	1) Co-Editor 'Key Clinical Topics in Critical Care', 2nd Ed Pub 2014 My husband who is a physiotherapist within the service and I have a small private physio practice.	1. Jul 20 - Ongoing 2. 2014-Ongoing	1. Previous royalties received - none at present 2. Yes	Yes	Yes	Yes
Low	Kayna	Cooke	Physiotherapy	Outpatient Physiotherapy	Yes	Yes	UHW	Yes	No	N/A	Nil	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	Nil	Yes	2019-Ongoing	Fees	Yes	Yes
Low	Stephen	Coombs	Podiatrist	Podiatry	Yes	No		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	No	N/A	N/A	N/A	Chair of Wales Branch of College of Podiatry	Nov-21	No	Private Podiatry work			Yes	Yes	Yes
Low	Julie	Cornish	Consultant Surgeon	General Surgery	Yes	No	UHW	Yes	Cornish Healthcare Ltd Partner: Sinff Ltd	01/04/2019 January 2020	No Salary	N/A	N/A	N/A	N/A	N/A	N/A	I am the Secretary for the Pelvic Floor Society (another charity) and the Treasurer for the MASC foundation (charity). Both receive industry funding for educational events from multiple industry partners. I have been paid honoraria by industry for participation in events which have been declared to CAAUHB and have been paid into Cornish Healthcare limited.	2018	None	T trustee and Exec Board Member of MASC Foundation	2018	N/A	N/A	N/A	N/A	I work in Spire Cardiff in a session which has been agreed as part of my job plan	Apr-18		Yes	Yes	Yes
Low	Richard	Cousins	Consultant in Immunology	Immunology	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	I have shares in AstraZeneca	ongoing	Dividends	Sponsorship for travel and attendance at educational meetings from Novartis and Gilfolis	Ongoing	Accommodation, travel and conference fees	N/A	N/A	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	Yes
Low	Claire	Cousins	Consultant	Sexual Health	Yes	No		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	Member of Fast Track Cardiff and Vale (HIV Prevention Network). Volunteer with a charity hosted by Pride Cymru	Nil	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Gareth	Creed	Consultant Anaesthetist	Anaesthetics	Yes	No	UHW	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	Responder member and treasurer of MEDSERVE Wales (Charity Number 1039020)	2018-Ongoing	No	2018-Ongoing	No	N/A	none	Yes	Yes
Low	Kate	Crompton	Pharmacist	Medicine	Yes	No	UHW	Yes	No	N/A	Nil	No	N/A	N/A	I took part in an advisory board meeting for Thame (uterotrichs Symtrel) in December 2020 and received an honorarium of £200	One off	£250.00	No	N/A	N/A	No	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	Yes	Yes	Yes
Low	Aniberdra	D'Costa	Consultant Urologist	Urology	Yes	No	UHW	Yes	Director of Urology Solutions Cardiff Ltd Spouse - Director of Urology Solutions Cardiff Ltd	01.02.18 - current 01.02.18 - current	Dividents ad hoc Dividents 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	Private practice at Spire Hospital	Sept 2001 - ongoing		Yes	Yes	Yes
Low	Judy	Daffin	Clinical Psychologist	Neurosrsychiatry Service	Yes	No		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. I work as an associate practitioner through an organisation called Headview		Fee	Yes	Yes	Yes
Low	Gareth	Davies	Clinical Scientist	Merges	Yes	No		Yes	Company Director of Penstome Property - dormant for +3 years	2019 - 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	N/A	N/A	N/A	N/A	Yes	Yes	Yes

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

Low	Ikram	Osanes	Consultant Paediatric Gastroenterologist	Child Health	Yes	Yes	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	Wife has done consultancy work for which she has been paid within the last 7 years with Janssen, Takeda and Jazz		Yes	N/A	N/A	N/A	Chair of NICE NG1 (2015), Previous Chair of the ESPGHAN Endoscopy Working Group and member of JAG (2012-2015). I have been a NICE expert witness in appeals in the last 5 years. I have an induction programme twice each year. Health Advisory Council of Coeliac UK since spring 2020 and Servelli Cross party Group on Coeliac Disease since spring of 2020. I am now on the consultant's committee of BMA Wales	2016	N/A	I raise money for and contribute to events (as a speaker) held by CCRA and Crohn's and Colitis UK. I am part of IBD Wales.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Robyn	Davies	Head of Innovation	Improvement and Implementation	Yes	No	Woodland House	Not Ticked	Chairman - Cultivvate Ltd	1.09.17	None	Chairman - Cultivvate Ltd (existing UHB customer)	1.09.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Visiting Professor - University of South Wles, Hon Innovation Fellow - Cardiff University	1.07.20 - 1.07.23 16.11.20 - 1.01.25	None	N/A	N/A	N/A	Yes	Yes
Low	Ikram	Osanes	Consultant Paediatric Gastroenterologist	Child Health	Yes	Yes	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	I have raised money for and contribute to events (as a speaker) held by CCRA and Crohn's and Colitis UK.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Paul	Davis	Consultant Paediatrician	Child Health	Yes	No	St David's Hospital	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	Scientific Advisor to The Lullaby Trust							Yes
Low	Imogen	Davis	Practitioner Psychologist	Psychology & Psychological Therapies	Yes	No	Links CMHT, CRI	Yes	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private clinic at Cyncoed Consulting Rooms. Undertake private practice in relation to child safeguarding tasks (legal proceedings)	1. CMC 2022 - Ongoing 2. Jan 2023-Ongoing	Fees per report	Yes	Yes
Low	Dov	Deitz	Consultant in Metabolic Medicine	Haematology/ Immunology / Metabolic Medicine	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	Honoria received for expert advice and speaker fees from Amgen, Sanofi, Actelx, Amryt, Kyowa Kirin, Novartis	2011 – ongoing	Financial	N/A	N/A	N/A	Trustee, HEART UK	2018	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice- Metabolic Clinic Ltd	2011	Financial	Yes	Yes
Low	Ceris	Devereux	Public Health Dietitian	Nutrition and Dietetics	Yes		UHW	Yes	N/A	N/A	N/A	N/A	N/A	I have done work advising Quorn foods around diet for monetary payment, I have also worked with the NHS in conjunction with stjon producing diabetic advice for monetary payment for E-learning	16th October 2019 and 10/02/20	one off payment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have undertaken some activities as part of my private practice	Ongoing	N/A	Blank	Yes
Low	Catherine	Doman	Programme Lead for Integrating Health and Social Care	PCIC	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	June 2021 - Ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	yes
Low	Catherine	Doman	Director of Health and Social Services Integration	Health and Social Services	Yes	No	Strategic Planning	Yes	No	N/A	N/A	Nil	No	N/A	N/A							Jan 20 - ongoing	Nil	No	N/A	N/A	N/A	No	N/A	N/A	N/A	Yes	Yes
Low	Nicholas	Drage	Consultant in Dental and Maxillofacial Radiology	Dental	Yes	No	UHW	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	N/A	Lecturing to dentists on all aspects of dental radiology	sessions	Lecturing- personal payment	Yes	Yes
Low	Mark	Drury-Smith	Consultant Cardiologist	Cardiothoracics and Medicine	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13.07.20	Honoraria	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
Low	Jonte	Duckers	Consultant Medicine	Specialised Medicine	Yes	Yes	UHL	Yes	N/A	N/A	N/A	N/A	N/A	GP service has previously received educational grant from Vertex	2015							ongoing		N/A	N/A	N/A	Research Ethics Committee- member of organising committee of CF research events	ongoing	N/A	N/A	N/A	N/A	Yes	Yes
Low	Martin	Edwards	Consultant Paediatrician	Paediatrics	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A															I work 2.5 sessions for HEIW as a deputy director for secondary care		Apr 21 - Ongoing	N/A	Yes	Yes
Low	Natalie	Elliot	National AHP lead for Dementia	Mental Health	Yes	Yes	Academic Centre UHL	Yes	No	N/A	N/A	N/A	No															Annual Planning Session (tutorship of NHS Working Hours) for Cardiff University	2017-ongoing	Paid and hourly rate	Yes	Yes
Low	Nabah	Elmusharaf	Consultant Haematologist	Haematology	Yes		UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		Fees for organising talks and to attend	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
Low	Susan	Elsmore	Independent Member of the Board	Executive / Corporate	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	Cabinet Member for Social Care, Health & Wellbeing Cardiff Council / Health & Social Care Spokesperson WLGA / C&V Regional Partnership Board Chair	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	George	Erasti	Consultant Neurosurgeon	Neuroscience	Yes	No	UHW	Yes	Director of my own PLC		Mar 20 - 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	Private Practice: Spire Hosp and Sancta Maria Hosp	01/03/2020 - ossesns	Fees	Yes	Yes
Low	Libby	Erin	Consultant Clinical Psychologist	Child Psychology	Yes	No	Global Link	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 privately seeing families where children are struggling with their mental health.	2018 - ongoing	N/A	Yes	Yes
Low	Kayla	Evangelou	Consultant Cellular Pathology	Cellular Pathology	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	N/A	Yes	2018 - January 2021	Fees	Yes	Yes
Low	Caroline	Evans	Consultant Healthcare Scientist	Biochemistry	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2022 - Ongoing	No personal financial gain	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Caroline	Evans	Consultant Anaesthetist	Perioperative Care	Yes	No	UHW/UHL	Yes	N/A	N/A	N/A	N/A	N/A															1. I do occasional private work at Spire Health - none this year but practicing privileges since 2011 2. Deputy Director for Secondary Care for Wales	1. Jan 11 - ongoing 2. 2022 - ongoing	1. Fees 2. 2 x sessions	Yes	Yes
Low	Kaveh	Fakhrzadeh	Consultant	Obstetrics	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	N/A	Private Practice at the Spire Hospital	N/A	Fees per session	Yes	Yes
Low	Kaveh	Fido	Radiographer	Radiology	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	N/A	Private Practice	Jul 08 - Ongoing	Fees per session	Yes	Yes
Low	Fatrick	Fielding	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			received travelling expenses and a lecturing fee for a GE molecular imaging symposium	Aug-18	Lecturing fee and travel	N/A	N/A	N/A	N/A	N/A	N/A	I undertake a small amount of private practice during my work at the UHB both in NM and via PETIC. I do not consider that these constitute a conflict of interest	Sept 2010 - ongoing	fee per patient basis	Yes	Yes
Low	Elaine	Flannery	Counsellor	MHSOP Psychology	Yes	No	CRI	Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	N/A	No	N/A	No	N/A	No	N/A	No	No	N/A	No	2 hours per week as a self employed counsellor.	2021-Ongoing	Yes	Yes	Yes
Low	Joseph	Flora	Genetic Counsellor	All Wales Medical Genomics Services	Yes	No	Institute of Medical Genetics, 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	N/A	Employed by prenetics EMEA Ltd - zero hours contract (Maximum 8 hours per week averaged over a week period)	18.03.21 - Ongoing	hourly rate	Yes	Yes
Low	Chris	Foreman	Director of Corporate Governance	Corporate / Executive	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	N/A	Company secretary for Safe Ventures Ltd	N/A	N/A	N/A	Yes
Low	Mark	Forster	Consultant Orthopaedic Surgeon	Trauma & Orthopaedics	Yes	Yes	UHW	Yes	Cardiff Knee Surgery Ltd (private practice)		2010 - ongoing			Partner, Cardiff Knee Surgery Ltd (private practice)	2010 - ongoing	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	Yes	Yes
Low	Aaron	Fowler	Head of Risk and Regulation	Corporate Governance	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, w/ks the health board contact for legal advice.	2019-ongoing	N/A	Yes	Yes
Low	Joanna	Fox	Consultant	Anaesthetics	Yes	Yes	UHW	Yes	One-over business Dr Jo Aesthetics		2022-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	Yes	Yes
Low	Malcolm	Graing	Consultant	PICU	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	N/A	1. Director of quality management HEIW 2. GMC Enhanced monitoring associate	2022	Ad hoc payments	Yes	Yes
Low	James	Galea	Consultant Neurosurgeon	Neurosciences	Yes	No	UHW	Yes	Neurosurgery Services Ltd (Not seeking to do business with UHB)		30.11.17 - ongoing	Nil	N/A	Clinical Research involving but not funded by pharmaceutical companies (IGOR Ab, Sweden)	2015 – 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	N/A	N/A	Yes	Yes
Low	Claire	Genderon	Senior Pharmacist	AKTTC	Yes	Yes	UHL	Yes	Director Spouse / Partner - Director		12.09.17 - ongoing 12.09.17 - 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	Yes	Yes
Low	Simona	Gatto	Consultant in Haematology	Haematology	Yes	No		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	Roche Advisory Board			Yes	Yes
Low	Sarah	Goldsmith	Consultant	Anaesthetics	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	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Andrew	Gorringe	Consultant in Haematology	Haemastology Laboratory	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	postpartum haemorrhage QI initiative that received funding from WG and an industry partner (Werfen). I have also agreed to speak at 2 x Werfen sponsored	2017-2019	Nil	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spire hospital in Cardiff including reporting occasional blood films and chairing their Blood Transfusion	June 18 - ongoing		Yes	Yes
Low	Vanessa	Goulding	Podiatrist	Podiatry	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	N/A	Honarary lecturer for Cardiff University. External lecturer for University of South East Norway - commitment for 1 x lecture per annum.		Costs only	Yes	Yes
Low	Sumit	Goyal	Consultant Surgeon	Surgery	Yes	No	UHW		Director of limited company Dr Goyal Ltd Spouse - secretary of company		Oct 2014 - 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	Member of Breast Centre Charity	2009 - ongoing		N/A	I am a Magistrate (Justice of the Peace) and sit on the Mid Wales Adult Criminal, family and Crown Court benches.	2020-Ongoing	Nil	N/A	N/A	N/A	Yes	Yes
Low	Craig	Greenstock	Counterfraud Manager	Finance	Yes	Yes	Woodland House	Yes	No	Q5 - (November 2021)		Nil	N/A	Nil	Member of Family works for another NHS Body	N/A	Nil	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	No	No	Jun-21	N/A	Yes	Yes
Low	Xian	Griffin	Consultant Nephrology & Transplantation	Nephrology and Transplant	Yes	No	UHW	Yes	N/A	N/A	N/A	Becton Dickinson - (June 2021)	N/A	N/A	Advisory Board attendance - Roche, Novartis, Reinsphin, Astra, Zeneca	17.08.20 - 16.11.20	Honoraria	N/A	N/A	N/A	General Secretary British Transplantation Society	01.03.18 - 31.03.21	None	N/A	N/A	N/A	N/A	N/A	N/A	Mar-22	N/A	Yes	Yes
Low	Helen	Griffiths	Occupational Therapist	Community Resource Team	Yes	No	Whitchurch Hospital	Yes	N/A	N/A	N/A	Billions Institute - (March 2022)	N/A	N/A	N/A	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	Jan-20	zero hour contract	Yes	Yes
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Yes	Yes	UHW	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Cardiology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	CHI/Singapore - January 2020)	N/A	N/A	N/A	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	2021	Income and Dividends	Yes	Yes
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Yes	Yes	UHW	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Cardiology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	I anticipate using this company for any oth	N/A	N/A	N/A	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
Low	Tristan	Groves	Lead Cardiology and Anticoagulation Pharmacist	Adult Cardiology	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	I work a number of weeks - outside my NH	N/A	N/A	N/A	N/A	N/A	N/A	Honoraria and meeting travel expenses	2016 - current		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Laura	Gwyther	CART Clinical Nurse Specialist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N	To be clear, I receive no financial benefit fr	N/A	N/A	N/A	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 partake in the discussion to get more understanding of the new product and hear about other nurses experiences. This is a 1 day event on the 15th October 2020 from 1pm until 5pm. This is a one off participation as far as my knowledge serves.	15/10/2020	£140	Yes	Yes
Low	Richard	Hain	Consultant and Clinical Lead, Paediatric Palliative Care	Child Health (Community)	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	N/A	N/A	N/A	N/A	CAUHB Office space within Ty Hafan Children's Hospice	2018		Office space, coffee			Yes	Yes
Low	Sarah	Hale	Consultant Ophthalmologist	Ophthalmology	Yes	No	UHW	Yes	N/A	N/A	N/A	Nominated member of Cardiff Eye Surgeons LLP. Company that carries out ophthalmic 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	N/A	N/A	Yes	Yes
Low	Khalid	Hamandi	Consultant Neurologist	Evidence Unit	Yes		UHW	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	Secretary, International League Against Epilepsy British Chapter, Chair Epilepsy Action Cymru National Advisory Council.	2019 - present	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Kathrin	Hammer	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	No	No	N/A	Nil	No	No	N/A	Nil	No	N/A	nil	No	N/A	No	N/A	No	No	N/A	No	Fee for service at Europoen screning centre Cardiff and Spire hospital Cardiff for radiology work	One session	One off payment	Yes	Yes
Low	Kathrin	Hammer	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	No	No	N/A	N/A	No	No	N/A	N/A	No	N/A	Nil	No	N/A	No	N/A	No	No	N/A	No	Clinical Private Practice	06.09.20 - Ongoing	Fees	Yes	Yes
Low	David	Hanna	Consultant Paediatrician	Emergency Medicine	Yes	Yes	UHW	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	N/A	N/A	N/A	Yes	Yes
Low	Abigail	Harris	Executive Director of Strategic Planning	Strategic Planning	Yes	Yes	Woodland House	Yes	No	N/A	N/A	N/A	No	N/A	N/A	N/A	No	N/A	N/A	No	N/A	My husband is an independent Board member of the Wales Council for Voluntary Action. My uncle is a Trustee of the Tennage 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
Low	Sara	Harrison	Consultant Radiologist	Radiology	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private patient scans at Cardiff Spire Hospital during non contracted time.	2022 - Ongoing	Fees	Yes	Yes
Low	Mary	Hart	Consultant Radiologist	Radiology: Medical Physics, Clinical Engineering	Yes	No	UHW	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	N/A	N/A	Self employment: Hart-Jones Consultancy LTD	Apr-19	Salary		
Low	Jamie	Hayes	Pharmacist	AKTTC	Yes	Yes	UHL	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	Programme Leader for University of Buckingham MSc		Ad hoc payments from Lexma Ltd	Yes	Yes
Low	Caroline	Hayhurst	Consultant	Neurosurgery	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	N/A	Neurosurgery	2022-Ongoing		Yes	Yes
Low	Rhys	Hewett	Consultant Gastroenterologist	Gastroenterology	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	Sponsored by Fresnius 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	N/A	Yes	Yes
Low	Julie	Hetherton	Consultant Clinical Psychologist /Associate Director	Critical Care	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	N/A	National Director of Wellbeing Intensive Care Society	15/06/20 - Ongoing	N/A	N/A	N/A	N/A	N/A	Occasional private practice	2005 Ongoing	within salary	Yes	Yes
Low	Christopher	Hingston	Consultant Critical Care	Critical Care	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	N/A	Spouse: Director and Trustee of Latch Childrens Charity	2014 - current	Nil	secondment from NHS 0.4WTE at N	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Gillian	Hingston	Consultant & Honorary Senior Lecturer Paediatric Dentistry	Paediatric Dentistry	Yes	No	UHW	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	N/A	N/A	N/A	Yes	Yes
Low	Peter	Hockey	Consultant Histopathologist	Cellular Pathology	Yes	Yes	UHW	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
Low	Rachel	Hodges	Physiotherapist	Bradley	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	N/A	Private Work as a Physiotherapist for Cardiff City Ladies Football Club.	9/12/20 - ongoing	2k/yr	Yes	Yes
Low	Paul	Hodgson	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics	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	N/A	N/A	N/A	N/A	Private Practice (company name PDH Ortho Ltd)	Feb 2013 - ongoing	payment per case	Yes	Yes
Low	Rebecca	Holt	Training Manager	Genomics Strategy	Yes	No	AWMGS	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	Yes - Volunteer at Cardiff Dogs Home	03/03/2022	n/a	n/a	n/a	n/a	n/a	Yes	Yes
Low	Mathew	Hoskin	Locum Consultant Psychiatrist	Adult Psychiatry	Yes	No	Barry Hospital	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	I am the Chief Investigator for a phase 2 clinical trial sponsered 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 received training funded by MAPS.			N/A	N/A	N/A	N/A	N/A	N/A	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
Low	Conn	Howell	Macmillan AHP Cancer Lead	Therapies	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	N/A	I undertake private dietetic practice	2008 - ongoing	Salary	Yes	Yes
Low	David	Howells	Consultant	MHSOP	Yes	No	South East Cardiff team	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	N/A	Health Inspectorate Wales - CIAO work Schedule 2 Mental Health Act Monitoring Visits Mental Health Lawyer for Charity 3BSEC Private Mental Health Clinical Work at Cyncoed Consulting Rooms, Cardiff	Jan 21 – Ongoing	Yes	Yes	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

Low	Richard	Hughes	Consultant Anaesthetist	Peri-Operative Care	Yes	No	UHW	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
Low	Lauren	Humphreys	Sonographer	Radiology	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 Practice	29.06.2022		Yes	Yes
Low	Nia	Humphry	Consultant	General Surgery	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	Cardiff University 0.1. WTE		Salary	Yes	Yes
Low	Jenny	Hunt	Psychology Manager	Child Psychology	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	My partner (Rob Kidd) is the professional lead for psychology and psychological therapies in the UHB	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	Yes	Yes
Low	Sarah	Hunt	Consultant Anaesthetist	Anaesthetics and Critical Care	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	2014 - ongoing	I do not draw a salary or dividends	Yes	Yes
Low	Nicola-Xan	Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for European Respiraotry Conference attendence 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
Low	Louise	Ingleton	Avanced Paediatric Clinical Nurse Specialist	Community Child Health Deurodevelopmental	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
Low	Wendy	Ingram	Consultant Haematologist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.Novartis Advisory Board Meeting 2. Takeda sponsored educational event - invited speaker. 3. Swedish Orphan Biovitrium advisory board meeting 4. Takeda sponsored attendnave at 2 x virtual meetings.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Bethan	Ingram Holden	Senior Nurse	Haematology	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Awardeed Florence Nightingale Foundation Scholarship (£9K) from Teenage Cancer Trust (Approved by Chief Nurse)	2021 - to be completed by end 2022	No personal gain	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Sharon	Irving	Senior Nurse ENT	ENT	Yes	No	UHW	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
Low	Carly	Jackson	Clinical Psychologist	Child Health	Yes	No	St David's Hospital	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
Low	Charles	Janczewski	UHB Chair	Executives / Corporate	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
Low	Benjamin (Ben)	Jelley	Consultant Gerentologist	Clinical Gerentology	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	Treasurer of the Welsh Stroke Conference Organising Committee	2020 - Ongoing	Nil	Associate Editor for the Age and Ageing Journal		Unpaid	Contract with Cardiff University for 1 session per week to deliver an MSc in Clinical Geriatrics	N/K	Fees	Yes	Yes
Low	Fiona	Jenkins	Executive Director of Therapies and Health Science	Executive	Yes	No	UHW	Yes	Interim Executive Director Therapies and Health Science, Cwm Taf Morganngw 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
Low	Lynda	Jenkins	Nursing Informatics Lead	Corporate Nursing	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
Low	Meriel	Jenney	Medical Director	Executive	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Chief Investigator for an international clinical trial funded by Bayer	Oct 21 - Dec 21	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	Yes	Yes
Low	Michaela	John	Programme Manager	Genomics Strategy	Yes	No		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 for a charity (The Margaret Bell School)	2022	No	N/A	N/A	N/A	Yes	Yes
Low	Adam	Jones	Consultant Dental Surgeon	Dental	Yes	No	UHW	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
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	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	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Ceri Hopcyn	Jones	Consultant Haematologist (BMT & CAR T)	Consultant Haematologist	Yes	No	UHW	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
Low	Lisa	Jones	Clinical Psychology	Neuropsychology	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	I work as a self employed clinical neuropsychologist	2014 - ongoing	salary	Yes	Yes
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	Yes	Yes		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
Low	Menna	Jones	Clinical Lead	Mental Health	Yes	No	Global Link	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
Low	Sharon	Jones	Consultant Rheumatologist	Specialised Medicine	Yes	No	UHW	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
Low	Stephen	Jones	Consultant	T&O	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 practice at the Nuffield Cardiff and Vale Hospital - performed outside NHS timetable	2022 - Ongoing	N/A	Yes	Yes
Low	Nia	Jones	Podiatrist	Therapies	Yes	No	CRI	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
Low	Anurag	Joshi	Consultant	Cellular Pathology	Yes	No	UHW	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
Low	Naushad Ali	Junglee	Consultant in Acute Medicine and Nephrology	Acute Medicine	Yes	No	UHL	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
Low	Sridhar	Kamath	Consultant Radiologist	Radiology	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	I have private practising privileges at Spire cardiff hospital, Nuffield hospital cardiff and St Josephs hospital Newport.			Yes	Yes
Low	Arul	Kandan	Service Group Manager	T&O	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	N/A	N/A	N/A	Private Physiotherapy in my own time	2022 - ongoing	Fees	Yes	Yes
Low	William Jonathan	Kell	Consultant Haematologist	Haematology	Yes	No	UHW	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
Low	Emma	Kempshall	Consultant Haematologist	Haematology / BMT	Yes	Yes	UHW	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
Low	Alexander	Kennedy	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Yes	No		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
Low	Mohid	Khan	Consultant Gastroenterologist	Gastroenterology	Yes	No	UHW	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
Low	Robert	Kidd	Consultant Psychologist	Mental Health	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 medicine at nottingham university .	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
Low	Caroline	Kirwan	Counsellor	Medical Genetics	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	Intermittent private genetic counselling workvia Innermost Healthcare	2022	Fees	Yes	Yes
Low	Anna	Kuczynska	Clinical Board Director	PCIC	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
Low	Howard	Kynaston	Consultant Urologist	Medicine	Yes	No	UHW	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
Low	Mary	Lawrence	Associate Specialist in Psychiatry	Mental Health	Yes	No	Hamadryad CMHT	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 undertaken in my own time)	Ongoing		Yes	Yes
Low	Mari	Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy	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	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
Low	Fong	Leong	Consultant	Cardiothoracic	Yes	No	UHW	Yes	Rhythmus Cordis Ltd	Jun 19 - 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	Private work at Spire Hosp Cardiff	Ongoing	Fees	Yes	Yes
Low	Robert	Letchford	Consultant Physiotherapist	Physiotherapy	Yes	No	CRI	Yes	POBREN 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
Low	Aled	Lewis	Consultant	Nephrology and Transplant	Yes	Yes	UHW	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
Low	Christopher	Lewis	Interim Executive Director of Finance	Finance	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	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
Low	Kenneth	Lim	Consultant Obs & Gynae	Obs & Gynae	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	Chair of South Wales Gynae Cancer Fund - registered chairity	2009 - ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Peter	Lindsay	Locum Consultant	Obs & Gynae	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	Treasurer - South Wales Gynaecological Cancer Fund	1997 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Kate	Littler	Principal Clincal Psychologist	Haematology	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 Practice	01/07/2020 - Ongoing	Salary	Yes	Yes
Low	Andrea	Liu	Consultant Neuroradiologist	Radiology	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	4Ways Healthcare and Spire Cardiff	2012 and April 2010		Yes	Yes
Low	Andy	Lodwick	Lead Clinician Psychological Therapy Hub	Psychology	Yes	Yes	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	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
Low	Ne-on	Loh	Consultant Paediatrician	Child Health	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	Consultant Paeditricin in Royal United Hospital Bath	February 2010 -	2PA	Yes	Yes
Low	Rachel	Long		Directorate Manager	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	Magistrate on Cardiff Bench	N/K	Expenses only	Yes	Yes
Low	Julie	Loxton	Clinical Lead Nurse	Vale Locality Office / Daytime Servi	Yes	No	Barry Hospital	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
Low	Alice	Loyal	Clinical Psychologist	Psych EMI Community	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
Low	Jill	Lubienski	Family Therapist	SHED	Yes	No	Global Link	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
Low	Helen	Ludlow	Macmillan Senior Nurse Band 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: £1105. 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 scrutiny if required	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Yes	Yes
Low	Jane	Maddison	Paediatric Physiotherapy	Acute Child Health	Yes	No	Woodland House	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
Low	Roger	Maggs	Laboratory Manager	Dental	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	Managing Director of a company for private work Wife - Director of same company	01/04/2015 - current 01/04/2015	salary	Yes	Yes
Low	Claire	Main	Nurse Manager	Clinical Board	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	Executive member of Association of Nephrology Nurses UK. I receive no renumeration for this.	29.05.2018 - ongoing	No	N/A	N/A	N/A	Yes	Yes
Low	Aleksander	Marin	Consultant Radiologist	Radiology	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	N/A	N/A	N/A	Medica Teleradiology Speciallity Advisor in Thoracic Radiology, Spire Hospital Cardiff Reporting Radiologist	20.06.16	Monthly p0ayable fees for service	Yes	Yes
Low	Carys	Marshall	Principal Clinical Psychologist	Clinical Health & Neuropsychology	Yes	No	Global Link	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
Low	Syed	Masud	Cousultant in Emergency Medicine & Pre-Hospital Emergency Medicine	Emergency Medicine	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	I am the director of a personnal company - COPMED Ltd. Small company specialising in teaching specialist medical skills to special Forces, military and police.	2020	Occasional salary for courses	N/A	N/A	N/A	N/A	N/A	N/A	I sit on multiple Police Clinical Governance Panels for TVP/Hampshire and SWP and Gwent - all are voluntary - NON PAID		Voluntary - non paid	Volunteer Special Constable for SWP		Volunteer	Advisor to company called Team Fusion Ltd - specilaist protection for high end clients and courses		Salary for advise given	Yes	Yes
Low	Joanne	May	Locum Consultant Paediatric Rheumatologist	Child Health	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Medical advisor to treat to target panel for systemic JI	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
Low	Kenneth	May	Consultant Cellular Pathology	Cellular Pathology and Mortuary Service, Laboratory Medicine	Yes	No	UHW	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
Low	Haydn	Mayo	Assistant Clinical Board Director, PCIC	Community Director	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	N/A	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
Low	Neil	McCann	Consultant Anaesthetist	Anaesthetics	Yes		UHW	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
Low	Mike	McCarthy	Consultant	Trauma & Orthopaedics	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	Ad Hoc educational contract with Globus Medical. I teach on 2 x courses per year.			Yes	Yes
Low	Annette	McLean	Dietetic Lead Mental Health	Dietetics	Yes		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	Ad hoc private dietetic work: Orbis education, plus dietetic consultation/training ad hoc on request, eg: cardiff uni/somek/knights-absorb.	2005 - ongoing		Yes	Yes
Low	Jan	Melichar	Consultant Psychiatrist	Addictions	Yes	No	CRI	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
Low	Angela	Miser	Associate Specialist, Paediatric Haematology / Oncology	Acute Child Health	Yes	Yes	UHW	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
Low	Biju	Mohamed	Consultant	Gerentology	Yes	No	UHW	Yes	Co-Director Medic Training Ltd	2017	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical expert NICE diagnostic pathway for PKG	Jan 2022 - Feb 2023	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	[illegible]	Moideen	Consultant Spinal Surgeon	Trauma and Orthopaedics	Yes	Yes	UHL	Yes	Director Private Practice Spouse: Director Private Practice	02.2022 02.2020	Salary Salary	N/A	N/A	N/A	1. Attended 2 x Training Programmes sponsored by Globus Medical. 2. Attended a training course sponsored by Stryker.	2022	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Hospital Cardiff	2020 - Ongoing	Fee	Yes	Yes
Low	Siobhan	Moore	Clinical Psychologists	Neurosciences	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
Low	Matthew	Morgan	Consultant in ICU	Critical Care	Yes	Yes	UHW		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
Low	Paul	Morgan	Consultant Critical Care	Critical Care	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	Lead volunteer, the UK Sepsis Trust	2013		Lecturer for Doctors Academy	Apr-19		Yes	Yes
Low	Rhiannon Meleri	Morgan	Consultant in Cellular Pathology	Cellular Pathology	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	Board Member of Manon Jones Foundation - not yet established as a charity	01.01.20	None	Coronial post mortem work for South Wales Central Coroner's Office	2004	£96 per individual PM	Yes	Yes
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Yes	Yes	UHW	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
Low	Ian	Morris	Consultant	Neonatal	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	2 sessions per week as programme director for neonatal MSc Cardiff University	Ongoing	Salary	Yes	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

Low	Jeffrey	Morris	Head of Electronic Assitive Technology Service for Wales	ALAS	Yes	No	Rookwood Hospital	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
Low	Sara	Moseley	Independent Member of the Board	Executives / Corporate	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
Low	Richard	Motley	Consultant Dermatologist	Dermatology	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	I undertake Private Practice at the Spire Cardiff Hospital and in The Welsh Institute of Dermatology	1994 - ongoing		Yes	Yes
Low	Sian	Moynihan	Consultant Paediatrician	Child Health	Yes	No	St David's Hospital	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
Low	Peter	Mullaney	Consultant Radiologist	Radiology	Yes	No	UHW	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
Low	Pippa	Mundy	Consultant Clinical Psychologist	Child Health	Yes		Global Link	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
Low	Alexandra	Murray	Consultant Medical Genetics	Genetics	Yes	No	UHW	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
Low	Ravindra	Nannapaneni	Consultant	Neurosurgery	Yes	No	UHW	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
Low	Jones	Nia	Podiatrist	Podiatry	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
Low	Peter	O'Callaghan	Medical Consultant	Cardiothoracic	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
Low	George	Oliver	Physiotherapist	Physiotherapy	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	I provide voluntary first aid cover for Ty Celyn U9 football team	2022 - Ongoing	N/A	Wife works as a journalist for BBC Wales - may occasionally cover a healthcare story.	Ongoing	Nil	N/A	N/A	N/A	Yes	Yes
Low	Balarao	Oruganti	Consultant in Psychiatry	Psychiatry	Yes	No	UHL	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
Low	Craig	Parry	Consultant Radiologist	Radiology	Yes	No	UHW	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
Low	James	Peaker	Clinical Scientist	Cellular Pathology	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Approached by a market research company of behalf of an undisclosed pharm. Company to complete a questionnaire on my thoughts around biomarkers within UGI adenocarcinomas	2022	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
Low	Frauke	Pelz	Associate Specialist in Clinical Genetics	All Wales Medical Genomics Service	Yes	Yes	UHW	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	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
Low	Thomas	Pembroke	Consultant Gastroenterologist	Gastroenterology	Yes	No	UHW		N/A	N/A	N/A	N/A	N/A	N/A	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
Low	Richard	Penketh	Consultant Obs & Gynae	Obs & Gynae	Yes	Yes	UHW	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
Low	Ceri	Phillips	Independent Member of the Board	Board	Yes	No	Woodland House	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 Honarary Professor at Cardiff University.	Sep 21-Ongoing	N/A	No	N/A	N/A	Yes	Yes
Low	Gwenda	Phillips	Clinical Psychologist	Psychology Therapies	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	Director in Carers Trust South East Wales	2018 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Katie	Pink	Respiratory Consultant	Medicine	Yes	No	UHL	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 management (Astra Zeneca)		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Katie	Pink	Respiratory Consultant	Medicine	Yes	No	UHL	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 management (Astra Zeneca)		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Laura	Price	Assistant Psychologist	Neuroscience	Yes		Rookwood Hospital	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 ithe community	9/09/20 - ongoing	paid hourly	Yes	Yes
Low	Ann Marie	Procter	Consultant in Medical Genetics & Clinical Board Director	AWMGS	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	Trustee of Kaleidoscope Addictions Charity	2018	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Michael	Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engin	Yes	No	Medicentre	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
Low	Rebekah	Pryce	Consultant Endocrinologist	Paediatric Endocrinology	Yes	No	UHW	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
Low	Clare	Quinn	Consultant Clinical Psychologist	Psychology and Psychological The	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
Low	Jessica	Quirke	Consultant Clinical Neuropsychologist	Neuroscience	Yes	No	Rookwood Hospital	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
Low	Ella	Rafferty	Consultant Clinical Psychologist	Welsh Gender Service	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
Low	Rajeswari	Ramaraj	Consultant	Gastroenterology	Yes	No	UHW	Yes	Director of own company	N/K	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	Registered to work for a private endoscopy company and a private virual consulting company.	2022 - ongoing	Fees	Yes	Yes
Low	Suzanne	Rankin	Chief Executive	Corporate Executives	Yes	No	UHW	Yes	Director of Welsh Wound Innovation Centre	1.04.2022 - ongoing	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	Lay Member (NHS) Cardiff University Council	28.04.2022 - 27.04.2025	None	N/A	N/A	N/A	Yes	Yes
Low	John	Rees	Consultant Radiologist	Radiology	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	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Hospital - one afternoon per week.	2022	Fee	Yes	Yes
Low	Suzanne	Rees	Lead Nurse CD&T	CD&T	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	N/A	N/A	N/A	N/A	N/A	N/A	Contract with HIW	2022	Salary	Yes	Yes
Low	Aled	Roberts	Clinical Board Director	Medical Consultant	Yes	Yes	UHW	Yes	Co-Director SAGE Roberts PLC Co-Director SAGE Roberts PLC	2018 - ongoing 2018 - ongoing	dividend 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
Low	Gareth	Roberts	Consultant	T&O	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 Practice	2022-Ongoing	Fees	Yes	Yes
Low	Stuart Ashley	Roberts	Consultant Radiologist	Radiology	Yes	No	UHW	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 ZD07662	21.04.20 - ongoing	Nil	Private Practice at Spire	1997 - Present	Fee per case payment	Yes	Yes
Low	Zoe	Roberts	Consultant	EU Medical Rota	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	Reviewer HIW	2022	Expenses	Yes	Yes
Low	Debbie	Roberts	Health Visitor	Flying Start	Yes	No	Eastmoors Road		N/A	N/A	N/A	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
Low	Angus	Robertson	Consultant in Trauma and Orthopaedics	Trauma and Orthopaedics	Yes	No	UHW	ESR	N/A	N/A	N/A	Managing Partner Cardiff Sports Ortthopaedics LLP	N/A	N/A	Occasional 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
Low	Natalie	Robertson	Principal Physiotherapist in Mental Health	Physiotherapy	Yes	Yes	UHL	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
Low	Darren	Robinson	Registered Nurse	Addictions	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	Trusteeship with Recovery Cymru	Jan-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Graham	Roblin	Consultant	Surgery	Yes	Yes	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	Clinical Private Practice	2022-Ongoing	Fees per session	Yes	Yes
Low	Matthew	Rodd	Senior Clinical Perfusion Scientist	Perfusion	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
Low	Sheelagh	Rogers	Dental Consultant	Orthodontics	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	Specialist Practitioner; Cathedral Orthodontics; Cathedral Road; Cardiff	Oct 20 - Ongoing	Fees	Yes	Yes
Low	Patricia	Romero	Community Food Worker	Capital Estates and Facilities	Yes	No	Community	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 Private Practice	Ongoing	Salary	Yes	Yes
Low	Clare	Rowntree	Consulant Haematologist	Haematology	Yes	No	UHW	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
Low	Rachel	Rushforth	Senior Nurse Education, Quality, Safety and Patient Experience	Mental Health	Yes	No	Hafan Y Coed	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
Low	Joanna	Rutkowska-Wheel	Specialist Occupational Therapist	neurology	Yes	No	UHW	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
Low	Ramsey	Sabit	Consultant Physician in General and Respiratory Medicine	Medicine	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	I have received honoraria from Pharm Companies (GSK, AstraZeneca, Cheiesi) to present at educational meetings.	N/A	N/A	Support for educational lectures/activities from Glead/Chiesi	2022	No personal benefit	N/A	N/A	Nil	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
Low	Seetal	Sall	POCT Lead	Laboratory Medcine	Yes	No	Ty Glas, Llanishen	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	Yes	Yes
Low	Caroline	Scherf	Consultant	Sexual Health	Yes	No	SE Cardiff Locality	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Gideon Richter sposored attendnace at 2022 European Society of Contraception Meeting in Ghent	May-22	approx £700	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Annete	Schlaudrdaff	Consultant SRH	DoSH	Yes	No	CRI	Yes	N/A	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 apporved 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
Low	Stefan	Schwarz	Consultant Radiologist	CD&T	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	Practising privileges at SPIRE Hospital Cardiff, I also hold a honorary position at the University of Nottingham as a 'Clinical Associate Professor' since May 2016 for which I receive honoraria.	Current	Honoraria	Yes	Yes
Low	Jane	Scourfield	Speciality Doctor	CAMHS	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
Low	Prabhu	Sekaran	Consultant Paediatrician Surgeon	Child Health	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	I undertaken private practrice in the Spire, Cardiff	N/A	N/A	Yes	Yes
Low	Sagar	Shah	Specialist in Acute and Special care dentistry	Max Fax Surgery	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	N/A	N/A	N/A	N/A	N/A	N/A	I work 1 day per week (7.5 hours) per week at NHS Business Services Authority	2021	Salary	Yes	Yes
Low	Nimish	Shah	GP MHSOP	MHSOP	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	Yes	Yes
Low	Swaroop	Shanbhag	Consultant Spinal Rehabilitation	Neurosciences	Yes	No	UHW	Not Ticked	Abergavenny Hand Surgery Ltd - Director Partner - Vasedev 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
Low	Aarti	Sharma	Consultant	Obs & Gynae	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	Spire Hospital	Feb-18	Payment for seeing patients	Yes	Yes
Low	Jacqueline	Sharp	Physio Manager		No	Yes		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	Husband works for private physion practice (Go Physiotherapy) in Cowbridge Health Centre.		Husband's salary.	Yes	Yes
Low	Andrew	Sharp	Consultant Cardiologist	Cardiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Consultant: Boston Scientific, 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
Low	Timothy	Sheppard	Locum Consultant O&G	Obs & Gynae	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
Low	Hamsaraj	Shetty	Consultant Physician	Medicine Stroke	Yes	No	UHW	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 - Ongoi	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Somashekara	Shivashankar	Consultant Psychiatrist	Adult Mental Health	Yes	No	CRI	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
Low	Anju	Sinha	Consultant Obs & Gynae	Obs & Gynae	Yes	No	UHW	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
Low	Philip	Smith	Consultant Neurologist	Neuroscience	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	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
Low	Alex	Speakman	PN Pharmacist	Pharmacy	Yes	No	UHW	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
Low	Sarah	Spencer	Deputy Head of Midwifery	Obs & Gynae	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
Low	Pushplata	Srivastava	Speciality Doctor	Dermatology	Yes	Yes	UHW	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	No	N/A	N/A	Clinical Lecturer Cardiff University 1 day per week	Apr 18 - Ongoing	Sal;ary	Yes	Yes
Low	Mark	Stacey	Consultant Anaesthetist	Anaesthetics	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	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 occasionally run private courses	2017 - current	Yes	Yes	Yes
Low	Michael	Stechman	Consultant Surgeon	General Surgery	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
Low	Michael	Stephens	Consultant Nephrologist	National Organ Retreival Service	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	Trustee of two charities - Kidney Wales and Believe Organ Donation	NK	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Emyr	Stephens	Prescribing Advisor	Pharmacy	Yes	No	Woodland House	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 (Lilly) 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
Low	Lawrence	Sunder Raj	Consultant Gastroenterologist	Gastroenterology	Yes	Yes	UHW	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
Low	Gillian	Swift	Consultant Gastroenterologist	Gastroenterology	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	I have worked 2 days for Remedy Healthcare providing endoscopy services as part of weekend insourcing at UHL/UHW as plans to reduce waiting lists.			Yes	Yes
Low	Indu	Thakur	Consultant Paediatric Oncologist	Child Health	Yes	No	UHW	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 £268.20		Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Abraham David	Theron	Consultant Anaesthetist, CD Perioperative Care	Anaesthetics	Yes	No	UHW	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	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
Low	Lena	Thia	Consultant in Paediatric Respiratory Medicine	Child Health	Yes	No	UHW	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
Low	Benny	Thomas	Consultant Neurophysiologist	Neuroscience	Yes	No		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
Low	Christopher	Thomas	Consultant Physician	Clinical Gerontology	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
Low	David Hywel	Thomas	Consultant Histopathologist	Histopathology	Yes	No	UHW	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
Low	Gareth	Thomas	Consultant in Gastroenterology	Gastroenterology	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
Low	Mary Annette	Thomas	Director Wegas	Wegas	Yes	No	Llanishen	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 2018.	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

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

Low	Matthew	Thomas	Consultant Restorative Dentistry	Dental	Yes		No	UHW	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	N/A	N/A	West Coast Dental Care - Self employed private practice	ongoing		Yes	Yes
Low	Nerys	Thomas	Radiographer	Radiology	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	N/A	N/A	PHW Ultrasound Advisor. 10 sessions per annum paid to radiology dept. No personal financial gain		none	Yes	Yes
Low	Alwen	Thomas	Independent Member of the Board	Executive / Corporate	Yes		No	Woodland House	Yes	N/A	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	N/A	N/A	N/A	Member of Glas Cymru Cyf (Welsh Water) Co-opted Board Director of Cardiff & Vale Credit Union	01.10.13 - present 15.05.20 - present	Voluntary Voluntary	Senior Lecturer - University of South Wales	04.05.20 - ongoing		Yes	Yes
Low	Rhian	Thomas-Turner	Clinical Research Facility Manager	Leeds Clinical Research	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	N/A	N/A	Office holder at MHRA - Paediatric Medicines Expert Committee	Ongoing	Expenses	Yes	Yes
Low	Andrew	Thorpinson	Psychologist	Mini Psychology Training	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	N/A	N/A	Occasional clinical psychology private practice (registered with HIMIC as a sole trader) - medico-legal reports, invited talks/teachings, occasional psychological therapy	Oct 20 - Ongoing	Yes	Yes
Low	Ryan	Trickett	Consultant	T&O	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	N/A	N/A	Private Practice - Vale Hand Surgery Ltd	2012-Ongoing	Few	Yes	Yes
Low	Ryan	Trickett	Consultant Head Surgeon	T&O	Yes	Yes	UHL			Dragon Locums		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	Spouse: Member BMA, RCGP	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	David	Tuthill	Consultant Paediatrician	Child Health	Yes		No	UHW	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 A Imerune on Pafloxta.	2021	Fee paid	Organiser of the South Wales Paediatric Allergy Update Course. I personally over the last 10 years. This meeting has been sponsored by a variety of pharmaceutical companies	2012 - Ongoing	N/A	I am a botard member of Medicines for Children	2006-Onwards	Nil	Cub Scout Leader	2008-Onwards	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Jonathon	Underwood	Consultant Physician	Infectious Diseases	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	Intermittent	Honoraria	On the executive committee and a trustee of the British HIV Association	2022 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	John	Urwin	Independent Member of the Board	Executives / Corporate	Yes		No	Woodland House	Yes	NED, Swansea Building Society Iqmaxx 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 Urwin 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, Cwmbrw Cwlfwlladwriaeth Ltd (Will step down shortly)	1.1.20 - ongoing 1.1.20 - ongoing	No salary No Salary	N/A	N/A	N/A	Yes	Yes
Low	Stephen	Ustun	Consultant Anaesthetist	Perioperative Care / Anaesthetics	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	N/A	N/A	Private Practice at Spire Hospitals	Mar 22 - Ongoing	Fees	Yes	Yes
Low	Judith	Van der Voort	Consultant Paediatrician	Paeds Nephrology	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	N/A	N/A	Clinical Support and consultancy to Chiesi (Phase 4 study) and Vifor (Iron Isomaltoside) re the Welsh medication group for inclusion of the medication to NHS Wales	2022	£1700 in total	Yes	Yes
Low	Akpot	Varghese	Consultant Clinical Geneticist	ABMGG	Yes	Yes	UHW	Yes	One of the directors of a ltd company - AppleMedics Ltd. Not linked to NHS or Cardiff & Vale UHB	01.01.2011 - 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	N/A	N/A	N/A	Yes	Yes
Low	Andrew	Vidgen	Consultant Psychologist	Mental Health	Yes		No	Whitchurch Hospital	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	private medico-legal work. Approximately 1.5 sessions / month outside normal working hours. Undertaken in Gwent area	Apr-17		Yes	Yes
Low	Andrew	Vidgen	Consultant Clinical Psychologist	Applied Psychology	Yes		No		Yes	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	N/A	N/A	N/A	N/A	N/A	N/A	Private medico-legal work. Approx 1.5 sessions mper month. Undertaken in Gwent area.	2022 - Ongoing	Fees	Yes	Yes
Low	Karen	Visser	Professional Unit Lead for Speech & Language	Community Child Health	Yes		No	Riverside Health Centre	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	Trustee of Community Music Wales	N/A	N/A	N/A	Yes
Low	Justin	Van Oppell	Consultant Cardiac Surgeon	Cardiac Services	Yes		No	UHW	Yes	Director - U & C Von Uppell Ltd	Nav 02	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	N/A	N/A	Yes	Yes
Low	Amar	Vrijhrd	Consultant Paeds Gastroenterology	Paediatric Gastroenterology	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	N/A	N/A	Private Practice Secretary for Private Practice	November - ongoing November - ongoing	Salary Salary	Yes	Yes
Low	Fiona	Walker	Head of Prescribing	Cardiff North and West Locality	Yes		No	Woodland House	2021	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	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Ruth	Walker	Executive Nurse Director	Executive	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	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	Yes	Yes
Low	Mark	Wardle	Consultant Neurologist	Neurology	Yes		No	UHW	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	N/A	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Jonathon	Watts	Senior Manager	Strategic Planning	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	N/A	N/A	Committee member of Whitchurch Hockey Club which has an interest in purchasing the land that CAVUHB are disposing of on the Whitchurch Hospital site	2022	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Peter	Welch	Senior Hospital General Manager Llandough/Barry	Executives / Corporate	Yes	Yes	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	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
Low	Richard	White	Consultant Radiologist	Radiology	Yes		No	UHW	Yes	Director of White Imaging Services Ltd	2022-Ongoing	Dividends	As per (a)	As per (a)	N/A	N/A	N/A	N/A	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 Radiologist with 4 Ways Healthcare Ltd	2020-Ongoing	Fees	Yes	Yes
Low	Simon	White	Consultant Orthopaedic Surgeon	Trauma and Orthopaedics	Yes		No	UHW	Yes	Director, Simon P White Ltd	2008 - Present	Nil	N/A	N/A	N/A	Educational contract with Zimmer Biomet	2018 - present	Annual lease	N/A	N/A	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
Low	Kelvin	Whalehouse	Consultant Neurosurgeon	Neurosurgery	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	N/A	N/A	Council Member for British Neurological Surgeons	N/A	N/A	N/A	Yes	Yes
Low	Rebecca	Whelan	Consultant Physician	EU Medical Boss	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	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Zoe	Whitlock	Head of Quality and Safety Improvement	Parent Safety and Quality Improvement	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	N/A	N/A	Development www.yourhotstick.co.uk . Since I work	2016 - ongoing	Nil	N/A	Yes	Yes
Low	Simon	Wilson	Consultant Vascular Surgeon	General Surgery	Yes		No	UHW	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	N/A	N/A	1 Trustee of Haven Homecare	2010 - ongoing	N/A	N/A	N/A	N/A	Yes	Yes
Low	Lauren	Whittington	Clinical Psychologist	CAMHS	Yes		No	St David's Hospital	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	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
Low	Joanne	Wilson	Deputy Director of Commissioning	Commissioning	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	N/A	N/A	Part-time lecturer University of South Wales	2021 - Ongoing	Fees	Yes	Yes
Low	Simon	Wilkins	Associate Editor Pharmacist	Therapeutics & Toxicology	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	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
Low	Ian	Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital	Yes		No	St David's Hospital	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	N/A	N/A	Tutoring with the Open University - Nursing	01/10/2020	Salary	Yes	Yes
Low	Matthew Gareth (Matt)	Williams	Nurse Manager	OOH Primary Care	Yes		No		Yes	Director and Safeguarding Officer of Pencoed Athletic Boys and Girls Football Club (a PLC)	2020 - 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	N/A	N/A	N/A	N/A	N/A	Occasional pitch side medical cover for Cardiff City Football Club - employed by Lubex Medical	2020 - Ongoing	Fees	Yes	Yes
Low	Paul	Williams	Principal Clinical Scientist	Therapies and Health Science	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	N/A	N/A	Yes	25.10.20 - 31.10.20	One off payment	Yes	Yes
Low	Claire	Wilson	Consultant Clinical Psychologist	Neuropsychology	Yes		No	UHW	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	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 medico-legal claim. I conduct medico-legal assessments for the courts. I do not take on any patients where there is a conflict of interests (e.g. on my NHS waiting list, a previous patient, or someone who might be referred to me, or are pursuing a claim against the UHB.	Sep 21 - Ongoing	Yes	Yes
Low	Katrina	Wilcock	Consultant Physician	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	N/A	N/A	Yes. I received travel grants and honoraria for talks from the following companies: Nagy, 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	N/A	Yes	Yes
Low	Zoon	Wong	Specialty Doctor in Paediatric Cardiology	Child Health	Yes		No	Childrens Hospital for wales	Yes	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	N/A	N/A	N/A	N/A	N/A	N/A	Employed by Independent General Practice Cardiff on a 0.2 WTE basis that I do for 8 hours per week An Children Heart Screening Day on behalf of the Welsh charity organisaion Welsh Hearts	Oct 2017 - ongoing Bird haven't done a session since October 2019	Fees	Yes	Yes
Low	Andrew	Wood	Consultant	Radiology	Yes		Yes	UHW	Yes	N/A	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	N/A	Occasional Lecturing Honoraria	Last date 2016	Fees	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Treasurer - Heart Research Fund Wales	2000 - Ongoing	N/A	N/A	N/A	Private Medico-Legal Cases	Current	Fees	Yes	Yes
Low	Karen	Wright	Clinical Endoscopist	Gastroenterology	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	N/A	N/A	Agency work in off duty time for an insourcing company.	2020 - Ongoing	payments	Yes	Yes
Low	Marcellus	Wulff	Consultant Anaesthesia	Perioperative Care / Anaesthetics	Yes		No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Research Cooperation (History of Technology) Cranger Company, Luebeck, Germany & Wood Library Museum, Schaumburg, IL., USA	2021/2022 - ongoing	No	Occasional sponsorship of conference and travel expenses	2021 - ongoing	nil secret	N/A	N/A	N/A	N/A	Welsh Medical Committee (Member)	2018 - 2021	No	N/A	N/A	Clinical private practice - Spire Hosp	2022 - ongoing	Fees	Yes	Yes
Low	Angela	Zaki	Consultant Cardiologist	Cardiology	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	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Yvette	Zelmer	Consultant Anaesthetist	Anaesthetics	Yes		Yes	Brockwer Clinic Ltd	Apr-18	Nil	Brockwer Clinic Ltd	Apr-18	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes

Report Title:	Internal Audit Recommendation Tracker Report				Agenda Item no.	7.6
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	06.09.2022
			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 and Assurance Committee ("the 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 Tracker").

The Tracker 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, 2021/22 and 2022/23.

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 increased from 91 individual recommendations to 115 during the period April 2022 to July 2022. The change can be attributed to the following:

- 25 entries reported as complete at the July Committee were removed from the tracker;
- 5 Entries related to the Arrangements to Support the Delivery of Mental Health Services (Advisory) Audit have been removed from the Tracker to be monitored offline. At the time of reporting 21 Advisory Recommendations continue to be tracked and are recorded as Partially Complete (5 in relation to the Arrangements to Support the Delivery of Mental Health Services review and 16 in relation to the IM&T Control and Risk Assessment review);
- A further 54 entries have been added to the tracker since July 2022.

The audit reports added to the tracker since July 2022 are:

- COVID 19 Vaccination Programme (Phase 3) Final Report (2 recommendations, 1 of which is complete)
- Health & Safety Final Report (3 recommendations, all of which are complete)
- Wellbeing Hub at Maelfa Final Report (6 recommendations, 2 of which are complete)
- Development of Genomics Partnership Wales Final Report (4 recommendations, 1 of which is complete)
- Network and Information Systems (NIS) Directive Final Report (4 recommendations)
- Welsh Risk Pool Claims Final Report (2 recommendations, 1 of which is complete)
- Nurse Rostering Children's Hospital for Wales, Children and Women's CB Final Report (5 recommendations (1 of which completed prior to committee), 4 of which have been added to the tracker and are reported as complete)
- Nurse Bank Final Report (8 recommendations, 4 of which are complete)

- Vaccination Programme – Phase 3 Delivery (2 recommendations)
- Recovery of Services and Delivery of the Annual Plan 2021-2022 (2 recommendations, both of which are complete)
- Risk Management Final – (3 recommendations, 2 of which are complete)
- Performance Reporting (Data Quality) (4 recommendations)
- ChemoCare IT System - Final – LIMITED (8 Recommendations)
- (2019/20) PCIC Adults CHC Adults Follow-up – Final (1 Recommendation)
- (2019/20) C&W Clinical Board CHC: Children Follow-Up Final (1 completed recommendation).

The last two entries have been added following a reconciliation exercise which identified that both had incorrectly been omitted from the register in 2020.

Advisory Reports

As confirmed above, the Advisory Arrangements to Support the Delivery of Mental Health Services review, which was shared with the Committee in July 2022 has been removed from the Tracker Committee to be tracked offline. At the time of writing, all tracked recommendations remain live and will continue to be monitored to establish whether best practice suggestions have been implemented.

Of the 115 recommendations listed within the Tracker, 31 are recorded as completed, 58 are listed as partially complete and 26 are listed as having no action taken or reported since the July Committee meeting.

Of those actions where no action is reported, 22 of the 26 relate to Audit Reviews shared at the July Committee. 4 of these are recorded as High Priority and will be flagged with relevant Executive Leads for updates prior to the November Committee Meeting.

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

There are currently 26 outstanding recommendations for 2019/20 and 2020/21, 8 of which are reported as complete. It is proposed that a review of the remaining 18 are subject to a targeted review in advance of the November Committee Meeting to ascertain whether or not the recommendations have been superseded or should be subject to a more up to date review to ascertain the present position.

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 and/or reflected in column I by an 'NA' entry.

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	14	2	3	31

Attached at Appendix 2 are summary tables which provide an update on the July 2022 position as of the 24/08/2022.

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 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 July 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

By maintaining an up to date Internal Audit Recommendation Tracker the Health Board mitigates the risk that it subject to legal or regulatory penalty.

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	

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 September 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	31.04.2020	PCIC Adults CHC Adults Follow-up - Final	R1/2	High	**Original Recommendation:** A timescale should be set to ensure the Head of Service Agreement is agreed promptly.	Interim Chief Operating Officer	Director of Nursing PCIC	PC	**Updated Management Response:** There has been significant progress with community stakeholders including Third sector providers, their legal representatives and Cardiff and Vale Local Authorities in developing an agreed contract process which will then lead to the updating of the Heads of service agreement. These discussions have been overseen by Regional Commissioning Board which has representatives from C&V UHB (PCIC and the Planning team) and both LA's. **UPDATE 12/8 •The Joint Contract was finalised and signed off in 2020** **•The new contract and service specification was fully implemented by October 2021 by both LA's albeit at slightly different times and is now fully implemented across the UHB footprint in alignment with the two LA timescales** **•The main overarching contract has been issued to all residential providers** **•There will be a review of implementation of the new contract in 2022 and the partnership team are working with the statutory partners to develop a quality outcomes based agreed joint contract monitoring process** **•Any proposed amendments to the contract are discussed and signed off by the Regional Commissioning Board of which I am a member on.**
2019-20	30.06.2020	C&W Clinical Board CHC: Children Follow-Up Final	R2/2	Medium	**Original Recommendation:** Individual Service User Agreements should be produced to cover health aspects of child residential placements and KPIs developed/expanded to monitor performance internally.	Interim Chief Operating Officer	Director of Nursing C&W	C	Testing identified that where appropriate, SLAs are in place between the Health Board and Continuing Care placement providers. Continuing Care KPIs have been developed and introduced within the Community Child Health Directorate during 2018/19 and these are also in place through to October 2019. However, there is no evidence that Continuing Care KPIs have been presented to the Directorate Performance Management meetings or any other Directorate group between April 2018 and October 2019 or to peers in neighbouring Health Boards. August 2022 - Work continues on the development of a local performance matrix for continuing care, however it is currently being reported through Business Meetings and Quality & Safety agenda within the Directorate. Work continues on National KPI's on an All Wales basis.
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. Meeting between BMA and Medical Director's team re-scheduled for June 2022. We believe dicussions are still ongiong, we will continue to chase for an update.
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	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. Meeting between BMA and Medical Director's team re-scheduled for June 2022. We believe dicussions are still ongiong, we will continue to chase for an update.
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. An initial review of the Health Board's current Policies Register (which details all of the policies and other written controlled documents held by the Corporate Governance Dept) has been undertaken by the Corporate Governance Directorate. A tracker has been produced which identifies all policies/other written controlled documents held on the Policies Register with corresponding Review Dates. All of those policies/other written controlled documents with an outstanding Review date having been coded "Red". A copy of current policies tracker has been sent to the Executive Directors for their individual review. Initial meetings with each individual Executive Director have been arranged to take place over the next few weeks so that each Executive Lead can feed back on how he/she intends to:- (i) identify which policies/other written controlled documents which fall to the respective Executive's Directorate require an urgent view together with proposed timescales relating to the same, (ii) identify which policies/written controlled documents may no longer be relevant/obsolete and/or have been superseded by new documentation, (iii) carry out a thorough cleanse of the documents to ensure correct terminology, fall to the most appropriate Exec Lead etc, (iv) determine which policies/other written contolled documents should be published on the Health Board's external website and/or Intranet site. As each Executive Lead undertakes his/her review of the tracker, the centrally held Policies Register will be updated accordingly. Given the scale of this piece of work, it is anticipated that the Executive reviews will be carried out in bite sized chunks with those policies/other written control documents which relate to patient safety taking priority. As such, it is unlikely that the action required to complete this recommendation will be fully completed until end of January 2023.

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 September 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	01/12/2020	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	as above
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	The Health Board's Policy and Procedure relating to Management of Policies, Procedures and other Written Control Documents (the "Policy on Policies") was recently reviewed/updated and was approved on 5 July 2022. This Policy on Policies sets out the Health Board's requirements for new/reviewed policies and other written controlled documents , including document format and templates, use of plain English, consideration of whether an Equalities Impact Assesments, a Health Impact Assessment and/or a combination of both should be undertaken. The Policy on Policies has been published and a copy was sent separately to each individual Executive to cascade to the relevant individuals within their respective departments. As part of the review being undertaken as highlighed above, each individual Executive is being asked to confirm the appropriate publication route per individual policy/other written controlled document (eg Health Board's external webiste , or its Intranet site and/or both). Once such confirmation is received, the Corporate Governance Team will update the website/Intranet accordingly. In order to improve the accessiibility of documents stored on the Corporate Policy Register, the Corporate Governance Department is undertaking some work with its archivist to enable staff (and, as appropriate, /members of the public) to be able to more easily locate policies/other written control documents.
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	C	Completed. The Corporate Governance Team has produced, and is using, a new and updated SOP which details how the team should attend to attend to requests to create new written contolled documents, from receipt to request to create, to issue of draft for consultation, maintenance of Corporate Policy Register.
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	C	Completed. As above. As part of the consultation process and in order to capture relevant / appropriate stakeholders, the consultation documents are sent to the Chairs of the CHC, the Stakeholder Reference Group and the Local Partnership Forum, in addtion to publishing the same via the Intranet.
2019-20	Mar-20	Charitable Funds	R1/3	High	Fund holders must be contacted and reminded that they should not allow funds to remain dormant and expenditure plans must be developed to ensure appropriate use of the funds. Where funds are not being utilised they should be reviewed and potentially re-allocated / transferred. To ensure there is a robust and adequate control system in place, the FCP should include more information on the treatment of dormant funds such as the requirement for periodic reporting and update of dormant funds and periodic exercises where dormant funds are reviewed by Finance etc.	Director of Finance	Deputy Director of Finance	C	This is a strategically important issue for the charity and a policy on the treatment of dormant funds will be specifically considered by the CFC/Trustee. This policy will consider these findings and recommendations.
2019-20	Mar-20	Charitable Funds	R2/3	Medium	Staff should be informed of the standardised documentation to be used for the completion of donations. Management should inform relevant staff and ensure they are aware that: The donation form should be adequately completed. Donation form copies should also be timely forwarded to the key departments responsible for the processing of the donations. Thank you letters should also be timely dispatched to the donors.	Director of Finance	Head of Arts and Health Charity	C	The Fundraising team will continue to engage with the Clinical Boards to ensure donation forms are completed correctly and submitted to the fundraising team within a timely manner.
2019-20	Nov-19	Charitable Funds	R3/3	medium	Management should remind key staff responsible for processing the Charitable fund expenditure to ensure that transactions have the required supporting documents and undergo the expected approval as stated within the Financial Control Procedure. All transactions entered into Oracle should accurately match their supporting documents.	Director of Finance	Charitable Funds Finance Manager	C	Staff will be reminded of the importance of ensuring that the correct supporting documentation exists at all times.
2019-20	Dec-19	PCIC Business Continuity	R1/4	Medium	Management should ensure that all Business Units and Service Areas which require a BCP produce a formally documented one as soon as possible.	Director of Operations PCIC	PCIC Business Manager	NA	PCIC Clinical Board management are aware that all Business Units and Service Areas have been involved in the BCP process although not all have a written document completed and approved. Reviews are planned or have taken place with all Business Units and finalised documents are anticipated to be received by the Clinical Board in November and December 2019. One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units.

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2019-20	Dec-19	PCIC Business Continuity	R2/4	Medium	Management should ensure all terms of references are reviewed and updated as required.	Director of Operations PCIC	Individual members of SMT / December 2019 Business Unit Leads / December 2019 PCIC Business Manager / November 2019	NA	PCIC Clinical Board Senior Management Team will ensure the terms of reference for any meetings they chair are reviewed and refreshed, and that future review dates are established. The Business Units will be advised to review the terms of reference for their established meetings and ensure they are refreshed if needed. This will also be added to the agenda for November 2019's PCIC Clinical Board Meeting, under a standing Governance update on Internal Audit.
2019-20	Feb-20	PCIC Business Continuity	R3/4	Low	Management should ensure that all members of staff are made aware of the existence of a BCP, the risk associated with possible occurrences and how to respond in such an event.	Director of Operations PCIC	Business Unit Leads	NA	Business Unit Leads will be asked to ensure that all Service Areas make all team members aware of the existence of a BCP, where the document is located, key risks for their Service Area, and their role in the use of the document.
2019-20	Jan-20	PCIC Business Continuity	R4/4	Low	Management will ensure that all service areas which require a BCP have their plans signed off.	Director of Operations PCIC	PCIC Business Manager	NA	One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units. The PCIC Business Manager maintains logs indicating the status of each BCP in the approval process and this will then form the basis of a tracker to ensure plans are reviewed on an annual basis within the Business Units.
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, Head of Financial Accounts and Services – 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. Since the last Committee meeting in July - Internal Audit has asked that this recommendation is verified before marked as complete
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	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	The Network Team use a product called Castle Rock (SNMPc Enterprise Products) This product provides active monitoring and alerting for the majority of networking devices. There are monitoring and alerts on the core / data centre networking in the main sites at CAVUHB and CRI. This has been expanded to Woodland Hosue and UHL in the past 12 months.

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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	C	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. The memorandum is a comprehensive parental agreement that sets out the role and expectations of the UHB and parents working together in partnership. August 2022 - MOU has been approved and virtual meetings will be offered to families on the return to schools in September 2022 and will be lauched as part of focus groups
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	31/12/2021	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.	Executive Director of Planning	Executive Director of Strategic Planning December 2021	C	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	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.	Executive 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	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.	Executive 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	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	C	Document to be formatted to usual UHB standard, with version control, date, authorising body.
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	1. An annual audit template has 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. This will be finalised at the next US Clinical Governance meeting on 29/06/2022 Opportunities to develop a digital audit tool will be explored with corporate IM&T teams. The online Ultrasound Training module will be uploaded to Learning@Wales in Sept 2022 and put on ESR at a later date (have been quoted 6-12 months for ESR upload). 2. Awaiting publication of the training module (Sept 22) 3. None 4. Report to Exec QSE June 2022
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	1. The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics, Critical Care and physiotherapy. Follow-up requests gone to all Clinical Board to ensure roles are in place 2. Delay in some resonses. 3. Lack of responses from some areas. Has been escalated. 4. Report to Exec QSE June 2022

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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. 15/6/22 - In progress. Investment was significanbtly less than required but has allowed for a Clinical Effectivness Lead to be appointed, which occured this week, this will increase capasity to move actions forward 8/8/22 A clinical audit strategy is under development and will be presented at the September CEC for ratification.
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. 15/6/22 - In progress. Investment was significanbtly less than required but has allowed for a Clinical Effectivness Lead to be appointed, which occured this week, this will increase capasity to move actions forward 8/8/22 AMaT (Audit Monitoring and Tracking) has been procured and will be implemented in C&W clinical board from the 12.9.22. Engagements events are ongoing with clinical boards regarding governance around clinical audit and a Clinical Audit Policy under development and will be presented at September CEC for ratification. A Clinical Effectiveness Lead that will lead on this work has been appointed and will start on the 30/8/22.
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. 15/6/22 . Investment was significanbtly less than required and will impact on the abilty to undertake some action is a timely way. Investment has allowed for a Clinical Effectivness Lead to be appointed (Interviewed this week) , and a Clical Effectivness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit traker and quality assurqnce system has been purchased The investment will allow actions to move forward. A phased approach over 1 year has been planned, Implementation to commence July/August 8/8/22 Clinical Effectiveness Lead starting in post 29/8/22, AMaT Officer in post. Engagements events are ongoing with clinical boards regarding governance around clinical audit and a Clinical Audit Policy and strategy is in draft which will be presented at September CEC for ratification. The Clinical Effectiveness Team is working with clinical boards regarding prioritising of Tier 2 audits and a guide has been developed and shared with the clinical boards.

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 September 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	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. 15/6/22 . Investment was significanbtly less than required and will impact on the abilty to undertake some action is a timely way. Investment has allowed for a Clinical Effectivness Lead to be appointed (Interviewed this week) , and a Clical Effectivness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit traker and quality assurqnce system has been purchased The investment will allow actions to move forward. A phased approach over 1 year has been planned, Implementation to commence July/August 8/8/22 Clinical Effectiveness Lead will start in post 30/8/22 AMaT officer in post. Superuser training on AMaT for the Clinical Audit team has commenced. Training in C&W clinical board will commence 12/9/22. The AMaT system has the functionality to monitor and track the quality assurance process from project to action plans and re -audit.

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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. 8/8/22 A survey has been developed and will be shared with clinical boards regarding Clinical Audit training needs. Training is in place for all health professionals to attend, currently there is limited capacity. The survey will evaluate staff understanding and training needs to prioritise and ensure that the training meets the needs of staff within the UHB.
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 8/8/22 AMaT (Audit Monitoring and tracking) has been procured, superuser training is in progress with the clinical effectiveness team. The system will be rolled out initially in C&W clinical board from the 12/9/22 The system will address governance issues around registering and approving clinical audits throughout the health board and ensure oversight of all clinical audit activity.
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 diffucult 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 15/6/22 . Development of Clinial Audit strategy and policy are in progress whcihb will include mandating aspects of the clinical aduit process, engagment with clinical boards and direcotrates underway. Investment was significanbtly less than required and will impact on the abilty to undertake some action is a timely way. Investment has allowed for a Clinical Effectivness Lead to be appointed (Interviewed this week) , and a Clical Effectivness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit traker and quality assurqnce system has been purchased The investment will allow actions to move forward. 8/8/22 AMaT (Audit Monitoring and tracking) has been procured, superuser training is in progress with the clinical effectiveness team. The system will be rolled initially in C&W clinical board from the 12/9/22 The system will address governance issues around registering and approving clinical audits throughout the health board and ensure oversight of all clinical audit activity. This will be mandated in the Clinical Audit Policy which will be presented in CEC in September for ratification

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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. 15/6/22 . Investment was significanbtly less than required and will impact on the abilty to undertake some action is a timely way. Providing direcotrates withg support and training will be very challenging as a result. This aspect will be reviewed as the second phase of the investment from the business case. Investment has allowed for a Clinical Effectivness Lead to be appointed (Interviewed this week) , and a Clical Effectivness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit traker and quality assurqnce system has been purchased The investment will allow some actions to move forward. 8/8/22 Implementation of AMaT in C&W will commence 12/9/22. Clarity of clinical governance arrangements for clinical audit will be made in the clinical audit policy which will be presented in CEC in September for ratification. The Clincal Effectivenss Group will hold a key role in the oversight and governance of loacl and national clincal audits and the progress of the improvement plans.
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 8/8/22 Several All Wales forums have been established to share good proactive between health boards include below. Information is discussed in CEC. • Welsh AMaT catch up • All Wales Health Board Quality-Safety and Effectiveness Learning Community • Clinical Audit and Effectiveness Group
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.

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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

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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	Staff will be reminded of the importance of ensuring that the correct supporting documentation exists at all times.
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 have written and completed a procedure titled 'Operating Theatre Scheduling, Cancellation and Utilisation' with the support of 'FourEyes Insight Ltd' This will be the 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 has been sent to all stakeholders that use the Peri-Operative Care service and attend the scheduling and utilisation meetings. **Update 11/08/2022 - This has been completed**. The SCB will continue to work with "Foureyes insight Ltd" until the end of June 2022 and the main focus will be on utilisation and efficiency. **Update 11/08/2022 - This programme has ended successfully.** The Directorate is writing 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 Perioperative 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; **Update 11/08/2022 - This has been completed.** - 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). **Update 11/08/2022 - This has been completed**.These policies/procedures will be available on the Health Board's intranet pages. **Update 11/08/2022 this is to be actioned.** The Policy and procedure will be found under the policies section within the PeriOperative 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. **Update 11/08/2022 - This is to be actioned**

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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	C	The policy on Operating Theatre Scheduling, Cancellation and Utilisation clearly states 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. **Update 11/08/2022 - Completed - The Theatres IT department email weekly reports to all directorates who use the operating theatre estate reminding them of their responsibility to accurately close down their theatre sessions. P Bracegirdle will verbally seek assurance of this action on a weekly basis during 6:4:2 SCRUM Process Meeting, Scheduling Meetings, Planned Care Performance and the newly formed Theatre Improvement Meetings.**
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	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	PC	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. Action plan templates are currently being drafted. Clinical Boards have begun to appoint Welsh language ambassadors
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	PC	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	PC	evelop, own and report upon progress at the ESWLSG meetings. Action plan templates are currently being drafted. Clinical Boards have begun to appoint Welsh language ambassadors
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	PC	The Equity and the Welsh Language Unit are participating in a resource assessment exercise to assess the workload / capacity of the current team.
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	In future ESWLSG meetings, Flash Reports are to be submitted by each Clincial Board detailing actions and work undertaken in their areas regarding the WL and ED&I agendas
2021-22	31.03.2022	Raising Staff Concerns (Whistleblowing)	R3/5	Medium	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.	Director of Corporate Governance	Head of Risk and Regulation	C	Agreed – Regular biannual updates will continue to be issued in conjunction with the Health Boards communications team. A series of communications pushes has been agreed which includes two drop in sessions during August and October which will continue monthly/bi-monthly moving forward.
2021-22	31.05.2022	Raising Staff Concerns (Whistleblowing)	R4/5	Medium	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.	Director of Corporate Governance	Head of Risk and Regulation	PC	Agreed – A cleanse of the Freedom to Speak up Log and Datix will be undertaken by the Head of Risk and Regulation - this has been slightly delayed following the introduction of a new DATIX system for which plans are being made to make F2SU entries appropriately confidential.

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2021-22	30.09.2022	IT Service Management (ITIL)	R1/8	High	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.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	1.1a June 2022 Update: A Business Case for additional staff within the IT support team In conjunction with a new ITIL compliant Service Desk software solution (Ivanti Service Manager – ISM), will allow CAVUHB to implement an ITIL based organisational chart. This process will begin from 16/06/2022 and is planned to take approximately 4-6 months. 1.1b June 2022 Update: The new Service Desk (ISM) implementation provides a digital front door which includes incident and problem management as well as service requests, change and asset management. There is a Self Service User Portal available on all CAVUHB issues devices. 1.1c June 2022 Update: 27x Staff have attended ITIL training with over 20x attaining the Foundation accreditation already. Further courses are scheduled every six months to train more Digital & HI teams. Advanced courses will be run annually based on demand.
2021-22	30.09.2022	IT Service Management (ITIL)	R2/8	High	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.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	2.1a June 2022 Update: CAVUHB continue to use the services of a dedicated Ivanti ITSM Implementation Expert. As part of the deployment Standard Operating Procedure documents have been implemented. A standalone and dedicated automation server has been installed and is waiting for configuration. June 2022 Update: CAVUHB are working with DHCW to allow the automation server access to Azure AD and the Ivanti Cloud Service. This work continues and is hoped to be completed by the end of June 2022. 2.1b - June 2022 Update: The ISM implementation now contains an FAQ and Staff Help portal which will continue to be developed and expanded as part of the product use.
2021-22	30.09.2022	IT Service Management (ITIL)	R3/8	High	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.	Director of Digital & Health Intelligence	Head of Digital Operations	NA	3.1a June 2022 Update: Automation 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 June 2022 Update: The majority of Free Text fields for call category, call type and priority fields have been removed. We have had to implement a small number of exceptions, as requested by two teams. 3.1c June 2022 Update: Call category, call type and priority fields are all mandatory when creating incidents and service requests.
2021-22	30.09.2022	IT Service Management (ITIL)	R5/8	Medium	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.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	5.1a - June 2022 Update: The creation of a Service Catalogue has begun all of the Digital Operations teams have been completed and some 40 have been created. As each team and department are onboarded to ISM their SRs are created. 5.1b - June 2022 Update: Basic SLAs have been associated to all Incidents and Service Requests. With the additional resourcing from the ,now approved staffing Business case, we will be in a position to implement reasonable SLAs and compliance reporting.
2021-22	30.09.2022	IT Service Management (ITIL)	R6/8	Medium	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	Director of Digital & Health Intelligence	Head of Digital Operations	PC	6.1a - June 2022 Update: High level SLAs have been configured within the new Service Desk. Built-in reports provide basically functionality. The need to have a dedicated reporting server is currently under review. 6.1b - June 2022 Update: Reference 6.1a Reporting Server.
2021-22	30.09.2022	IT Service Management (ITIL)	R7/8	Medium	7.1a A Problem Management process should be fully defined together with an associated SOP and guidance for staff.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	7.1a - June 2022 Update: Problem Management is scheduled to be implemented in Phase 2 ISM which forecast for July/Aug 2022.

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2021-22	15.08.2022	Covid-19 Vaccinatinon Programme - Phase 3	R1/2	Low	There is scope to undertake a formal lesson learnt exercise, now that the Health Board has progressed through a number of phases of the COVID-19 Vaccinations Programme. The exercise could focus on: How the Health Board has reacted to mobilise the Programme and subsequent plans; and How it has achieved objectives and aims with a particular focus on what has gone well across the planning and operational phase including the booking, data entry and logistics and deployment arrangements of the vaccine. The outcome of this exercise should be documented within a Lessons Learnt report with an action plan for improvement.	Executive Director of Public Health	Director of Ops, PCIC	PC	Update as at Aug 2022: A full review has not yet been undertaken and documented in a formal report. The main reason for this has been the loss of both the Head of Ops and the Deputy Head of Ops within the immunisation team (the new Head of Ops will start in post in Oct and the Deputy Head in Sep, there have been interim arrangements in place but this has not given sufficient time to undertake this and other actions). Resources within the team have also been required to decommission the MVC sites at Bayside and Splott and to establish the new MVC at Woodland House. There has however been learning discussed from the previous phases of delivery and this has been used to inform the planning and delivery of the Autumn boosters (scheduled to commence on 1 Sep 2022). There has also been an assessment of the workforce requirements.
2021-22	30.06.2022	Covid-19 Vaccinatinon Programme - Phase 3	R2/2	Low	To continue as planned, to ensure that the Health Board progresses further with the action plan to prepare for the COVID-19 Inquiry, particularly the arrangements for moving governance documentation into an online system for accessibility and controlled ownership.	Executive Director of Public Health	Director of Ops, PCIC	C	A Teams channel has been established where all core documentation is collated. The Head of Ops - Immunisation is responsible for ensuring relevant documentation is saved on a regular basis so it can be accessed, as required, by the inquiry team.
2021-22	6.06.2022	Health and Safety - Final	R1/3	Low	Looking ahead and once approved, the form of reporting against the 'Health and Safety Culture Plan 2022-2025' is to be considered, to ensure the Health and Safety Committee is offered assurance of the deliverables, whilst being sufficiently informed to provide challenge and scrutiny.	Executive Director of People and Culture	Head of Health and Safety	C	The Health and Safety Culture Plan has been added as an ongoing agenda item for the quarterly Health and Safety Committee meetings. A paper was submitted to the meeting on 19/07/2022.
2021-22	29.07.2022	Health and Safety - Final	R2/3	Low	To continue as planned to formalise and seek approval of the Health and Safety Culture Plan 2022- 2025, which will address the recommendations proposed within the external review of Health and Safety.	Executive Director of People and Culture	Executive Director of People and Culture	C	Health and Safety Culture Plan was approved by both Management Executives and the Board at their June and July 2022 meetings respectively.
2021-22	19.07.2022	Health and Safety - Final	R3/3	Low	To formally close the recommendations made within the external review of Health and Safety, the Health and Safety Committee should be informed and note the approach taken in instances where recommendations are not taken forward as proposed.	Executive Director of People and Culture	Head of Health and Safety	C	The Health and Safety Committee was formally informed of the approach taken not to compile a Health and Safety Charter or include 'Wellbeing' in the title of the department at the meeting on 19th July 2022.
2021-22	31.05.2022	Development of Genomics Partnership in Wales	R1/4	Low	The Project Director should provide written reports to the GPW Governance Board.	Executive Director of Planning	Project Director	PC	Agreed. Project monthly progress reports will be issued to GPW Governance Board as an appended paper for information.
2021-22	At future Projects	Development of Genomics Partnership in Wales	R2/4	Medium	2.1a Future Assurance The financial implications of approvals should be taken into account when determining from which UHB forum the approval should be sought, ensuring compliance with the UHB's Standing Orders and Delegation of Powers. 2.1b Future Assurance When briefing papers are prepared to seek approvals, it should be ensured that associated benefits and/or risks are highlighted to the relevant decision-making forum. 2.2 Future Assurance Whilst recognising that nothing can be done in this instance, when submitting future business cases for Board approval, members should be made aware of any deviations from the Welsh Government Infrastructure Investment Guidance, or increased risks to the UHB, in the approach being taken.	Executive Director of Planning	Project Director	C	2.1a Agreed. Approvals shall be directed to the appropriate forum in terms of financial delegated limits. 2.1b Agreed. Impact Assessment section within Template Report to Board and Committee to be populated with appropriate detail. 2.2 Agreed. See 2.1b
2021-22	At future Projects	Development of Genomics Partnership in Wales	R3/4	Low	3.1 Future Assurance Contracts should be in place before duties/works commence. 3.2 Future Assurance Letters of Intent do not represent good practice and should only be used in exceptional circumstances. 3.3 Future Assurance - Contracts should be dated at time of execution 3.4 Appropriate document control arrangements should be implemented for key documents such as those with contractual implications. 3.5 Management should continue to seek the early resolution of the Project Bank Account provision.	Executive Director of Planning	Project Director	PC	3.1 Recognising the legal advice received via NWSSP:SES, the UHB will seek to minimise the period between commencement of works and contract signature 3.2 It can be noted in this particular instance, the issued LOI makes specific reference to the provisions of the Contract under which it would be executed, providing a defined scope of works and a cap on total payment under the LOI further mitigating the risk to the Health Board. 3.3 Agreed. Contracts to be dated at point of execution 3.4 Agreed. Major Capital Project folder structure has been reviewed for implementation on existing and future projects. 3.5 Agreed. Risk and Assurance are currently agreeing approach to execution of PBA joining deed.
2021-22	Ongoing where appropriate	Development of Genomics Partnership in Wales	R4/4	Low	The UHB / Genomics Partnership's project risk register should be costed where appropriate.	Executive Director of Planning	Project Director	PC	Whilst it is common practice to cost the construction risk register under the NEC form of contract this approach does not necessarily translate across to operational and service risks.
2021-22	31.05.2023	Wellbeing Hub at Maelfa - Final	R1/6	Low	The terms of reference for both the Project Team and Delivery Group should be reviewed to identify a smaller number of key individuals to form the core membership; with individuals invited to attend as appropriate. Quorum requirements should be documented within the terms of reference.	Executive Director of Planning	Head of Capital Planning, Estates & Facilities	C	**Agreed.** The terms of reference will be reviewed by both the Programme Board and the Project Team and will be changed to reflect the positions of its members and not individuals by name. Whilst other individuals may be invited for specific discussions or input this approach should reduce the numbers. There will also be opportunity to send deputies if not available. **Agreed.** The above approach will enable the identification of quorum as it will be an agreed number from the core group.

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2021-22	31.05.2022 30.06.2022	Wellbeing Hub at Maelfa - Final	R2/6	Low	The governance structure of the workstreams should be reviewed to ensure meetings are held as required and attendance of members is improved. Standard processes within the workstreams should be established that highlights clear accountability for tasks; and that the individual tasks are SMART (Specific, Measurable, Agreed, Realistic and Timely).	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Support Manager	PC	**Agreed.** It is accepted that attendance at the workstream meetings was better in some than others; and the Project Director has relayed this view to o workstream group Chairs at the last project team meeting and asked that membership be reviewed to ensure attendance is improved. **Agreed.** Chairs of workstreams will be asked to provide verbal reports of progress against the tasks agreed which will be SMART.
2021-22	30.06.2022	Wellbeing Hub at Maelfa - Final	R3/6	Medium	The risk management processes operating at workstream level require review, to ensure risks are appropriately scored, managed and escalated (where applicable).	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Support Manager	PC	Agreed. Workstream Chair's have been requested to prepare risk registers for their respective areas and ensure that any high risks are brought forward at project team meetings for inclusion on the overarching risk register as appropriate
2021-22	April 2022 and ongoing	Wellbeing Hub at Maelfa - Final	R4/6	Low	The UHB should ensure delays in issuing Project Manager's Instructions are minimised.	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Manager	PC	Noted and this will be monitored. However, where there is delay this needs to be reported on the project team highlight report with the mitigation.
2021-22	n/a	Wellbeing Hub at Maelfa - Final	R5/6	Low	Further explanation on changes to the cost position should be included within the Monthly Highlight Reports	Executive Director of Planning	Head of Capital Planning, Estates & Facilities	PC	Actioned since audit fieldwork.
2021-22	April 2022 and ongoing	Wellbeing Hub at Maelfa - Final	R6/6	Medium	Payments should be made in accordance with contractual or legislative requirements.	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Manager	C	Noted and with the PBC now set up this should address this matter.
2021-22	31.12.2022	Network & Information Systems (NIS) Directive - Final	R1/4	Medium	Management should ensure that for all future annual self-assessments, records of discussions and information provided to and from the CRU are captured and retained.	Director of Digital & Health Intelligence	Head of Information Governance and Cyber Security	NA	1 We recognise and appreciate the importance of recording adequate evidence to support any self-assessment process and will where possible ensure that future assessments include further context which justifies the answers provided.
2021-22	n/a	Network & Information Systems (NIS) Directive - Final	R2/4	High	Management should ensure that the CAF is reviewed and accurately completed to include assessed status and justifications for each IGP and objective.	Director of Digital & Health Intelligence	Head of Information Governance and Cyber Security	NA	This was an oversight on one of the questions that has now been amended.
2021-22	Q3 2022/2023	Network & Information Systems (NIS) Directive - Final	R3/4	Medium	Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation.	Director of Digital & Health Intelligence	Head of Information Governance and Cyber Security	NA	The competition of our improvement action plan and adherence to this will be one of the first duties undertaken by the dedicated cyber resource, which we are currently recruiting to. We have the information required to develop this plan and the work needs to be appropriately scheduled / prioritise.
2021-22	n/a	Network & Information Systems (NIS) Directive - Final	R4/4	Medium	Management should ensure that the current cyber security risk (A4/0023) included within the Corporate Risk Register is reframed to reflect the high-level risks identified from the self assessment process	Director of Digital & Health Intelligence	Head of Information Governance and Cyber Security	NA	Risk register updated to reflect NIS and the international situation, both of which elevate the cyber risk.
2021-22	31.10.2022	Welsh Risk Pool Claims - Final	R1/2	Medium	Following the review of current processes, management need to ensure that the Concerns and Claims Management Policy (UHB 332) is updated and approved.	Executive Nurse Director	Assistant Director of Patient Experience	PC	The policy is in draft to include awaited confirmation of the updated national guidance. Policy will be ratified at October 22 Quality, Safety and experience committee
2021-22	31.05.2022	Welsh Risk Pool Claims - Final	R2/2	Medium	To continue as planned to seek reimbursement from the Welsh Risk Pool for the late invoices identified (Cases 3191, 3627, and 3652); and Consideration should be given to current reconciliation arrangements to ensure all relevant costs have been identified and captured.	Executive Nurse Director	Steve Monk, Losses and Taxation Accountant Suzanne Wicks, Head of Clinical Negligence Claims	C	The financial accountant will seek reimbursement for the late invoices captured during this audit. With immediate effect, the claims team will send a payments schedule captured on Datix to financial accounts when cases are concluded to assist cross reference purposes
2021-22	Immediate	Nurse Rostering: Children's Hospital for Wales (Children & Women's Clinical Board) - Final	R1/5	Medium	Prior to the transition to HealthRoster, the Neonatal Intensive Care Unit, C2, should document the approval of the off-duty rotas in advance of making them available to staff.	Interim Chief Operating Officer	Lead Nurses	C	Ward Managers are reminded of the importance of keeping training records for staff in relation to mandatory and core clinical skills training. This should be reviewed at least annually as part of the Value Based Appraisal processes and every 3 years as part of revalidation. Lead & Senior Nurses will regularly m+J88:J92onitor this activity. The Acute Child Health directorate will ensure that CAU/Seahorse are able to get education support from existing Practice educator resources within CH4W were required. August 2022 - In process of transitioning across to allocate. System in place for signing off rota.
2021-22	Immediate	Nurse Rostering: Children's Hospital for Wales (Children & Women's Clinical Board) - Final	R2/5	Medium	Prior to the transition to HealthRoster, Neonatal Intensive Care Unit, C2, should hold evidence of timely roster dissemination, by documenting the date within records held.	Interim Chief Operating Officer	Ward Managers	C	Recommendation discussed with both NICU and C2 management teams and agreement to record the approval of off-duty rotas through documentation of both approval date and dissemination date on them. This will soon be unnecessary in NICU with Acute Child Health being an early adopter site for Healthroster. August 2022 - In process of transitioning across to allocate. System in place for signing off rota.
2021-22	Immediate	Nurse Rostering: Children's Hospital for Wales (Children & Women's Clinical Board) - Final	R3/5	High	In line with the advice provided by the Health Board's Information Governance Manager, mobile messaging, via WhatsApp should not be used as a means of disseminating rosters. In wider instances where it is deemed on a case-by-case basis that there is a clinical need to use mobile messaging, clear parameters should be introduced.	Interim Chief Operating Officer	Ward Managers / Lead Nurses	C	Recommendation discussed with both NICU and C2 management teams and agreement to cease sharing of off-duty rotas through messaging platforms. This will soon be unnecessary with introduction of Healthroster. August 2022 - In process of transitioning across to allocate. In cases where mobile messaging is deemed necessary, staff informed of need to maintain confidentiality on disseminating rotas.
2021-22	Immediate	Nurse Rostering: Children's Hospital for Wales (Children & Women's Clinical Board) - Final	R4/5	Medium	Prior to the transition to HealthRoster, ward management must ensure that there is documentary evidence and approval of make up shifts, enhanced overtime, and all shift 'swaps'/changes.	Interim Chief Operating Officer	Ward Managers	C	Recommendation discussed with both NICU and C2 management teams and agreement to record the approval of approval of make up shifts, enhanced overtime, and all shift 'swaps'/changes. August 2022 - System in place.

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2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R1/8	Medium	Management should review the Temporary Staffing Department's procedural guidance to support the Nurse Bank, to ensure the resilience of the team, and to provide clarity of processes. Consideration should be given to the impact of the roll-out of HealthRoster on existing processes.	Executive Director of People and Culture	Executive Director of People and Culture	C	Review complete and revised processes and procedures have been implemented.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R2/8	High	The Assistant Director of Workforce Resourcing is to review the current structure of the Temporary Staffing Department, giving consideration to the resilience issues highlighted in this review, to ensure the Nurse Bank is operating effectively.	Executive Director of People and Culture	Executive Director of People and Culture	PC	Revised structure agreed to include changing the Professional Lead role to also become the deputy role. This is cost neutral and will be implemented when the current post holder retires in January 2023. Changes to other parts of the structure are also being proposed and will be implemented by the end of 2022.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R3/8	High	Management need to ensure that there is greater resilience within the Temporary Staffing Department, to ensure transactional functions do not come to a stop, due to the absence of one individual.	Executive Director of People and Culture	Executive Director of People and Culture	C	Processes have been articulated to reduce the reliance on specific individuals in the team. A number of the processes relating to the payment of invoices that had caused issues previously should not re-occur with the implementation of self billing and Allocate's Health Roster.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R4/8	Medium	The Health Board should draw on the experience from recruiting at pace during the COVID-19 pandemic, to reaffirm the most effective means of recruiting Bank staff, and where this is best placed.	Executive Director of People and Culture	Executive Director of People and Culture	C	All recruitmant processes have been fully reviewed and updated and both HCSW and Regististered Nurses are advertised on the first week each month and ae monitored via a performance management KPI.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R5/8	Medium	The Temporary Staffing Department's approach to engagement with service users, including ward management and bank staff requires a review, to ensure the team are continually striving to meet the needs of the Health Board, informed by service users. Engagement mechanisms used should be varied beyond face-to-face, to ensure the maximum reach	Executive Director of People and Culture	Executive Director of People and Culture	NA	This action is part of the TSD's action plan and will be implemented by the end of March 23 due to other actions needing priority.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R6/8	Medium	The operational management of the Temporary Staffing Department requires improvement. A personal file for all members of the team should be held by the relevant manager and updated in a timely manner, which should reconcile to electronic records.	Executive Director of People and Culture	Executive Director of People and Culture	C	Personal files are now held for all staff and are updated as appropriate. Administration manager has enrolled for sickness absence management course for September.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - LIMITED	R7/8	High	The Temporary Staffing Department is to maximise all available agency options via framework agreements, to ensure a greater fill rate, to support the safer operation of wards.	Executive Director of People and Culture	Executive Director of People and Culture	NA	This action is part of the TSD's action plan and will be implemented by the end of March 23 due to other actions needing priority.
2021-22	n/a	Nurse Bank (Temporary Staffing Department) - Final - **LIMITED**	R8/8	Medium	The Temporary Staffing Department are to engage with and remind ward managers of the requirement to verify agency shifts worked, until agency self-billing becomes an embedded process within the wards, to ensure timely payment.	Executive Director of People and Culture	Executive Director of People and Culture	NA	This action will commnece in the Autumn of 2022 and complete in accordance with the plan deadline of March 2023.
2021-22	15.08.2022	Vaccination Programme - Phase 3 Delivery	R1/2	Low	There is scope to undertake a formal lesson learnt exercise, now that the Health Board has progressed through a number of phases of the COVID-19 Vaccinations Programme. The exercise could focus on: How the Health Board has reacted to mobilise the Programme and subsequent plans; and How it has achieved objectives and aims with a particular focus on what has gone well across the planning and operational phase including the booking, data entry and logistics and deployment arrangements of the vaccine. The outcome of this exercise should be documented within a Lessons Learnt report with an action plan for improvement.	Executive Director of Public Health	Director of Operations, PCIC	NA	Whilst there has been review and learning undertaken throughout the delivery of the programme, we agree there would be merit in undertaking a lessons-learned exercise at the end of the current phase (Phase 4) of the programme which could help to inform the planning for future delivery, including the autumn booster programme.
2021-22	30.06.2022	Vaccination Programme - Phase 3 Delivery	R2/2	Low	To continue as planned, to ensure that the Health Board progresses further with the action plan to prepare for the COVID-19 Inquiry, particularly the arrangements for moving governance documentation into an online system for accessibility and controlled ownership.	Executive Director of Public Health	Head of Operations Immunisations	NA	A Teams channel has been established where all core documentation is collated. A lead will be nominated within the Operations team to ensure relevant documentation is saved on a regular basis so it can be accessed, as required, by the inquiry team.
2021-22	31.07.2022	Recovery of Services & Delivery of the Annual Plan 2021-2022	R1/2	Low	Within the governance arrangements for 2022/23 onwards, where slippage requires funds to be redirected, that information on where the funds have been reallocated to is included in the reports to the appropriate governance group.	Interim Chief Operating Officer	Recovery & Redesign Programmes Delivery Director	C	In reporting against the 2022/23 plan, any financial under or overspend will be included. Where slippage is identified, plans for deployment of slippage will be agreed and reported through the Operational Plan Delivery Group and on to Management Executives. August 2022 - Monthly Operational Plan Delivery Group (OPDG) meetings are in place and as part of the agenda a financial report is presented detailing the current spend against the programme and any forecast over/under spend. To date, the programme is not forecasting any underspend. Should there be any underspend anticipated in future months, plans to deploy slippage will be agreed via the OPDG.

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 September 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	from 1.07.22 throughout the year	Recovery of Services & Delivery of the Annual Plan 2021-2022	R2/2	Low	It is acknowledged that the Board Assurance Framework (BAF) will be redrafted for 2022/23 and that the risk reviewed is no longer relevant. However, future reviews of the BAF should ensure that the 'Gaps in Assurances' are updated as the risks evolve to reflect an up to date position.	Interim Chief Operating Officer	Director of Corporate Governance with relevant Executive Lead for BAF Risk	C	This question is now raised in each discussion with the Executive Lead therefore it will be important to ensure that Executive Leads reflect changes to the BAF in their discussion with the Director of Corporate Governance.
2021-22	31.12.2022	Risk Management - Final	R1/3	Low	Consideration should be given to the roles and responsibilities associated with the 'check and challenge' process of proposed corporate risks, beyond the Risk and Regulation Team, and whether there would be value in holding a risk management steering group.	Director of Corporate Governance	Head of Risk and Regulation	PC	It is agreed that consideration will be given to this recommendation albeit the ability to achieve this recommendation will, to a large degree be dependent on the availability of risk leads to meet to discuss and review their risks at an agreeable and consistent time. Discussions will be had with Risk Leads throughought August and Sepetember in person.
2021-22	30.09.2022	Risk Management - Final	R2/3	Medium	Risk owners should be reminded of their roles and responsibilities to ensure that the risk management information held within the risk registers is complete and regularly reviewed and updated.	Director of Corporate Governance	Head of Risk and Regulation	C	It is agreed that consideration will be given to this recommendation albeit the ability to achieve this recommendation will, to a large degree be dependent on the availability of risk leads to meet to discuss and review their risks at an agreeable and consistent time. Discussions will be had with Risk Leads throughought August and Sepetember in person.
2021-22	1.07.2022	Risk Management - Final	R3/3	Low	Continued efforts should be made to provide risk management training to risk owners, to maintain momentum of risk management maturity within the Health Board.	Director of Corporate Governance	Head of Risk and Regulation	C	Recommendation Agreed – Training continues and will continue to be provided to staff both proactively through offers for training, and reactively in response to specific requests. Training has during July, August and September been agreed with Risk Leads in corporate directorates and clinical boards alongside directorate leads in Speech and Language Therapy and Obstetrics & Gynecology.
2021-22	30.09.2022	Performance Reporting (Data Quality)	R1/4	Low	To continue as planned to finalise and seek approval of the 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting'.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	NA	The content of the "Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting" has changed considerably recently and will continue to evolve as we test the effectiveness of the report with Board members. To support future content changes, we will refine our process to ensure this is clearly documented and shared with all executive director leads and their staff
2021-22	30.06.2022	Performance Reporting (Data Quality)	R2/4	Medium	The quality assurance arrangements of the Integrated Performance Report should be reviewed to ensure processes are in place to mitigate the risk of the anomalies highlighted within the audit sample.	Director of Digital and Health Intelligence	Information Manager	NA	Where no source information or data are available a standard message or indication (with an asterisk) of "No information or data available at source" will be used. With regards to decimal place accuracy, we will seek advice from the relevant leads for individual measure accuracy and introduce a new quality check.
2021-22	30.06.2022	Performance Reporting (Data Quality)	R3/4	Low	Consideration should be given to risk assessing the defined indicators within the Balanced Scorecard, to identify those at greater risk of error. Appropriate quality assurance arrangements should be defined to mitigate the potential risk of error.	Director of Digital and Health Intelligence	Information Manager	NA	The compilation of the report is mainly a manual administrative task with limited automation. We have introduced additional quality assurance tasks to reduce administrative error.
2021-22	30.06.2022	Performance Reporting (Data Quality)	R4/4	Medium	In keeping with managements intention to further develop the Balanced Scorecard and Integrated Performance Report, the audit observations should be addressed in future reporting periods to enhance the completeness and transparency of the report.	Director of Digital and Health Intelligence	Information Manager	NA	We have accepted your recommendations and have implemented steps to mitigate these risks. For example, we have expanded on the indicator labels to ensure those people with limited knowledge of these can understand these and we will indicate where a target is inappropriate or not required for an indicator. We have also introduced a new quality check.
2021-22	Start Log July 2022 with first annual review July 2023	ChemoCare IT System - Final	R1/8	Medium	1.1 A formal supplier's performance monitoring mechanism should be established within both Adult Haematology and Paediatric services to ascertain that there are no frequent and significant breeches of SLA. 1.2 Outcome of the performance review should be periodically shared with the Shared Services Procurement team, as required by the procurement manual. 1.3 If possible, penalty clauses should be agreed with the supplier during the subsequent contract renewal process.	Director of Digital and Health Intelligence	Paeds System	NA	1.1 Create SLA breech log with annual review of this. 1.2 Annual review can be shared with Shared Services Procurement team. Will commence post-implementation of Version 6. 1.3 Penalty clauses will be discussed at next contract renewal (there is a national procurement process underway)
2021-22	Complete in UAT go live July 2022 Complete in UAT go live July 2022 September 2022 September 2022 September 2022	ChemoCare IT System - Final - **LIMITED**	R2/8	High	2.1 Windows servers should be upgraded to versions for which support is available; 2.2 SQL Server 2008 R2 should also be replaced with new versions for which support is available; 2.3 Database authentication should be moved to Windows authentication; 2.4 User passwords should be encrypted within the database; 2.5 The core user account should have the dba role removed and a more appropriate user access role defined; and 2.6 Database management tasks should be defined and regularly undertaken, this should include review and clear out of the error table.	Director of Digital and Health Intelligence	Gareth Richards (Server Manager) Gareth Richards (Server Manager) Kerry Crompton, David Trigg / CIS Kerry Crompton, David Trigg / CIS Kerry Crompton, David Trigg / CIS	NA	2.1 As part of the chemocare upgrade to version 6 Windows servers OSrs have been replaced with a version which is supported i.e Windows 2016 2.2 As part of the Chemocare upgrade to version 6, SQL Server 2008R2 has been replaced with a version which is supported. i.e. SQL Server 2019. 2.3 Discussion with the supplier and service will take place post upgrade to understand if this is doable. 2.4 Not required if using Windows Authentication (as suggested in 2.3). 2.5 Discussion required with the service and supplier. 2.6 Discussion required with the service and supplier.

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 September 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	July 2022 (Allowing 2 months of user groups to discuss, agree and implement)	ChemoCare IT System - Final - **LIMITED**	R3/8	Low	Individual user training logs should be signed off and archived for record purpose	Director of Digital and Health Intelligence	David Trigg (Adult Haematology)	NA	Electronic training log to be completed for all current users and updated training logs to be signed reflecting appropriate training for current users. Reporting module to be used to establish current list of active users. Discussions with system managers at both CTM and AB UHB's to ensure training logs completed locally and fed into central database of active users.
2021-22	May 2022 April 2022 April 2022	ChemoCare IT System - Final	R4/8	Medium	4.1 The new user form should be updated to reflect the current roles, and the process as set out in the SOP should be followed for new user accounts; 4.2 Generic accounts must not be used and identified accounts must be replaced with unique users. If any account is not required, then it should be deleted; and 4.3 A process for periodic reconciliation of staff leavers to users should be established to ensure that accounts are deactivated on a timely basis.	Director of Digital and Health Intelligence	Kerry Crompton (for paediatric system) David Trigg (Adult Haematology)	NA	4.1 Update SOP to reflect all current roles. This will need to be done separately for adults and paediatrics as the roles differ slightly. 4.2 All generic accounts archived on the paediatric system. 4.2 Time to archive user accounts will be reduced from 180 days to 90 days within the paediatric system to reduce the risk of staff who have moved on still having access to the system.
2021-22	30 April 2022	ChemoCare IT System - Final	R5/8	Medium	Password controls should be set to enforce a level of complexity, with a minimum length of 8 and with a standard use and re-use time.	Director of Digital and Health Intelligence	Kerry Crompton (for paediatric system)	NA	Paediatric system updated to reflect practice of adult system. Minimum of 8 characters.
2021-22	31 July 2022	ChemoCare IT System - Final	R6/8	Medium	System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.	Director of Digital and Health Intelligence	Kerry Crompton (for paediatric system) David Trigg (Adult Haematology)	NA	Will look at this as part of the V6 upgrade and ensure an auto alert system is in place.
2021-22	31 July 2022	ChemoCare IT System - Final	R7/8	Medium	7.1 HBAs should be updated and signed by the relevant department. Also, monthly back-up report should be sent to the relevant department; and 7.2 A schedule for testing the backups to restore should be established.	Director of Digital and Health Intelligence	Server Manager (Gareth Richard	NA	7.1 BCP will be reviewed as recommended.As part of the ChemoCare upgrade all HBAs will be updated to reflect the new infrastructure and signed by all relevant parties. 7.2 As part of the HBAs review, a backup regime will be agreed and a plan to restore agreed.
2021-22	31 August 2022	ChemoCare IT System - Final	R8/8	Medium	The identified gaps should be taken into consideration at the time of the next BCP update once the version 6 goes live.	Director of Digital and Health Intelligence	Kerry Crompton (for paediatric system) David Trigg (Adult Haematology)	NA	BCP Will be reviewed as recommended

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

	Update September 2022				Update September 2022				Update September 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		2	2			2	4	2		2		2
No date set												
Total	**4**	2	2		**8**	2	4	**2**	**4**	2		**2**

Total number of recommendations outstanding as of 24th August 2022 for financial year 2019/20 is 16 (6 of which are complete) compared to 24 outstanding recommendations noted at the July 2022 Audit and Assurance Committee Meeting.

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

	Update September 2022				Update September 2022				Update September 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												
Overdue over 6 months under 12 months						1	5			1	3	
Overdue more than 12 months												
Total					**6**	1	5		**4**	1	3	

Total number of recommendations outstanding as of 24th August 2022 is 10 (2 of which are listed as complete) compared to the position in July 2022 when a total of 13 outstanding recommendations were noted.

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

	Update September 2022				Update September 2022				Update September 2022			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached		2	3	4		9	4	6			5	1
Overdue under 3 months							1			8	3	4
Overdue by over 3 months under 6 months			5			3	13	7			3	
Overdue over 6 months under 12 months			2				3				1	
Overdue more than 12 months										1		
Total	**16**	2	10	4	**47**	12	22	13	**26**	9	12	5

Total number of recommendations outstanding as of 23nd June 2022 is 89 (23 of which are listed as complete) compared to the position in July 2022 when a total of 54 outstanding recommendations were noted.

Report Title:	Audit Wales Recommendation Tracking Report				Agenda Item no.	7.7	
Meeting:	Audit and Assurance Committee	Public	x		Meeting Date:	06.09.2022	
		Private					
Status *(please tick one only):*	Assurance	x	Approval		Information		x
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 and Assurance Committee ("the 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:

The Tracker records 24 Audit Wales recommendations brought forward from the Audit and Assurance Committee in July which are all partially complete. This represents an increase of 7 entries which are attributable to the 'Review of Quality Governance Arrangements' Audit which was presented to the July Committee meeting. The status of the recommendations are as follows:

- Three recommendations are 1+ year's overdue with one showing no date specified
- Two are 6+ months overdue
- Five recommendations are greater than three months
- One recommendation is under three months overdue and
- Thirteen of the recommendations are on target to be completed on the agreed implementation date.

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

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in 19/20, 20/21 and 21/22 as at 23 August 2022.

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	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	
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	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
By maintaining an up to date Audit Wales Audit Recommendation Tracker the Health Board mitigates the risk that it subject to legal or regulatory penalty.
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:

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

External Audit	Complete	No action	Partially complete	0 mths	< 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	-	-	4	1	1	2		-	4
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
Structured Assessment 2021 (Phase 2)	-	-	1		1	-	-	-	1
Taking Care of Carers	-	-	6	5	-	1	-	-	6
Review of Quality Governance Arrangements	-	-	7	7	-	-	-	-	7
Total	**-**	**-**	**24**	**6**	**1**	**5**	**2**	**3**	**24**

From the above table it can be seen that since the last report to Committee in July 2022, 7 recommendations attributed to the 'Review of Quality Governance Arrangements' have been added to the tracking report. The number of recommendations currently stand at 24 which are all partially complete. There are three outstanding actions which are 1+ years overdue with one indicating no date specified for completion, two are 6+ months overdue, one is less than three months overdue and four are greater than 3 months overdue. Thirteen actions have not exceeded their agreed implementation date.

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. **Aug '22 Update** An internal audit plan has been approved to undertake a tracking audit - * Fieldwork - September 2022 * Audit Completion - December 2022
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 – 2 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet. One case requiried a face to face meeting which had not been possible due to Covid, meeting was held at the end of May 2022 with written negotiation now in process. The other claim was awaiting correct legal authority which has now been received and claim is progressing through negotiation process.
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	Denis Williams	PC	POAC was succesful in securing additional investment through recovery monies to increase POAC activity. Through this investment a number of additional staff have been appointed. The POAC service will move into a resdesigned facilitity to support POAC flow in June 2022. Work with external partners "Foureyes" to review the POAC service has gone well with a focus on booking, clinic flow, standardisation of clinic templates with the aim to reduce preventable cancellations. Once the services is fully embedded in the new facility there will be a focus on increasing the number of booked clinics vs walk in. We are also developing electronic POAC documentation with a view to being paperless to increase efficiency. **11/8/22 POAC have successful moved into their new facility, good progress on the electronic POAC documention ongoing planning on increasing capacity when service is fully embedded**
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	The regular 2:1 Theatre Managerand Lead Nurse/General Manager meetings and the regular 2:1 Clinical Leader, Lead Nurse and General Manager meetings will continue for the forseeable future. 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. Update 17/08/2022 - These meetings occur on a regular basis, are scheduled in advance either monthly or bi-monthly and are well attended. There are agendas and minutes are recordrd that are fed back during Directorate Management Team Meetings by each of the Theatre Managers. Actions are discusssed and closed when completed. THIS RESPONSE CAN BE CLOSED Workforce Manager appointment was made 20/12/2022. 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 has been implemented and progress will be monitored. Update 17/08/2022 - The current status of main focus/priorities that are disciussed at the bi-weekly Directorate Management Meeting and 1:1 with the General Manager are 1) General establishment review, continual progress and good practice is being made that also links in with the whole workforce structure project 2) Band 7 Anaesthetic Associate role - The JD has been finalised and the role will be discussed at the All Wales Recruitment Meeting before approching the Executive Board for funding approval (awaiting update) 3) Work continues to progress well to recruit additional Anaesthetic Pactitioners 4) The Workforce Manager continues to work closely with the Cardiology and Trauma & Orthopaedic Theatre Teams to resolve ongoing cultural and stafing behaviours and this work will be completed by end of September 2022. THIS RESPONSE IS ALMOST COMPLETED 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. Update 17/08/2022 - The booklet has been provided to all Clinical Leaders who have all completed this work. This document will be discussed at each Value Based Appraisal on an annual basis and any issues addressed as appropriate. THIS RESPONSE CAN NBE CLOSED.

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
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. June 22 Update: a programme for digitally enabling the entire workforce is being developed, focussing initally on nursing staff, provide NADEX and email accounts to them, starting in September 2022 to support the imlpemention of the Welsh Nursing Care Record. the aim is to extend to all staff during 2022/23. Aug '22 Update: Roll out of additional devices to nursing staff on track to commence September 2022.
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 decommissioning 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 dedicated Ivanti patch management solution. A new Anti-Virus solution has been implemented for the CAVUHB server estate in Dec 2021. June 2022 Update: Work continues to identify legacy server operating systems. This progress is affected by the patient and clinically critical systems/applications existing on them. AV has now been deployed to all servers and a patching/maintenance windows are being agreed with departments and services. All CAVUHB Workstations will have been migrated to Win10 before end June 2022. Aug 2022 Update - Over 75% of the existing server base has AV installed. All new servers now have McAfee AV installed by default. All compatible servers have the base AV agent on and the team is working with the clinical boards and departments to agree maintenance windows. Less than 75 Windows 7 machines remain the project is expected to completed by Sept 2022.
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 updated as part of a programme 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. June 2022 Update: A comprehensive audit of all backups and associated devices has been completed. New disk based storage totalling 1.5PB has been procured. Implementation of this new backup solution is planned for July/Aug 2022 working with HPE consultants. Aug 2022 Update - A comprehensive review of CAV server backups has been completed. CAV are in the final stages of consolidating on a single backup vendor/product. Deployment of the new HPE storage will follow this backup work, both are expected to be completed by Dec 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. June 2022 Update: The Change Control module with Ivanti has been configured and is going through UAT testing and approval. It is expected to be completed and fully "Live" by the Mid to late July 2022. Aug 2022 Update: Ivanti Change Control has been deployed in UAT and tested successful. The adoption of Digital teams using Ivanti has delayed the go live for Change Control which is now expected by Sept 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 datacentres 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. June 2022 Update: Additional HPE Servers and storage DR hardware has been procured as part of the 21/22 capital allocation. UHL has been confirmed as the Primary DR location for CAVUHB, a secondary localised contingency location in Woodland House has also been identified. New cabinets will be installed and appropriate electrical/UPS protection work is scheduled for June/July 2022. Both locations are expected to in use by Aug 2022. Aug 2022 Update: New UPS devices for UHL, Woodland House and CRI have been procured. Cabinets have been delivered and further electrical work is required in Woodland House and UHL before DR sites can be setup. In the interim a small impementation of DR servers have been installed in Woodland House. Electrical work expected to be completed by Sept 2022 with DR capability in WH by Oct and UHL Dec 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
2021-22	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 which include UHB-wide interventions (e.g. supporting the capacity of the Employee Wellbeing Services; wellbeing conversations promoted as part of VBAs and regular 1-2-1s; effective inductions) and targeted pieces of work (e.g. Shwartz Rounds; Med TRiM, hydration stations and staff rooms and Wellbeing Retreats). The overarching framework for this is the People and Culture plan which has been informed by colleague feedback, data and the Health Intervention Report (specifically in relation to staff wellbeing). 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, and monthly flash report highlight progress in each area, with regular updates to the Strategy and Delivery Committee, Local Partnership Forum; Strategic Wellbeing Group and Strategic Portfolio Steering Group. With COVID Restrictions being removed by Welsh Government, including the requirement to 'shield', the organsation has communicated guidance to staff via national guidelines which can be found at https://gov.wales/public-health-advice-employers-businesses-and-organisations-coronavirus-html . The People and Culture Team continue to porvide support and guidance to managers to manage risk in more complex situations. Work is currently under-way to further support and enhance the focus on staff wellbeing, with the development of a health and wellbeing framework.
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 continues to take its toll on both the delivery of services and the wellbeing of our staff. With many COVID restrictions lifted, the challenges of increasing service demand, waiting lists and financial strain continue. The People and Culture Plan sets out the themes we will focus on 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. The specific developments under the People and Culture Plan are reported upon monthly and progress is documented in a flash report. Ongoing review of actions and priorities continue, informed by direction provided by WG, feedback from colleagues and workforce data. Recent engagement exercises with staff have included a Wellbeing Survey for the Medical Workforce (closed 31st July 2022), and the launch of a three month engagement platform (Winning Temp) aimed at our Nursing and Midwifery Staff and ODPs. Feedback from these exercises will inform response and priorities to ensure safe, effective and high quality healthcare.
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	The People Health and Wellbeing Services Team, which includes Occupational Health, Employee Wellbeing Servies, Health Intervention and Physiotherapy Services, are developing effective means of measuring both delivery of services (e.g. Counselling appointments; Pre-Employment Health Checks); and impact of those services. This information is being developed to be incorporated into a quarterly report which will also feed the progress reports on the People and Culture PLan. Base-line information is collated in all areas where targeted interventions are being developed, to ensure an effective means of measuring impact and outcomes. The development of the Wellbeing Framework will also incorporate tools and templates to ensure that interventions, projects etc are effetcively measured. The People and Culture Team are working with Innovation and Improvement to shape monitoring and evaluation.
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	Recent developments in this area include Cardiff and Vale's participation and involvement in the All Wales Staff Welfare Group, looking at ways to support and improve the wellbeing of NHS colleagues across Wales. Part of this involvement is the sharing of the work CAV are doing around Wellbeing Retreats; hydration and physical environment work. Work continues to progress, and the UHB now has representation on the working groups that have stemmed from the over-arching steering group.
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 - latest update 03/08/2022 Ongoing evaluation of staff wellbeing offer, including access, impact and value awaiting OH Services evaluation. 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 ; EHIA completion to support policy / process and decision making - EHIA Process currently being reviewed in partnership with Innovation and Improvement Team to embed in organisational programmes of work. 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). MES Workshops took place in March and April 2022, follow up focus groups scheduled for June and July 2022 led by the Medical Director and AD of Organisational Development. Wellbeing Survey for Medical Workforce going live in June 2022. Winning Temp engagement platform being trialled with all Nursing and Midwifery staff opened w/c18th July 2022, open until mid October 2022, enabling weekly 'check ins' and temperature checks. Communication plan in development to be shared with staff to manage expectations and provide regular updates. Wellbeing retreats have started, two held to date - informal feedback very positive with further engagement to obtain more meaningful feedback scheduled for September 2022 working with The Fathom Trust. Analysis of the Medical Workforce Wellbeing Survey to be carried out in August 2022. This information to be triangulated with other engagement outputs (MES; other surveys) to inform wellbeing priorities via the Executive Medical Director. Work also commencing on Anti-Racist Wales Action 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	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 - planned for October 2022 (as per information from HEIW) •Medical Engagement Scale - follow up online engagement sessions in March/April 2022; focus groups and visits to targeted areas planned in June/July 2022 and a follow-up wellbeing survey to all Medical Workforce June-August 2022 •Freedom to Speak Up - CAV part of all Wales working group •HR Processes and Procedures •Respect and Resolution Policies and Procedures •Trade Union Representatives •Existing Staff Networks – LGBTQ+; One Voice (Black, Asian, Minority Ethnic); Long Covid; Access Ability Network launched April 2022 •14,000 voices campaign (on-site visits / staff groups / teams etc) •Live, online 'Ask the CEO / Exec etc' sessions held bi-monthly •Applied engagement aligned to specific strategic projects, e.g. Shaping our future clinical services
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.
2022	Sep-22	Review of Quality Governance Arrangements	R1/7	The Surgery Clinical Board and Surgical Services Directorate revised their quality priorities in response to the COVID-19 pandemic. However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. The Health Board, therefore, should ensure there is better alignment between operational and strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.	Executive Nurse Director	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality		To work with all Clinical Boards to agree the QSE priorities aligning to the framework and Annual Plan and to the IMTP. Develop generic and specific Quality indicators aligned to the QSE Priorities in the QSE framework for Clinical Boards which are reported through QSE structure. and QSE Committee. These will be reported by exception as required and in totality at their scheduled presentation to the Committee.
2022	Oct-22	Review of Quality Governance Arrangements	R2/7	Risk management There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.	Director of Corporate Governance	Head of Risk and Regulation		a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality Safety and Experience Committee. b) The Health Board's Risk and Regulation Team operate a check and challenge system to manage the escalation and de-escalation of risks from the Corporate Risk Register. Training is also provided to risk leads to improve the detail recorded within risk registers. Both areas remain a work in progress and will continue to be implemented and improved.
2022	Oct-22	Review of Quality Governance Arrangements	R3/7	Clinical Audit The Health Board is developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to capacity and IT system challenges within the Clinical Audit Team. Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021 and gave a limited assurance rating, identifying several key matters that need to be addressed. Whilst the Health Board is making some progress in this area, it should: a) complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits informed by areas of risk. This plan should be approved by the corporate Quality, Safety and Experience Committee and progress of its delivery monitored routinely; and b) ensure that recommendations arising from the Internal Audit review of clinical audit are implemented as a priority.	Executive Nurse Director	Head of Quality Assurance & Clinical Effectiveness		The Clinical Audit Plan is to be shared at the Audit and Assurance Committee and discussed at the October QSE Committee meeting. The plan will reference all of the actions from this report. Compliance with internal audit findings will continue to be monitored via the Audit and Assurance Committee. Some investment has been provided to Clinical Audit from in year one form the internal Business case (monies to be provided over a 3 year period). Posts are being recruited into - investment was provided for a Clinical Effectiveness lead Band 8a and an Audit co-ordinator band 5. Additional resource was provided for a band 5 post to support the AMAT programme. AMAT - Audit management and tracking system has been purchased and is being rolled out through a phased implementation

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
2022	QSE Framework to 2026 May 2023 Project plan completion October 2022	Review of Quality Governance Arrangements	R4/7	The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses, incidents, and raising and listening to staff concerns. The Health Board, therefore, should undertake work to understand why some staff feel: a) that their mistakes are held against them or kept in their personal file; b) that the Health Board does not provide feedback about changes put into place following incident reports or inform staff about errors that happen in their team or department; and c) they don't feel free to question the decision or actions of those with more authority and are afraid to ask questions when something does not seem right .	Executive Nurse Director	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme		A safety culture with a focus upon psychological safety is an enabler of the QSE Framework. Members of the team are undertaking an IHI (Institute for Healthcare Improvement) Leadership course, and their focussed piece of work will address these issues. A project plan is being developed and will be part of the QSE implementation of the framework Culture surveys and feedback will be part of the evaluation with our quality metrics and will be undertaken annually in quarter 4 to assess whether values and behaviours have improved. Work will be aligned with organisational development colleagues supported through the people and culture plan.
2022		Review of Quality Governance Arrangements	R5/7	**Personal Appraisal Development Reviews (PADRs)** The Health Board compliance rate for appraisals is consistently below the national target of 85%. The Health Board reports that operational pressures are adversely affecting compliance and enabling work has not delivered the level of improvement anticipated over the COVID-19 pandemic period. The Health Board, therefore, should take appropriate action to improve performance in relation to PADRs at both corporate and operational levels.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture		The UHB has recognised the issue regarding VBA compliance and an improvement plan has been put in place focusing on communication and engagement, training and support and the impact on staff wellbeing and performance outcomes. This improvement plan has been developed with Trade Union Partners and will be delivered in collaboration with TU Partners. Recognising ongoing service pressures across the UHB as we manage the pandemic recovery phase and ever increasing service demands, the UHB target is to increase compliance to 50% in 2022/23, followed by a target of 85% in 2023/24. These KPIs are reflected in the People and Culture Plan and are reviewed monthly. A focus on promotion and engagement of the new VBA approach (launched in 2019), will develop manager capability and team buy-in through effective and accessible training and development, engagement and support, including development in delivering an effective VBA, the importance of
2022	May 2024 September 2022 October 2022	Review of Quality Governance Arrangements	R6/7	**Resources to support quality governance** Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational	Executive Nurse Director	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality Executive Nurse Director	C	The increase in concerns remains significant and resource is an issue There has been some investment through the Business case which is spans a 3-year period Management of resources through the pandemic was challenging for the Infection Prevention & Control team. However as the pandemic reduces the focus for the IPC team is back on normal tier 1 IPC targets, we are now seeing the move back to normal business. Active recruitment also in place to recruit to outstanding vacancies. Recently surgery clinical Board have a dedicated QSE nurse who liaises with corporate teams The corporate team will work with the clinical board to identify QSE leads and responsibilities with an exercise to identify the time required to effectively deliver these agendas
2022	Aug-22	Review of Quality Governance Arrangements	R7/7	**Monitoring and Reporting** There is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. Furthermore, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate Quality, Safety, and Experience Committee. The Health Board, therefore, should ensure that the four harms associated with COVID-19 are routinely considered by Clinical Boards and reported to the corporate Quality, Safety, and Experience Committee and Board	Director of Corporate Governance	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality		The revised template for the Clinical Boards QSE meetings will incorporate the 4 harms associated with COVID-19 reporting The notes and action logs of the clinical Boards will be shared at the QSE Committee meetings.

Status of Report Overall	(All)
Please confirm if completed (c), partially completed (pc), no action taken (na)	(All)
Financial Year Fieldwork Undertaken	(All)

Count of Age	**Column Labels**
Row Labels	**Date not Specified**
Audit of Accounts Report Addendum - Recommendations	
Audit of Financial Statements Report Addendum - Recommendations	
Clinical Coding Follow-up From 2014 not yet completed	2
Follow-up of Operating Theatres	
Implementing the Wellbeing of Future Generations Act	
Structured Assessment 2018	
Grand Total	**2**

Due Date Not Reached	over 6 Months	Over One Year	under 3 months	(blank)	Grand Total
			3		3
		1			1
				4	6
5					5
	7				7
		1			1
5	**7**	**2**	**3**	**4**	**23**

List	Status
Chief Executive	C
Chief Operating Officer	PC
Director of Corporate Governance	NA
Director of Finance	
Director of Planning	
Director of Public Health	
Director of Therapies &	
Director of Transformation &	
Director of People & Culture	
Executive Medical Director	
Executive Director of Nursing	

Clinical Coding Follow-up From 2014 not yet completed
Audit of Financial Statements Report Addendum - Recommendations
Implementing the Wellbeing of Future Generations Act
Follow-up of Operating Theatres
Follow-up of Operating Theatres
Assessment of Progress Against Previous ICT Recommendations

Audit of Accounts Report Addendum - Recommendations
Audit of Accounts Report Addendum - Recommendations
Audit of Accounts Report Addendum - Recommendations
Audit of Accounts Report Addendum - Recommendations
Audit of Accounts Report Addendum - Recommendations

Report Title:	Assurance Mapping Update			Agenda Item no.	7.8
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	06.09.2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

At the April 2021 Meeting of the Audit and Assurance Committee approval was given to develop an Assurance Strategy ("the Strategy") for the implementation of a Framework of Assurance.

The paper in April 2021 described that the organisation had a number of tools which provided assurance but no overarching strategy which pulled those tools together to give an overall view on assurance.

A copy of the newly developed Strategy was shared at the July 21 meeting of the Audit and Assurance Committee which recommended the Strategy to Board for approval. The Strategy was subsequently reported to, and Approved by the Board at the September 2021 Board Meeting.

It is hoped that the implemention of the Strategy will improve the overall governance of the organisation and the assurance provided to the Board by identifying gaps or limited assurance. This in turn will enable better targeting of resources in order to obtain assurance where required.

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

Since September 2021, due to competing Clinical and Pandemic response pressures, it has proven difficult to secure the time of colleagues to move the Strategy and the development of an Assurance Map forward, particularly as we entered the winter period.

Following an initial round of discussions with Clinical Board Triumvirates and Corporate colleagues progress stalled, however, over the past two months, meetings have recommenced and the Head of Risk and Regulation has had the opportunity to meet with Clinical and Corporate colleagues to re-engage and begin populating the Health Board's Assurance Map.

Coupled with this Internal Audit have begun an Advisory Review of the Strategy which is split into two phases:

- Phase 1: A desktop review of key documentation, including the Assurance Strategy, Audit Committee and Board papers; and
- Phase 2: Meeting with key staff as appropriate to determine the progress being made with the objectives set within the Assurance Strategy, such as the progress of developing assurance maps.

Phase 1 of the Review has now completed with three possible opportunities to enhance the Strategy being identified. These opportunities are:

1) To consider reviewing and revising the Health Board's approach to the 'Three Lines of Defence' model, so that it aligns to external risk, governance and assurance models.
2) To consider reviewing and revising the current Assurance Map template, appended to the Assurance Strategy, so that the layout and content takes a risk-based approach, which will assist in prioritising areas to take forward; and
3) To consider developing an action plan with actions, designated responsibility and timescales for implementation / review of the Assurance Strategy.

Following receipt of this feedback it is proposed that time is taken to work on the above opportunities and to share a further update with the Audit and Assurance Committee and the Board in November 2022.

Recommendation:

The Committee is requested to:

- **NOTE** the Assurance Mapping Update and agree that a further update, following implementation of the opportunities identified by Internal Audit be shared at the November Audit and Assurance Committee Meeting.

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	
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	
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	x	Collaboration	x	Involvement	x

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

Risk: Yes

The Health Board's Assurance Strategy forms part of a suite of documents that support the Health Board's Risk Management and Assurance processes. No specific Impact assessment has been undertaken, however by its very nature, the development of the Assurance Strategy will consider risk and the areas detailed below.

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:

Report Title:	Regulatory Compliance Tracking Report			Agenda Item no.	7.9
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	6 September 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.

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 Deadline, Red	Comments
2021\006	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 11th July 2022. Since the July 2022 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

- WHC/2022/018 - Guidelines for managing patients on the suspected cancer pathway
- WHC/2022/019 - Welsh Health Circular - Non-Specialised Paediatric Orthopaedic Services
- WHC2022/020 - Never Events – Policy and Incident List July 2022
- WHC/2022/021 – National Optimal Pathways for Cancer 2022 Update
- WHC/2022/022 - Welsh Health Circular - The Role of the Community Dental Service and Services for Vulnerable People

As of the 25.08.2022 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.

<u>Patient Safety Solutions: Alerts and Notices</u>

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 Number	Notice	Type of Documen	Status	Date PS Team Notified	Date sent to Distributionlist	Date Responses Due	Date Compliance Declare	CW	Medicine	CD&T	MH	PCIC	Spec Servic	Surgery	Dental	Corporat
PSN062	https://dhcw.nhs.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.

No additional PSN's have been noted or recorded since the last update shared at the July 2022 Committee Meeting

Regulatory Tracker

The Regulatory Tracker attached to this report is up to date as of the 25th August 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 July's Committee Meeting a total of 3 completed entries were removed from the register. A further 3 entries have been reported as complete since July's meeting and are recorded on the attached tracker.

Following July's Committee Meeting additional entries have been added to the register in the following areas:

- **Authorising Engineer – NWSSP**
  Three additional/new entries have been added following inspections of the Health Board's Ventilation, Low Voltage and Medical Gas Pipe Line systems.
- **Community Health Council**
  Two additional/new entries have been added following inspections at Ward B1 and the Stroke Rehab Ward.
- **Health Inspectorate Wales**
  Three additional/new entries have been added following inspections of the Health Board's processes with the Welsh Ambulance Services NHS Trust and at HMP Cardiff and A&E.

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	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	
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	

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

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: Yes
Whilst no specific Legal Impact assessment has been undertaken the monitoring and tracking of compliance with regulatory recommendations contribute to the Health Board's compliance with it's legal requirements.
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
06/09/2022 09:09:15

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														
AUTHORISING ENGINEER - NWSSP														
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	Medical Gas Pipeline System	May-22	Authorising Engineer (Ventilation) Annual Report - Ventilation AE	Executive Director of Finance	Strategy and Delivery Committee/Ventilation Safety Group	Director of Capital Estates and Facilities	May-23	4 recommendations	May-23	A review of recommendations made has been undertaken. 1 of the 4 Recommendations has complete - 3 remain Partially Complete		PC
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	Low Voltage Systems	Feb-22	Authorising Engineer (Low Voltage) Annual Report	Executive Director of Finance	Strategy and Delivery Committee	Director of Capital Estates and Facilities	Feb-22	9 recommendations	Feb-23	A review of recommendations made has been undertaken. 2 of the 9 Recommendations have been completed - 7 remain Partially Complete		**PC**
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	(Medical Gas Pipe Line Systems	May-22	ngineer (Medical Gas Pipe Line Systems) A	Executive Director of Finance	Strategy and Delivery Committee	Director of Capital Estates and Facilities	May-23	13 recommendations	May-23	A review of recommendations made has been undertaken. 3 of the 13 Recommendations have been completed - 10 remain Partially Complete		**PC**
ALL WALES QUALITY ASSURANCE PHARMACY														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	27.01.2020 - Re - Inspected 04.05.2022	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	05.05.2023	105 Actions Highlighted	05.05.2023	Currently reviewing actions for action plan submission. **No update since July 2022 meeting.**		**pc**
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	06.08.2020 - Re Inspected - 22.11.21	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	01.11.2023	50 deficiencies highlighted	01.11.2023	Deficiencies addressed and completed. Decision as to the funding for the 4 glove isolator and the required works on the facilities required to progress several of the deficiencies. **No update since July 2022 meeting.**		**pc**
BRITISH STANDARDS INSTITUTE														
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygeine Ratings	Central Production UHW	12.05.2022	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	A Food Hygiene rating of 2 was received which, in the main, was due to kitchen drains leaking into a non food store room located below the production kitchen	23.06.2022	An update was shared at the July Health and Safety Committee meeting providing assurance to the Health Board.		**PC**
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygeine Ratings	Barry Hosptial	14.06.2022	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	A Food Hygiene rating of 5 was achieved with no major contraventions.	14.09.2022	An update was shared at the July Health and Safety Committee meeting providing assurance to the Health Board.		**C**
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	All 21 recommendations are recorded as complete. The remaining reported at the July Committee meeting, which relates to the review of contract documention is now reported as complete.		**C**
Clinical Coding														
Digital Health	Clinical Coding	DHCW	Clinical Coding	24.06.2022	Clinical Coding Audit	Director of Digital Health Intelligence	Digital Heath Intelligence Committee	**Director of Digital Health Intelligence**	N/A	A total of 5 recommendations were made regarding clinical coding practice within the Health Board.	N/A	Of the 5 recommendations, 4 are recorded as complete. Work remains ongoing within endoscopy to compete/close out the final recommendation.		**PC**
COMMUNITY HEALTH COUNCIL														
Specialist Services - Ward B1	Ward B1	CHC	Ward B1	TBC	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Specialist Services CB Director of Nursing	N/A	A total of 7 recommendations were made regarding ward B1's facilities.	ASAP	2 of the 7 Recommendations are reported as complete. The remaining recommendations remain in progress.		**pc**
Medicine	Stroke Rehab Ward	CHC	Medicine CB - Stroke Rehab Ward	TBC	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Medicine CB Director of Nursing	31.08.2022	A total of 4 recommendations were made regarding the Stroke Rehab Ward's facilities.	ASAP	All 4 recommendations require estates input. An estates survey was request on 08.08.2022		**pc**
FIRE AND RESCUE SERVICES														
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services Barry, Hospital	14.04.2021	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."	19.05.2021	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 still rests with the Fire Authority's Compliance team for deliberation as to whether they might proceed with prosecution. 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. This information was duly forwarded to the Fire Authority. A letter under caution was issued against the executive director for public health on 01/12/2021. This has been responded to and a subsequent meeting held with the chief fire officer for SWFRS, the UHB CEO, new responsible exec for fire and new fire safety manager. The notice remains open but close collaboration exists between the two parties. On 1st November 2021 significant organisational changes were made resulting in the fire team moving to sit under H&S.		**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	31.03.2023	Measures have been agreed with and implemented by senior managers of the UHB's Estates Service Board. Consequenlty the enforcing authority inspector has agreed to extend the date of this notice for 12 months to enable all works to be completed.		**PC**
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**
PCIC	HMP Cardiff	HIW	HMP Cardiff	N/A - Desktop review	HIW	Executive Nurse Director	QSE Committee	Executive Director of Nursing - Head of HMP Cardiff Healthcare	**N/A**	A total of 11 recommendations made.	**Various**	3 of the 11 recommendations have completed with a number of the remaining entries recroded as partially complete.	**PC**
Medicine	Welsh Ambulance Services NHS Trust	HIW	A&E	Oct-21	HIW	Executive Nurse Director	QSE Committee	Executive Nurse Director/Chief Operating Officer	**N/A**	A total of 13 recommendations were made.	**N/A**	10 of the 13 recommendations have completed. The remaining 3 recommendations are parially complete.	**PC**
Medicine	Emergency / Assessment Units	HIW	A&E	20.06.2022	HIW	Executive Nurse Director	QSE Committee	Executive Nurse Director	**TBC**	A total of 16 recommendatons were made	**N/A**	4 of the 16 recommendations are reported as complete completed. The remaining 12 recommendations have not been progressed with additional detail required to update HIW.	**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 Digital Health and Information Committee in June 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	01.09.2024	Minor deficiencies noted	01.09.2024	Programme received formal re-accrediation notice - There are ongong discussions with the executive board regarding a new facility for BMT / Haematology as the service will not achieve re-accreditation post he next inspection cycle. A capital planning project team has been established to develop the business case to support the development of a refurbhsied facility for the service.	**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**
CD&T	Pharmacy	MHRA	Pharmacy SMPU	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	8 Recommendations	16/12/2021	Following inspection and KPI improvement, restrictions to licence removed and no longer subject to IAG but de-escalation to compliance management team with quarterly KPI data submission for the next 9 months	**PC**
NATURAL RESOURCES WALES													
OFFICE FOR NUCLEAR REGULATION													
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES													
RESEARCH AND DEVELOPMENT													
UKAS													
WELSH WATER													
Capital Estates and Facilities	UHW	Welsh Water	UHW	13.05.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee	Director of Capital Estates and Facilities	tbc	Contraventions of sections 73-75 Water Industry Act 1991 and Water Supply (water fittings) Regulations 1999 (The Regulations) relating to contamination, waste, misuse, erroneous meassurement and undue consumption of water at the premises.112	20.06.2022	Action plan developed and working through actions before Revisit.	N/A
Capital Estates and Facilities	St Davids	Welsh Water	St Davids Hospital	20.05.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee	Director of Capital Estates and Facilities	n/a	Contraventions of sections 73-75 Water Industry Act 1991 and Water Supply (water fittings) Regulations 1999 (The Regulations) relating to contamination, waste, misuse, erroneous meassurement and undue consumption of water at the premises.	04.08.2022	Update following reinspeWelsh water had arranged to meet 4/8/22 to go through the remedial actions but they did not attend, however they have arrived 10/08/2022 and have visited the remedial actions completed.ction awaited	C
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	01.11.2024	Results awaited.	01.01.2022	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	01.11.20224	85% target met in individual standards and 90% overall target met - 95.22% overall compliance score achieved	01.01.2022	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:	Procurement Compliance Report				Agenda Item no.	7.10	
Meeting:	Audit Committee		Public	X	Meeting Date:	6th September 2022	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that the purchase of all goods and services be subject to competition in accordance with good procurement practice, making reference to minimum thresholds for quotes and competitive tendering arrangements.

There are some situations where this is not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) are made in accordance with the Procedure for the Approval of Single Tender Action. There are sound reasons why STA/SQA's are permitted within the Health Board, these are as follows but not limited to:-

- Sole Supplier of Goods or Services
- Proprietary items, i.e. Trademarked, patented
- Capability with existing equipment or service
- Regulatory, i.e. Human Tissue Act (HTA)
- Urgent Operational Requirement
- Covid-19
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

To support the management of STA/SQA requests, an online quotation system was implemented in April 2019, to test the market and promote competition, this should reduce the number of STA/SQA's.

There are also some situations where contracts are extended outside of the original contract scope to ensure patient safety and operational delivery of the Health Board's core services.

Unfortunately, there are times where individuals act outside Procurement Regulations and Standing Financials Instructions which need to be reported as a non-compliant process, which is a direct breach, and could compromise competition and value for money. There are some exemptions within these breaches in relation to unforeseen/unplanned circumstances, emergencies and more recently, Covid-19.

Should Non-Compliant Activity occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

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

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (9)

This is activity where departments have engaged suppliers without Procurement involvement and therefore, have incurred a direct breach of SFI's.

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Provision of Agency Staff (Hays)	£10,064.00	N/A	4 months	Executives – D&HI	Services already provided. No Procurement involvement in engagement of agency worker	Resolved – No further requirement for this agency worker
Firely Server (Vonk) licenses	£7,000.00	31st May 2023	12 months	Executives – D&HI	Contract engaged without Procurement involvement.	Resolved - On workplan for the next renewal
World Courier (UK) Ltd	£16,152.94	N/A	1 month	Executives – R&D	No Procurement involvement in engagement of services	Completed – No future requirement
Vascular Grafts	£16,077.00	N/A	One off requirement	Surgery	Products used on sale or return without Procurement involvement	Resolved – products requested to be included on All Wales Framework for future purchases
Provision of Agency Staff (Michael Page)	£11,100.00	N/A	One off requirement	Executives – D&HI	Services already provided. No Procurement involvement in engagement of agency worker	Actioned – Contract completed and agency staff no longer required for this project
Dermatology Training for GPVTS Scheme	£5,000.00	N/A	One off requirement	PCIC	No Procurement involvement in engagement of training.	Resolved – One off requirement
Nursery Grounds Preparation	£19,725.00	N/A	One off requirement	Executives – People and Culture	No Procurement involvement in engagement of services	Resolved – One off requirement
Provision of Agency Worker	£9,753.70	N/A	1 month	Children and Women	No Procurement involvement in engagement of services	Ongoing – Procurement awaiting Service to advise on future requirement
Provision of Ophthalmology Services	£17,120.00	N/A	2 months	Surgery	Service engaged Consultant without STA being submitted and approved	Ongoing – Procurement awaiting STA from Surgery to progress with approval for future provision

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (3)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Managed Service for Bank, Direct Engagement Services and Agency Staff	£135,025.00	31st August 2022	3 months	Executives - People and Culture	Contract activity has been high and cost savings objections have not been	Ongoing – Additional value being sought
Provision of Agency Staff (Ranstad)	£7,631.56	31st March 2022	2 months	Executives – D&HI	Additional hours undertaken and no Procurement involvement to include this within the contract that was live at the time	Resolved – Contract completed and agency staff no longer required for this project
CLIMB Awards	£6,611.00	N/A	One off order	Executives – Innovation and Improvement	STA approved, however, increase in fees including machine hire, raw materials and technical specialist time uplifted the overall value of the expected service.	Resolved – Contract completed and final invoice paid.

Other Non-Compliant Activity (5)

This section details activities which were out of the Department/Health Board's control as a result of any of the following;

- Emergency activity
- Unforeseen/Unplanned circumstances
- Exemptions

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Legal Services (Devereux Chambers)	£5,293.75	N/A	One off legal advice	Executives – Risk and Regulation	Urgent legal advice required and retained via NWSSP Legal and Risk team, therefore, UHB cannot influence	Resolved – legal advice obtained
Legal Services (Civitas Law)	£5,860.00	N/A	One off legal advice	Executives – Risk and Regulation	Urgent legal advice required and retained via NWSSP Legal and Risk team, therefore, UHB cannot influence	Resolved – legal advice obtained
OBIZUR 500 IU Consumable	£23,600.00	N/A	One off emergency order	Specialist	Order over the weekend for emergency case and this is stock not normally utilised	Resolved - One off emergency order.
Talk Project	£16,517.00	N/A	12 months	Surgery	EU Grant funded project on the basis that University of Barcelona are	Resolved – Final year of EU Grant funded project

					paid for the project	

Contracts engaged at risk as a result of Covid-19 requirements (1)

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action/Status
Rental of sports centre for PPE Stores	£87,360.00	N/A	1st October 2021 to 31st March 2022	Executives	Covid-19 requirement	Resolved – Final invoice payment

Report of Single Tender/Quotations Actions

Retrospective – (1 Return)

The report outlines all SQA/STA (2) requests during the period the 1st June 2022 to 31st July 2022.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
CD&T	GE Healthcare	Emergency repair of a CT Scanner	£80,000.00	Sole Supplier of Goods or Services

Should Retrospective STA/SQA's occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (11) requests during the period the 1st June 2022 to 31st July 2022. The volume processed was higher than normal activity, as a consequence of the following:-

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Covid-19/ Unforeseen circumstances/Emergencies
12. Exemptions

Clinical Board	Supplier	Name of Project	Total Value of Contract Excl VAT	Type
Medicine	Osler	Funds to cover Finders fees for Indian Doctors	£78,000.00	Urgent Operational Need
PCIC	IQUS	GP Online Booking System	£16,844.00	Sole Supplier of Goods or Services
Medicine	Mediteam	Provision of Consultants and Locums	£102,190.00	Urgent Operational Need
CD&T	Softpro	Support contract for Clinical Engineering's Medusa Asset Management Database	£10,012.00	Sole Supplier of Goods or Services
PCIC	NB Medical Training	Training Subscription	£36,000.00	Sole Supplier of Goods or Services

PCIC	Cwtch Dental, Clifton Dental Care, Rumney Hill Dental Practice, Cox and Hitchcock, Colchester Dental Practices	Endodontic Non-Recurring Funding	£94,000.00	Sole Supplier of Goods or Services
PCIC	Mill Systems	DoSH Bespoke IT System Support	£20,212.80	Sole Supplier of Goods or Services
Specialist	Boston Scientific	LSPRO Maintenance and Upgrade	£15,000.00	Sole Supplier of Goods or Services
Surgery	Two Ten Health Limited	Salud Dental Licenses	£95,000.00	Capability with existing equipment or service
Specialist	Ovidius Medical Limited	Purchase of Carbon Fibre/Peek screws and Rods	£13,092.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	HSS Hire Services Group Ltd	Emergency Hire of AC Units	£15,000.00	Urgent Operational Need
Executives	SimplyDo	Support for the CCR Endoscopy Challenge - Supplier Discovery Proof of Concept	£4,987.50	Urgent Operational Need

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year	**2021/22**			**2022/23**		
Clinical Board	**Non-Compliant Breaches**	**Exemption**	**Covid-19**	**Non-Compliant Breaches**	**Exemption**	**Covid-19**
AWMGS	1	0	0	0	0	0
Children and Women	2	1	0	1	0	0
Capital Planning, Estates and Facilities	7	8	1	2	0	1
Clinical, Diagnostics and Therapies	6	0	1	1	0	0
Executives	14	8	3	2	2	0
Medicine	3	0	0	0	0	0
Mental Health	0	0	0	0	0	0
PCIC	1	0	0	0	0	0
Specialist	6	0	0	0	0	0
Surgery and Dental	4	0	1	2	0	0
TOTALS	**44**	**17**	**6**	**10**	**2**	**1**

Please note that in February 2021, the reporting of non-compliant activity was spilt into the above criteria to reflect accuracy in reporting the justifications behind certain breaches i.e., emergency works.

STA/SQA's by Department

	2020/21		**2021/22**		**2022/23 (Year To Date)**	
Clinical Board	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**
AWMGS	N/A – Previously recorded as part of CD&T		4	3	3	3
Children and Women	3	0	2	0	2	0
Capital Planning, Estates and Facilities	3	1	2	0	1	0

Clinical, Diagnostics and Therapies	28	4	14	1	5	0
Executives	20	4	9	3	11	0
Medicine	6	3	6	1	1	0
Mental Health	3	0	1	0	0	0
PCIC	8	2	2	0	1	2
Public Health Commissioning Team	0	0	1	0	0	0
Specialist Services	7	1	6	2	3	0
Surgery Services and Dental	9	3	5	1	1	0
Grand Total	**87**	**18**	**52**	**11**	**28**	**5**

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the 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:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:

As outlined in the above section	
Legal:	
As outlined in the above section	
Reputational:	
As outlined in the above section	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Counter Fraud Progress Report			Agenda Item no.	7.11
Meeting:	Audit and Assurance Committee	Public	X	Meeting Date:	06/09/2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	X
Lead Executive:	Catherine Phillips - Executive Director of Finance				
Report Author (Title):	Gareth Lavington – Head of Counter Fraud				

Main Report
Background and current situation:

This report builds on the interim Counter Fraud progress report verbally presented at the Audit Committee meeting on 5th May 2022, and the full period 1 Counter fraud progress report delivered to Audit Committee on 5th July 2022. This report provides an update of all the work undertaken by the CF team at CAVUHB on behalf of CAVUHB between the dates 20/06/2022 – 17/08/2022 (submission date of papers)

The reports seeks to provide assurance that the planned activity in the Annual Plan is being carried out and that the CF fraud provision for CAVUHB is robust and fir for purpose.

It is asked that the Committee note the content of the report.

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

Progress made against the Annual Counter Fraud Plan.
Current Investigations.
Other activity

Recommendation:

The Committee is requested to:

a) Note the content of the 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	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	
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	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: Yes
Financial loss impacting upon patient care. Risk of reputational impact as a secondary result.
Safety: No
Financial: Yes
Possible financial loss as a result of fraud which will lead to impact upon patient care
Workforce: Yes
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes
Use Statutory legislation to conduct investigations
Reputational: Yes
Negative publicity resulting in negative publicity that undermines public confidence
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

NHS WALES
Cardiff and Vale University Health Board

Counter Fraud Progress Report
20/06/2022-12/08/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

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 on behalf of Cardiff and Vale Health Board from the 20 th June 2022 to 12th August 2022.

The report's format has been adopted in order to update the Audit and Assurance Committee about counter fraud referrals, investigations, activity and operational issues.

At 12th August 2022, 141 days of Counter Fraud work have been completed against the agreed 500 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness, investigating referrals in relation to fraud and financial crime.

This report builds upon the interim period 1 report that was delivered to Audit Committee on 12th May and detailed the work covered until 25th April, and the full period 1 report detailing progress made within the CAVUHB counter fraud team from 1st April – 20th June 2022 delivered to Audit Committee on 5th July 2022.

The breakdown of these days is as follows: (P=Period) () = Running Total

TYPE	Days P1	Days P2	Days P3	Days P4
Proactive	15	14 (29)		
Reactive	70	42 (112)		

2. Progress

Staffing

A member of the team has during this period, applied for a new role within the Counter Fraud Service Wales regional team. They were successful in their application and as a result they will be leaving the Cardiff and Vale Team in early September. Recruiting a new team member will be undertaken as soon as is practicable but it is anticipated that there will be a temporary reduction in staffing resource during reporting period 3 of this financial year.

Activity

Infrastructure/Annual Plan

During this reporting period, work has continued in developing the infrastructure that will allow successful compliance with the Counter Fraud Plan for 2022-2023. In this period the below activity has taken place in relation to this area of work -

a. The maintenance of a comprehensive activity database which is already assisting in maintaining a detailed and accurate record of work undertaken.
b. Review of the Counter Fraud Bribery and Corruption Policy – the CAVUHB Counter Fraud Bribery and Corruption Policy is in date but requires review and updating by December 2022.
c. Review of CF digital presence – Fully functional, modern, Counter Fraud Intranet site has now been developed and is operational on the wider Cardiff and Vale Intranet site. This is operated on the Microsoft Share point platform and is available to all staff within the organisation and to wider staffing cohorts that we maintain a Counter Fraud provision for in other NHS organisations. (Link to the site for reference : Counter Fraud - Home (sharepoint.com))
d. Counter Fraud e-Learning arrangements – as previously reported work is underway with the LED team at CAVUHB to develop a modern fit for

purpose learning site on the All Wales Learning @ Wales Platform. Development of this platform continues and whilst it was aimed that this will be up and running at this point this has been delayed. The reason for the delay is beyond the control of Cardiff and Vale as it awaits the new All Wales eLearning package to be finalised and distributed by the Counter Fraud Service Wales. It is anticipated that this will take place in September. When complete this will be available to all Cardiff and Vale University Health Board staff as a, Counter Fraud, education, learning and awareness tool. It will be signposted internally within the organisation in order that staff can access at the click of a button.

e. New Counter Fraud posters have been designed, developed and printed in high volume by the print team at Cardiff and Vale University Health Board and have now been delivered. They have been placed in impactive locations around Health Board sites in order to improve awareness and presence. Further sites to be visited.

f. The most recent newsletter has been printed in high volume as an awareness tool. The aim is for this to be handed out to staffing cohorts at different health board sites at Fraud Awareness 'pop ups' in areas of high footfall around the organisation.

g. Counter Fraud screen saver has been developed and is now in use as an awareness tool on every computer being used in the health board.

Fraud Prevention Notices and IBURN notices

During this reporting period two Fraud Prevention Notices (FPN) have been issued by the NHS Counter Fraud Authority. These have both been issued in relation ongoing attempts Cyber enabled Mandate fraud.

During this reporting period one Counter Fraud Authority intelligence bulletin (IBURN) has been issued. This was issued also in relation to Cyber enabled Mandate fraud.

These documents reinforce the high-risk impact factors that NHS organisations face in relation to this type crime. The documents have been cascaded accordingly as per the dissemination list.

Investigation into the subject matter with both NHS Wales shared services partnership and with the Cyber Security team at Digital Health and Care Wales has resulted in the findings that the organisation has **not** had interaction with the malicious sites and or 'rogue' suppliers. The results of this has been reported on the CLUE case management system operated by the NHS Counter Fraud Authority.

These documents are classified as Official Restricted and as a result the information contained these notices can only be shared with those staff identified in the Handling Information.

Local Alerts/Bulletins

During this reporting period there has been one local fraud alert issued. This alert was issued in relation to a text messaging phishing scam targeting overseas nursing cohorts. (Appendix 1.)

Awareness Sessions

During this reporting period two general fraud awareness sessions have been delivered; one to CAVUHB Primary Care Team at Woodlands House. This was delivered to a total of 29 staff; one to Corporate Induction of overseas nurses, delivered to 30 staff. The aim is to deliver this on a monthly basis moving forward.

Further arrangements are underway to deliver sessions to staff in relation to general fraud awareness and risks associated with pre-employment checks to Human Resources staff.

Newsletters

During the reporting period one newsletter has been produced, published and communicated to all staffing groups. (Appendix 2.)

Referrals/Enquiries

During this reporting period the Counter Fraud team have received nine (9) referrals via the online reporting tool. All of these referrals have been informally resolved with none being promoted to formal investigation.

The informal investigations undertaken into these are as follows:

1. Suspected prescription fraud in relation to an overseas patient. **No offences disclosed and advice fed back.**
2. Staff member working whilst being on long term sick leave – **No issues with the situation and no offences disclosed. Advice fed back and reported Human Resources team for information only.**
3. Suspected tampering with an LFT test in order to take sick leave – **not possible to prove or disprove. Advice provided no offences disclosed.**
4. Request for guidance about treating overseas paediatric patients and fraud – **advice given and referred to the relevant department**
5. Altering of a smoking cessation prescription to obtain free smoking cessation products – **no issues, alteration was legitimate and subject entitled to the products, pharmacy advised**.
6. Report from a foreign member of staff that they had received a phishing text as per the alert distributed at Appendix 1. They had not fallen foul of the scam – **advice given, and the mater reported to action fraud.**
7. Report from a foreign member of staff they they had received a phishing text as per the alert distributed at Appendix 1 – **this staff member had been defrauded to the amount of approximately £500. Reassurance given and advice given in relation to reporting the matter to their**

bank and to the Police. Reported to action fraud and to CFS Wales for appropriate preventative action to take place.

8. Report from Primary Governance team that GP was on sick leave from the practice where they worked but carrying on their role with the health board – **legitimate sickness from GP practice relating to stress specifically in that role. No offences disclosed, advice given.**
9. Report of a telephone phishing scam to a staff members private phone **– reported on to Action Fraud and advice given.**

Investigations

At the beginning of this reporting period (20/06/2022) there were six **(6)** formal investigations open in relation to Cardiff and Vale Health Board as detailed below. Two of these investigations have since been closed with no further action being taken. This means that four **(4)** live investigations have been carried over from Period 1.

1. Salary Overpayment – **case closed. Subject entered a repayment plan. Civil remedy.**
2. Salary Overpayment – **enquiries ongoing**
3. Working elsewhere whilst on sick leave – **enquiries ongoing**
4. Running a business whilst on sick leave – **cased closed, no offences disclosed, HR informed.**
5. Salary overpayment – **enquiries ongoing**
6. Salary overpayment – **enquiries ongoing**

During this reporting period two **(2)** new formal investigations have been opened. One **(1)** remains open and one **(1)** has been closed.

1. Falsifying overtime claims – **enquiries underway**.
2. Working elsewhere whilst sick – **investigation conducted. No case to answer. Believed malicious. No further action required.**

Therefore, at the close of this reporting period there are five **(5)** live formal investigations being conducted by the Counter Fraud team carrying over into Period 3.

Other

NA

Appendices

Appendix 1

13 July 2022

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

Fraud Alert – Scam Text to Overseas Nurses

It has been brought to our attention from a neighbouring Health Board that there have been a number of scam messages being sent to overseas nurses.

The messages are being sent as Text Messages or WhatsApp messages purporting to be from "**Criminal Court Birmingham**", are showing as having the following number "**0121 681330**" and shows a "**Gov UK**" Logo.

The messages are convincing in appearance, contain genuine information about the recipient and state that the hospital have made an error with tax payments and demanding a payment of £1,500 to avoid arrest and prosecution. A number of members of staff have fallen victim to this.

These are not genuine messages!

If there was an error in tax HMRC would contact you directly via post or alterations would be made by payroll

The Criminal Courts are not involved with tax payments and would not make contact regarding tax matters

Do not make payment if you receive this message

If you have already received one of these messages and made payment please report the matter immediately!

There was a similar incident in 2021 where scammers were using "courts phone numbers" in a tax scam, further details and information from HMCTS can be found HERE.

Counter Fraud Enquiry Form (LINK)

Report any concerns or queries to the Counter Fraud Team using the link above or QR code.

Counter Fraud SharePoint Intranet (LINK)

Access our SharePoint Intranet site for further information, useful links and recent news.

CounterFraudEnquiries.CAV@wales.nhs.uk

Gareth Lavington
Tel: 029218 36265
Gareth.Lavington2@wales.nhs.uk
Counter Fraud Manager

Nigel Price
Tel: 029218 36481
Nigel.Price@wales.nhs.uk
Local Counter Fraud Specialist

Emily Thompson
Tel: 029218 36262
Emily.Thompson@wales.nhs.uk
Local Counter Fraud Specialist

Henry Bales
Tel: 029218 36264
Henry.Bales@wales.nhs.uk
Local Counter Fraud Specialist

Office: Counter Fraud Department, 1st Floor Woodland House, Maes-Y-Coed Road, Cardiff, CF14 4HH

Appendix 2

(Front)

Counter Fraud Newsletter

July 2022

CAVUHB | Velindre | HEIW | PHW | DHCW

Local Counter Fraud Specialists (LCFS)

Welcome to the July 2022 edition of the Counter Fraud Newsletter

Over the past two months we have set up a new **Counter Fraud Intranet Page** it can be accessed via the link above or the QR code. It is hosted on the Cardiff and Vale SharePoint Platform however is accessible to anyone in NHS Wales.

On the site you will find out more information about your counter fraud team, NHS Fraud, how to report fraud, how to request awareness sessions and useful links. You will also find information about recent cases and investigations. We look forward to your visit.

Topic of the month: Overpayments

Background:

An overpayment case will generally occur when a member of staff leaves the organisation and a termination form is not completed or is completed incorrectly. This results in the now ex-employee continuing to get paid their normal wage when they are no longer working for the organisation. Overpayments can also occur in a number of other situations such as sickness, maternity leave, change in hours etc.

Overpayments result in financial loss to the NHS as the person in receipt of payments is not entitled to the money. Any loss to the NHS has an impact on the service that can be delivered and as a result patient care.

Your responsibilities:

Whilst overpayments are a result of a systematic failing by the organisation it is the subsequent action of the employee that dictates how the matter will be dealt with. It is imperative that you are aware of the Overpayments Policy and your responsibilities. If you do receive an overpayment or suspected over-payment you should contact your manager or the payroll department at the earliest opportunity for it to be looked into.

Outcome:

In an overpayment case where the employee/ex-employee has made contact with the organisation (as soon as possible) then it would be resolved by repaying the money over an agreed time scale.

Counter Fraud Department:

However, if there is a prolonged overpayment / there is suspected to be an element of dishonesty involved / no contact is received from the employee/ex-employee then the matter is referred to the Counter Fraud Team for initial assessment. This can result in a formal investigation and the possibility of being charged with a criminal offence and going to court. Pease turn over to read about a recent case!

Remember: be honest, if you are aware you are being overpaid, tell someone!

Appendix 2

(Rear)

ABUHB — Nurse convicted of Theft at Merthyr Magistrates Court — Overpayment of Salary

As a result of the work of the Local Counter Fraud Team at Aneurin Bevan University Health Board, a former employee has been convicted of Theft at Merthyr Magistrates Court as a result of dishonestly retaining salary overpayments. They are due to appear at Merthyr Crown Court later in July for sentencing.

The former nurse at ABUHB left their position at the health board in November 2020, however, due to a system error continued to be paid until the error was discovered in July 2021. The value of the overpayment was in the region of £21,000.

A subsequent investigation by the Local Counter Fraud Team discovered no attempts had been made by the former employee to contact payroll or management in relation to overpayment. Furthermore it was discovered all of the money had been spent and the nurse was in alternative employment during the time of the overpayment.

This case underpins the importance of staff members alerting payroll/managers to incidents of overpayments in a timely manner.

Cardiff based Pharmacy worker sentenced at Cardiff Crown Court for Fraud

A prescriptions clerk at a Cardiff Pharmacy has been convicted of Fraud and sentenced to 20 weeks in prison (suspended for 2 years), to complete 15 days of Rehabilitation Activity Requirements and to pay a victim surcharge.

The prescriptions clerk became addicted to co-codamol having taken the medication due to suffering chronic pain. Having become addicted to the medication the clerk used their position to create false prescriptions in other peoples names with the intention of taking those medications themselves. The matter came to light after concerns were raised due to one of the medications she was prescribing being out of stock.

A subsequent referral and investigation by the Counter Fraud Team at Cardiff and Vale found there to be 199 false prescriptions over a period of 4 years, with a value of the medication totalling over £1700.

NHS fraud. Spot it. Report it. Together we stop it.

Local Counter Fraud Team

The counter fraud department has a **new online reporting tool** which can be accessed from the link or by scanning the QR Code below. There is also a new generic email inbox which can be used to contact the Fraud Department. Any information provided is treated **confidentially**.

Counter Fraud Enquiry Form (link)

CounterFraudEnquiries.CAV@wales.nhs.uk

Gareth Lavington
Tel: 029218 36265
Gareth.Lavington2@wales.nhs.uk
Counter Fraud Manager

Nigel Price
Tel: 029218 36481
Nigel.Price@wales.nhs.uk
Local Counter Fraud Specialist

Emily Thompson
Tel: 029218 36262
Emily.Thompson@wales.nhs.uk
Local Counter Fraud Specialist

Henry Bales
Tel: 029218 36264
Henry.Bales@wales.nhs.uk
Local Counter Fraud Specialist

Office: Counter Fraud Department, 1st Floor Woodland House, Maes-Y-Coed Road, Cardiff, CF14 4HH

Report Title:	Procedure for Internal and External Tracking Reports Updates			Agenda Item no.	7.12
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	06.09.2022
		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:

Following discussions with Internal Audit and at the July 2022 Audit and Assurance Committee ("the Committee") it was agreed in principle that the frequency with which the Health Board's Internal Audit, Regulatory and Audit Wales Tracking Reports are reported to Committee is revised.

It was proposed that each tracker is reported to every other Committee Meeting (ensuring that an update is shared at all April/End of Year) Meetings, as opposed to updates being shared at each meeting.

The rationale for this proposal is that many recommendations take significant time to enact and often, very little progress is made within the 2 months between each Committee Meeting. It is also felt that providing a longer period of time between updates will allow the Risk and Regulation team and Recommendation Owners to take additional action to inform updates and close out recommendations.

It is also hoped that the time saved at Committee Meetings by this reduction will provide additional time to devote to targeted reviews of aged and high priority recommendations that may have become stagnant.

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

Currently, the following Reports are shared at each Committee Meeting:

- Internal Audit Tracking Report
- Audit Wales Tracking Report
- Legislative and Regulatory Recommendation Tracking Report

It is proposed that the Committee Workplan is updated so that each of the above reports are reported at the following Committee meetings for the remainder of 2022/23 and into 2023/24:

- February 2023
- April 2023
- September 2023
- February 2024
- April 2024

At the meetings scheduled for November 2022, July 2023, November 2024 the Committee will be invited to propose targeted Audit Recommendations for targeted review.

Recommendation:

The Committee is requested to:

Approve: the amendment of the of the Committee work plan to reflect the reduction in frequency with which the Internal Audit, Audit Wales and Legislative and Regulatory Recommendation Trackers are reported to Committee.

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	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	
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	x	Integration		Collaboration	x	Involvement	x

Impact Assessment:

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

Risk: Yes/No

By maintaining up to date Recommendation Trackers the Health Board mitigates the risk that it subject to legal or regulatory penalty.

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:

Report Title:	**Internal Audit Reports for Information**				Agenda Item no.	9.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	06/09/22	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
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 2022/23 plan was formally approved by the Audit Committee at its April 21 meeting.

As individual audit reviews are completed, the final reports are submitted to the Committee for assurance and information.

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

Five audit reports have been finalised since the last meeting of the Committee, with the following assurance ratings:

- One Substantial Assurance
- Four Reasonable Assurance

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider and note** the final Internal Audit reports.

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	x	Integration	x	Collaboration	x	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
06/09/2022 09:09:15

Monitoring and Reporting of Staff Sickness Absence

Final Internal Audit Report

August 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 2122-07
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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 Monitoring and Reporting of Staff Sickness Absence.

Overview

We have issued reasonable assurance on this area.

We have made two medium priority recommendations, which look ahead, to support the Health Board's recovery from the pandemic. We have suggested that reporting on sickness absence within the Clinical Boards and Corporate Departments looks beyond the high level sickness rates, and provides greater analysis of sickness absence.

In response to the pandemic the role of the HR Advisors has moved away from traditional relationships focused within the Clinical Boards, to locating to specialist teams such as the Managing Attendance at Work Team. There is opportunity to clarify the People and Culture Operating Model with regards to roles and responsibilities for sickness absence.

A further low priority recommendation is within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Review and reporting of staff sickness absence rates at a Health Board wide level	Substantial
2	Systems and processes in place to review and report on Clinical Boards and Corporate Departments sickness absence	Reasonable
3	Appropriate actions are put in place to further analyse and support poor performing areas identified through the review and reporting of sickness absence	Reasonable
4	The Board Assurance Framework adequately highlights the risk of staff sickness	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Enhanced reporting of sickness absence within the Clinical Boards	2	Design	Medium
2	Clarification of roles and responsibilities	2	Design	Medium

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1. Introduction

1.1 The review of 'Monitoring and Reporting of Staff Sickness Absence' was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the Health Board), Due to operational pressures within the Health Board through 2021/22 Internal Audit were asked to postpone the commencement of the audit until May 2022 and the outcome will therefore feed into the Head of Internal Audit Opinion for 2022/23.

1.2 The NHS Wales Managing Attendance at Work Policy directs the Health Board's processes and arrangements to manage staff sickness. The objectives of the policy are to: support the health and wellbeing of employees in the workplace; support employees to return to work following a period of sickness absence safely and as quickly as possible; and support employees to sustain their attendance at work.[1]

1.3 The minimum standards of Workforce and OD detailed within the Policy include 'Support the management of sickness through the collation of information and provision of data to enhance decision making and workforce planning'.

1.4 The focus of this audit was to provide assurance around the arrangements for the monitoring and reporting of sickness absence data, rather than the actual levels of sickness absence within the Health Board.

1.5 Whilst planning this audit we referred to the Board Assurance Framework (November 2021). The Health Board had acknowledged the impact of the COVID-19 pandemic on staff wellbeing. Risk nine within the Board Assurance Framework noted, *"There is a risk that staff sickness will increase, and staff wellbeing will decrease due to the psychological and physical impact of the pandemic. Which together with limited time to reflect and recover will increase the risk of burnout in staff."*[2] The most recent iteration of the Board Assurance Framework still holds the risk (May 2022).

1.6 The Health Board's People and Culture Plan was approved by the Board in January 2022, which is made up of seven themes, the first relates to an engaged, motivated and healthy workforce, which if achieved has the potential to lower levels of staff sickness.

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

[1] NHS Wales Managing Attendance at Work Policy http://www.wales.nhs.uk/sitesplus/documents/862/768-AW%20NHS%20Wales%20Managing%20Attendance%20at%20Work%20Policy2.pdf

[2] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/6-7a-board-assurance-framework-nov-2021-docx/ Board Assurance Framework (November 2021)

Audit Risks

1.8 The potential risks considered in this review are as follows:

- The Health Board fails to provide adequate health and wellbeing support to employees in the workplace, which leads to greater sickness absenteeism;
- Non-compliance with the All Wales Managing Attendance at Work Policy; and
- Failure to meet Health Board and Welsh Government sickness absence targets due to poor monitoring arrangements.

2. Detailed Audit Findings

Objective 1: There are appropriate systems in place for the review and reporting of staff sickness absence rates at a Health Board wide level.

2.1 The Health Board arrangements for reporting on sickness absence are informed by ESR Business Intelligence reports, where information is extracted from ESR. The Head of People Analytics is responsible for producing reports on sickness absence, such as the Health Board wide position on sickness absence.

2.2 The Strategy and Delivery Committee routinely receive the Executive Director of People and Culture's report on 'Key Workforce Performance Indicators – People Dashboard'.[3] The report provides a brief overview summary, which includes sickness absence, detailing the rate comparable to previous periods, and the top five reasons for sickness.

2.3 To supplement the 'Key Workforce Performance Indicators' presented to the Strategy and Delivery Committee, the Executive Director of People and Culture has instigated a series of deep dives. In November 2021, the deep dive focused on sickness absence / managing attendance, and detailed key priorities to take forward in response to staff sickness absence. The report highlighted that since March 2021 sickness rates have not followed the usual pattern but have risen steadily. The absence rate for September 2021 was the highest it had ever been for the month of September.[4]

2.4 We were advised by management that a further planned deep dive of sickness absence / managing attendance at work will be presented to the Strategy and Delivery Committee during 2022/23.

2.5 Through 2021/22 the Health Board introduced the Integrated Performance Report. The report remains under development and includes an emerging Balanced Scorecard, with indicators that bring together Quality and Safety, Finance, Workforce, Performance and Population Health for the Health Board. Within the

[3] https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2022-23/2022-07-12-public-sd-papers-v3pdf/ (Item 2.1.2a)

[4] https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2021-22/2021-11-16-s-amp-d-final-papers-v5-pdf/ (Item 3.3.1)

Workforce section of the Balanced Scorecard, the following is captured, 'Achieve annual local sickness and absence workforce target (rolling 12 month)', in May 2022 a rate of 6.9% was reported, which exceeded the target of 4.6%.[5]

2.6 The Local Partnership Forum is the formal mechanism for the Health Board and Trade Union / Professional Organisation Representatives to work together to improve health services. The Forum receives the Integrated Performance Report, including the Workforce Key Performance Indicators Trends.

2.7 Through the COVID-19 pandemic all Health Boards were required to report daily to Welsh Government on staff COVID-19 sickness, this has now reduced to fortnightly. We were provided with copies of the returns that were submitted.

Conclusion 1: We were able to evidence the Health Board wide arrangements for reviewing and reporting on staff sickness absence rates, through a number of governance fora. It was encouraging to note that beyond the sickness rates, further analysis was offered by way of assurance, such as the deep dive into sickness absence / managing attendance at work. (Substantial Assurance)

Objective 2: In alignment with Health Board wide arrangements for reporting of sickness absence, there are systems and processes in place to review and report on Clinical Boards and Corporate Departments sickness absence.

2.8 Prior to the COVID-19 pandemic Clinical Boards and Corporate Departments each had localised sickness absence targets, which were reviewed annually. The staff sickness targets have remained unchanged over the previous three financial years (2019-20, 2020-21 and 2021-22).

2.9 The Integrated Medium Term Plan 2022-2023, presented to the Board in June 2022 includes sickness targets for the financial year 2022/23:

- *"Improve the health and wellbeing of our workforce and in doing so reduce absence to a more sustainable position. A reduction to 6% in 22-23 and 5.5% in 23-24. With an aim to further reduce in 24-25.*
- *Aim to reduce the number of staff on long term sick leave suffering with stress, anxiety, depression by 10% in 22-23 and a further 10% in 23-24."*[6]

2.10 In April 2022, sickness absence data became available for mangers to self-serve through SharePoint. The HR advisors were previously required to provide these reports on a monthly basis to their Clinical Boards and Corporate Departments. Managers now have the ability to extract reports when required.

2.11 We reviewed the arrangements for reporting on sickness absence within a sample of Clinical Boards and Corporate Departments, which included the Specialist Services Clinical Board, Surgery Clinical Board, and Capital, Estates and Facilities

[5] https://cavuhb.nhs.wales/files/board-and-committees/board-2022-23/26522-public-board-meeting-v6pdf/ (Item 6.6)
[6] https://cavuhb.nhs.wales/files/board-and-committees/board-2022-23/2022-06-30-special-board-v5pdf/ (Item 5.1)

Services. However, we had limited engagement with Capital, Estates and Facilities Services, through failed attempts to engage or meet with the auditor, we are therefore unable to provide assurance around this area.

2.12 We note that reporting arrangements were relaxed through the pandemic, which removed some of the structure and frequency of reporting within the Clinical Boards. However, we met with the Head of People and Culture for each of the Clinical Boards, who provided information on the reporting arrangements locally.

2.13 We were able to evidence the reporting of sickness rates within Clinical Boards meetings, for instance Partnership Forums, meetings of the Clinical Board, and Senior Team Meetings. However, we found that the reporting was on the 'sickness rates' and there seemed to be no further analysis or qualitative assessment. *(Matter Arising 1- Medium Priority)*

Conclusion 2: We were able to evidence the reporting of localised sickness absence rates within the Clinical Boards. However, to support the Health Board recover from the pandemic reporting within the Clinical Boards could be enhanced, which looks beyond the high level workforce key performance indicator reports. (Reasonable Assurance)

Objective 3: Appropriate actions are put in place to further analyse and support poor performing areas identified through the review and reporting of sickness absence

2.14 The People and Culture Plan 2022 - 2025 sets out the actions that the Health Board will take over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement with the workforce.

2.15 The approach and the actions taken by the Health Board to respond to sickness absence through the pandemic has evolved, and continues to develop. As an example HR support officers within the Clinical Boards and Corporate Departments were moved to specialist teams, one of which was the 'Managing Attendance at Work' team, from December 2021 onwards. The team was formed to support operational pressures of COVID-19 and winter pressures.

2.16 Part of the rationale for establishing the specialist team was due to the impact the pandemic was having on front line services, the high sickness rates across the Health Board, and the ability to respond and manage all instances of sickness.

2.17 The team focuses on long term sickness cases, redeployments, long COVID cases, options of alternative tasks / duties to bring staff back into the work place, support for management in managing long term sickness absence, and working alongside the Health and Wellbeing Team to prevent sickness.

2.18 During the current recovery period from the pandemic it would be beneficial to provide clarity to the Clinical Boards and Corporate Departments of the People and Culture operating model, given the changing and evolving roles of the HR Advisors and the instigation of the specialist teams. *(Matter Arising 2 – Medium Priority)*

2.19 The Managing Attendance at Work Team hold two sickness trackers, the long term sickness tracker and the long COVID sickness tracker. These are key documents that are owned and populated by the team and used to support the management of sickness absence. Whilst we were made aware of these trackers and their purpose, these were not shared with the auditor.

2.20 The People Services Manager who leads the Managing Attendance at Work Team, along with the HR Advisors provided an overview of the actions taken by the Team to work with management to address staff sickness, examples of the actions taken include:

- Holding one to one meetings and surgeries, although this is yet to be fully embedded across all Clinical Boards and Corporate Departments;
- Signposting and circulating appropriate HR tools, policies and supporting management to apply the policies;
- Delivering bespoke bitesize training courses;
- Following up on sickness cases; and
- Ensuring that the sickness trackers are maintained to facilitate the timely management of staff sickness.

2.21 We were provided with a list of Managing Attendance at Work training dates offered by the Team, both past and future, noting the number of attendees to date. The training sessions offered are bitesize (one hour duration).

2.22 We reviewed the Health Board website to determine the available resources to support managing attendance. We noted the resources available and the reference to training, although the training section requires a refresh. *(Matter Arising 3- Low Priority)*

Conclusion 3: The pandemic has been unprecedented and has had a significant impact on staff sickness absence within the Health Board. Within the scope of this objective we looked to consider actions being taken to support poor performing areas, but various versions of the Workforce Key Performance Indicator report highlighted that the majority of areas are off target. Through the Managing Attendance at Work Team we were able to evidence that support is being provided and action taken to respond to the challenges created by sickness absence. Although, as the recovery progresses there is opportunity to clarify the People and Culture Operating model, with regards absence management within the Clinical Boards and Corporate Departments. (Reasonable Assurance)

Objective 4: The Board Assurance Framework adequately highlights the risk of staff sickness and the associated controls and assurances, in addition to identifying the gaps in controls and assurances.

2.23 The Board Assurance Framework presented to the Board in May 2022, includes the risk of 'Staff Wellbeing', the full description is noted as, *"There is a risk that staff sickness will increase and staff wellbeing will decrease due to the psychological and physical impact of the ongoing pandemic. Which together with limited time to reflect and recover will increase the risk of burnout in staff."*[7]

2.24 We note that the focus of the risk is on staff wellbeing, but as the risk description outlines, this aligns to staff sickness. We reviewed the risk to ensure a sample of the controls and assurances reported reasonably mitigate the risk, we were able to evidence the following:

- References to the People and Culture Plan, which many of the themes contained within the Plan outline reduced sickness levels as a 'measures of success'. There are arrangements in place to monitor the Plan;
- The People Health and Wellbeing Service, which has a host of resources available on the Health Board's website for staff; and
- The output of the Health Intervention Team, which has now reported on the research undertaken with staff.

2.25 Further consideration will be given to this risk when the planned audit for 2022/23 of 'Staff Wellbeing' is undertaken, scheduled to commence in quarter two.

Conclusion 4: Whilst the focus of the risk within the Board Assurance Framework is on staff wellbeing, the risk acknowledges the direct link to staff sickness and the impact of the pandemic. For the sample of controls and assurances we reviewed within the staff wellbeing risk, we note the relevance of the mitigation identified to assist in supporting staff and reducing staff sickness. (Substantial Assurance)

[7] https://cavuhb.nhs.wales/files/board-and-committees/board-2022-23/26522-public-board-meeting-v6pdf/ (Item 6.4)

Appendix A: Management Action Plan

Matter Arising 1: Enhanced reporting of sickness absence within the Clinical Boards (Design)	Impact
We reviewed the arrangements for reporting on sickness absence for a sample of Clinical Boards, the Specialist Services Clinical Board and Surgery Clinical Board. We had attempted to engage with the Capital, Estates and Facilities Services but received limited contact and were therefore unable to confirm their arrangements. Through our audit contacts within the Clinical Boards, the Heads of People and Culture, it was noted that localised reporting focused on high level Workforce Key Performance Indicators, which include the current sickness rate and cumulative rates for a period. We found no instances where the reports where supplemented by analysis or qualitative assessment of sickness such as sickness hot spots.	Potential risk of: • Lack of awareness of key sickness related issues facing the Clinical Boards as a whole.

	Recommendation	Priority
1	To support the Health Board's recovery from the COVID-19 pandemic, Clinical Board reporting of staff sickness absence should look beyond the high level Workforce Key Performance Indicators and provide more meaningful analysis or qualitative assessment of sickness absence.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
1	Heads of People & Culture to provide Workforce booklet for each Clinical / Service Board to be discussed at Monthly Clinical / Service Board meetings. Representative from People Services to attend meeting as required and discuss impact of sickness absence on all KPI's and further MAAW information.	September 2022	Katrina Griffiths, Head of People Services

Matter Arising 2: Clarification of roles and responsibilities (Design)			Impact
The pandemic has had a noted impact on the Health Board and the approach taken to proactively manage staff sickness absence, for example the creation of the specialist 'Managing Attendance at Work Team', and the move to manager self-service of sickness absence reports through SharePoint. Given the revised and evolving approach to HR support offered to Clinical Boards and Corporate Departments it would be beneficial to provide clarity of roles and responsibilities, to help bridge the gap around the reporting responsibilities. Particularly of the HR advisors who were previously embedded within the Clinical Boards and attended many meetings.			Potential risk of: • The Health Board fails to provide adequate health and wellbeing support to employees in the workplace, which leads to greater sickness absenteeism.
Recommendation			**Priority**
2	As a result of the changes that have taken place through the pandemic, clarification should be provided to Clinical Boards and Corporate Departments of the roles and responsibilities to manage staff sickness absence.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	Communication in relation to allocation of People Services team to be cascaded and communicated to the Health Board, including Trade Unions.	September 2022	Katrina Griffiths, Head of People Services, Rachel Gidman, Executive Director of People and Culture, and People Services Team.

Matter Arising 3: The Health Board Website requires a refresh (Operation)			Impact
There are available resources on the Health Board website which relate to managing attendance at work. There is specific mention to training in 2020, which requires a refresh, noted on the following webpage: https://cavuhb.nhs.wales/staff-information/people-services-toolkits/managing-attendance/managing-attendance-training/			Potential risk of: • Misconception that other resources are outdated and irrelevant.
Recommendation			**Priority**
3	Reference to the Managing Attendance at Work training on the Health Board website requires a refresh, to specifically remove dates referring to training in 2020.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	The Managing Attendance at Work Training to be updated on the Health Board website.	August 2022	Lucy Smith, People Services Manager

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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Follow-up: Ultrasound Governance
Final Internal Audit Report

August 2022

Cardiff & Vale University Health Board

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

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Cardiff and Vale University Health Board

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Auditors:	Lucy Jugesser, Audit Manager Wendy Wright-Davies, Deputy Head of Internal Audit
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Distribution:	Paul Rogers, Interim Assistant Director of Therapies and Health Science Dr Kate Bryant, Consultant Clinical Scientist, Head of Non-Ionising Radiation, Medical Physics Dr Paul Williams, Principal Clinical Scientist, Ultrasound Quality Assurance Lead, Medical Physics
Committee:	Audit and Assurance Committee

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Acknowledgement

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Disclaimer notice - please note

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

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Ultrasound Governance (CVU 2122-27) review that was reported as part of our 2021/22 work programme, which provided 'Limited' assurance.

Overview of findings

Management have made good progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

The two high priority recommendations raised are now complete, and moves the overall rating from a 'Limited' to 'Reasonable' Assurance, given the mitigation in risk.

Of the five recommendations made, only one medium priority remains incomplete and is work in progress. Whilst were able to evidence progress of recommendation two being taken forward, the recommendation remains at medium priority, given the importance of the exercise to provide complete assurance to the Executive Director of Therapies and Health Science. The recommendation will remain on the Audit Committee's Tracker of Internal Audit Recommendations until fully complete.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1	Lack of communication of the revised Policy and Procedure	High	Complete
2	Absence of Clinical Board assurance	Medium	Medium
3	Design and feedback of the Ultrasound Risk Management Procedure	Medium	Complete
4	Ultrasound governance arrangements	High	Complete
5	Roles and responsibilities outlined by procedure	Medium	Complete

1. Introduction

1.1 The follow-up review of Ultrasound Governance was completed in line with the 2022/23 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 Our follow-up review was of the original report that was issued in August 2021, which identified five issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The Lead Executive Director for this review is the Executive Director of Therapies and Health Science.

Audit Risks

1.4 The potential risks considered in the original review were as follows:

- There is no effective clinical governance framework;
- Equipment is poorly specified or maintained;
- Examinations are undertaken or interpreted by untrained or poorly trained individuals; and
- Inadequate monitoring of performance and scrutiny of outcomes.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	2 (R1 & R4)	-	-
Medium	3	2 (R3 & R5)	1 (R2)	-
Low	-	-	-	-
Total	**5**	**4**	**1**	**0**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Management Action Plan

Previous Matter Arising 2: Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science (Control Operation)		
Original Recommendation		Original Priority
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).		**Medium**
Management Response	Target Date	Responsible Officer
An annual audit template will be developed by the membership of the UCGG 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.	March 2022	Assistant Director of Therapies and Health Science
Current findings		**Residual Risk**
As noted within the Interim Assistant Director of Therapies and Health Science update on progress to the Audit Committee in July 2022, the Ultrasound Clinical Governance Group (UCGG) are considering various audit tools. All Clinical Boards have been contacted to provide details of their designated roles outlined within the Ultrasound Clinical Governance Procedure, at the time of our review responses remained outstanding. **Conclusion:** The actions taken do mitigate the risk posed in the initial audit, but further action is required to complete this recommendation and the planned management action.		**Medium**
Management Response	**Target Date**	**Responsible Officer**
The Ultrasound Clinical Governance Group has achieved good progress against the issues raised from the Aug 2021 internal audit findings.	December 2022	Assistant Director of Therapies and Health Science

The Ultrasound Clinical Governance Group (USCGG) has been re-established and clear reporting lines through to the responsible Executive Director of Therapies and Health Sciences (EDoTH) have been agreed and communicated via Exec QSE and the Audit and Assurance Committee via the USCGG ToRs. An engagement exercise has been conducted with Clinical Boards to identify key staff responsible for the delivery and training of Ultrasound in respective areas, the results of which will be made accessible to all once complete. This will complete the outstanding Clinical Board assurance recommendation. The USCGG have agreed an audit template and will arrange audit scheduling and recording at the next USCGG, where all key US staff will have been identified. Work to create an online Ultrasound Clinical Safety course is on-going and is on course to be made available later this year (2022). This is being aligned with similar information provided by the British Medical Ultrasound Society (BMUS) for a consistent UK approach.		

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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

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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Integrated Medium Term Plan 2022 – 2025: Development Process

Final Internal Audit Report

July 2022

Cardiff & Vale University Health Board

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Executive Summary

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the 'Integrated Medium Term Plan 2022 - 2025 Development Process'.

Overview

We have issued substantial assurance on this area.

The Health Board's Integrated Medium Term Plan aligns with the requirements of the NHS Wales Planning Framework 2022 – 2025. The initial deadline for submission to Welsh Government by 31 March 2022 was achieved, but subsequent actions were required as a result of the financial deficit underpinning the Plan.

The Health Board has good governance arrangements in place to oversee the development of the Integrated Medium Term Plan, although we have made a medium priority recommendation to enhance accessibility and transparency.

We have made two further low priority recommendations / advisory points which are in the detail of the report.

Report Classification

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	⇔ Annual Planning Process 2021-22 (May 2021)

Assurance summary[1]

Assurance objectives		Assurance
1	Appropriate governance arrangements are in place.	Reasonable
2	Lessons learnt are identified as part of the planning cycle.	Substantial
3	The planning process is aligned to the NHS Wales Planning Framework 2022 – 2025.	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Accessibility and transparency of governance arrangements	1	Operation	Medium

1. Introduction

1.1 Our audit review of the 'Integrated Medium Term Plan - Development Process' was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 The NHS Wales Planning Framework 2022 – 2025 was published on 9th November 2021, which notes, *"This Framework looks ahead to the next three years to deliver sustainable services for patients in Wales as we learn to live with COVID. The requirement is for organisations to produce a three year Integrated Medium Term Plan (IMTP) covering the period 2022-2025".*

1.3 The Framework sets out the core content expected within the Health Board's Plan. In context with Ministerial priorities with particular emphasis on demonstrating strong financial control and sustainable control within organisations, at the start of the new Welsh Government term and on multi-disciplinary, multi-agency cluster planning teams to improve cluster population health and wellbeing.

1.4 The Executive Director of Strategic Planning is the lead for this review.

Audit Risks

1.5 The risks considered in the review are as follows:

- Non-compliance with the NHS Wales Planning Framework 2022 – 2025, including matters of quality, timeliness and oversight.
- The planning process fails to address patient outcomes, and the quality and resilience of services.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the Plan is subject to scrutiny and review prior to submission to the Welsh Government.

2.1 The Strategy Development and Delivery Group, (the Group) is a key management forum for overseeing the development of the IMTP, which is chaired by the Deputy Director of Planning and feeds into the Management Executive team. Our previous review of the planning process (CVU 2021-08 Annual Planning Process) identified that the Terms of Reference for the Group had not been reviewed since July 2018. On this occasion, we were able to evidence discussions by the Group in May through to July 2021 considering the Terms of Reference, but we were still unclear from review of the document when it was approved, and it also contained a draft watermark. *(Recommendation 1 – Low Priority).*

2.2 The Operational Planning Group, led by the Chief Operating Officer, includes representatives from the Operations Team and Directors of Operations from the

Clinical Boards. We were advised that the development of the IMTP was considered in this forum.

2.3 In our previous review of the Annual Planning Process, we noted that there was a lack of clarity of the role the Strategy and Delivery Committee, given that developments of the IMTP were previously reported directly to the Board. Within this review, we were able to evidence the role of the Strategy and Delivery Committee and the opportunity they had to input and challenge prior to presentation to the Board. The revised approach reflects the implementation of our recommendation (CVU 2021-08-R2).

2.4 We were able to evidence that the Board was fully involved throughout the development process of the IMTP, culminating in review and approval of the final version in accordance with Welsh Government's submission requirements. We also acknowledge the role of the Finance Committee in supporting the Board, which gave detailed consideration and scrutiny to the financial plan, which underpins the IMTP.

2.5 The various iterations of the IMTP presented to Board and Committees, and available on the public website was in a PDF version, in accordance with all Board and Committee papers. However, the IMTP includes a number of embedded documents which cannot be opened from a PDF version. This restricts accessibility and transparency. *(Recommendation 2 – Medium Priority)*

2.6 The approval of the final IMTP took place at the Special Board Meeting on 30 June 2022. However, the paper was only available on the Health Board's website 48 hours prior to the meeting, although meeting papers should be published 10 days in advance. The meeting was held virtually on Microsoft Teams, and the start time on the Health Board's website was 30 minutes later (11.30 am) than the actual meeting start time (11 am). Although we note that all meetings can be viewed retrospectively. *(Recommendation 2 – Medium Priority)*

Conclusion 1: The Health Board has good governance arrangements in place to oversee the planning process and development of the IMTP which ensures the Plan is subject to scrutiny and review prior to submission to the Welsh Government. However, we have identified some minor points which relate to the transparency and accessibility which could be refined. (Reasonable Assurance)

Objective 2: Lessons learnt are identified and form part of the continual improvement of the planning cycle.

2.7 The Head of Strategic Planning confirmed that no formal lessons learnt exercise is undertaken at the conclusion of the planning cycle, noting the cyclical nature of the process. The planning cycle for 2022-25 has brought together a wider collective, given that recovery and redesign arrangements now fall within the remit of Strategy Development and Delivery Group. *(Recommendation 3 – Low Priority)*

2.8 We noted the Health Board's willingness to actively engage in a Welsh Government feedback process to enhance the planning process. A representative from the Health Board was involved in the All Wales feedback on the Minimum Data Set (MDS), which supplements the IMTP. The template was reviewed and recommendations for improvement were submitted to Welsh Government for incorporation into the final version to be completed by each Health Board for 2022/23.

2.9 Audit Wales, within their Structured Assessment (Phase 2), made a recommendation 'Strengthening operational plan reporting and monitoring'. Specifically, recommendation two noted that the Health Board's arrangements for monitoring and reporting on plan delivery were less robust. To address this, on 17 May 2022, a new Delivery Report template was presented to the Strategy and Delivery Committee, which will be used to monitor and provide delivery assurance against the 2022 – 2025 IMTP's objectives.[1]

Conclusion 2: We note the Health Board's appetite to engage and improve current planning arrangements, but there is an opportunity for an internal lessons-learnt exercise to be built into the planning timeline. (Substantial Assurance)

Objective 3: The University Health Board's planning process is aligned to the NHS Wales Planning Framework 2022 – 2025.

2.10 In the guidance letter issued by Welsh Government to all Health Boards on 7 February 2022, it states that plans are expected to be Board approved and IMTP's, which must be submitted by 31 March 2022, and will need to be financially balanced over a three-year period. However, where a Health Board decides that this is not possible, it must inform Welsh Government by way of an Accountable Officer letter and as a minimum must submit an Annual Plan for 2022 – 2023.

2.11 On 31 March 2022, the Board approved submission of a draft 2022 – 2025 IMTP to Welsh Government which was not financially balanced as it showed a planned deficit of £20.8m. This was done on the basis of ongoing work during the first quarter of 2022 – 23 to address this, which we have been informed by the Health Board was an approach agreeable to Welsh Government.[2] However, the potential risks which could arise from not submitting a financially balanced IMTP were reflected in the Board Assurance Framework (BAF).[3]

2.12 The draft IMTP, supported by the MDS to ensure validation and triangulation of robust underpinning services, workforce and finance plans, and an explanatory

[1] https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2022-23/2022-05-17-sandd-papers-v6pdf/ (Paper 2.2)
[2] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/ (Paper 7.1, see recommendations)
[3] https://cavuhb.nhs.wales/files/board-and-committees/board-2022-23/26522-public-board-meeting-v6pdf/ (Paper 6.4, Risk 5 - Delivery of IMTP 22-25

letter from the Health Board's Chief Executive were submitted to Welsh Government on 31 March 2022.

2.13 We reviewed the IMTP to determine whether it was aligned to the NHS Wales Planning Framework 2022 – 2025 and that it had been developed cognisant of Ministerial priorities, current context and priorities, cluster planning and statutory requirements. We found it to be a detailed, well-structured and comprehensive document with no obvious gaps or inadequacies, apart from the previously noted financial deficit.

2.14 We note that formal feedback from Welsh Government is yet to be received, although the single key issue that prevented approval of the submitted Plan in March 2022 was the financial deficit.

2.15 On 30 June 2022, following further work on the planned deficit by the Health Board a 2022 – 23 Annual Plan was approved by the Board which showed that the core financial plan for 2022 – 23 had improved by £3.7m to a £17.1m deficit. Welsh Government required an Annual Plan given the deficit, but the basis of reaching a surplus position in founded on a 3-year IMTP. The Health Board intends to deliver a surplus in 2024 – 25 on its core plan and so bring the overall expenditure and income / allocation into a sustainable position. This was submitted along with a CEO accountability letter to Welsh Government immediately following the meeting.

2.16 We reviewed the updated IMTP submission for changes compared with the previous draft version. As expected, the main changes related to the financial plan, although we also noted some updated narrative and improvements to its presentation.

Conclusion 3: The Health Board's planning process is aligned to the NHS Wales Planning Framework 2022 – 2025 and the Plan has been developed cognisant of Ministerial priorities, current context and priorities, cluster planning and statutory requirements. The financial deficit has impacted the submission of the IMTP, which was initially submitted by the deadline, 31 March 2022. With a further requirement from Welsh Government for an Annual Plan by 30 June 2022, which the Health Board achieved. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Strategy Development & Delivery Group (SDDG) Terms of Reference (Design)	**Impact**
Our previous review of the planning process (CVU 2021-08 Annual Planning Process) finalised in May 2021 identified that the Terms of Reference of the Strategy Development and Delivery Group required review. We could evidence that a review commenced, noting the following: • Prior to the Strategy Development and Delivery Group meeting on 2 June 2021, the Terms of Reference was shared on 1 June 2021; • Following the meeting, a revised draft Terms of Reference was sent out on 15 June 2021 with a request for any further amendments, in particular relating to membership or job titles, by the end of the week; and • The minutes of the meeting held on 7 July 2021 recorded further comments received on the Terms of Reference. However, on review of the document, it was still unclear when the document was approved and by which forum. We also noted that the document had a draft watermark.	Potential risk of: The Terms of Reference of the SDDG may not accurately reflect each member's understanding of its role and responsibilities.
Recommendation 1	**Priority**
Following review, the Terms of Reference for the Strategy Development and Delivery Group should be updated with the following: - The approval date; - The date of next review; and - Version number.	**Low**

Agreed Management Action 1	**Target Date**	**Responsible Officer**
As is the case with all formal groups and committees it is appropriate to ensure periodic review of ToR takes place. As such at the next annual review of the group which will be during Qtr 2 22/23 we will ensure the ToR is updated (if necessary) but that regardless of any changes a subsequent approval date / next review date / version number is added.	By September 2022	Jonathan Watts, Head of Strategic Planning

Matter Arising 2: Accessibility and transparency of governance arrangements (Operation)	**Impact**
We make the following observations on review of the governance arrangements to support the development and scrutiny of the Integrated Medium Term Plan 2022 - 2025: • The various iterations of the IMTP submitted to the Strategy and Delivery Committee and the Board are in PDF format, but contain embedded documents which are not accessible to Board and Committee members, or members of the public. Example documents include the nine regional Cluster Plans in Annex 1, and a PowerPoint presentation relating to the Population Health priority measure in Annex 3; • The IMTP presented to the Special Meeting of the Board on 30 June 2022 was only available on the Health Board's website 48 hours before the meeting, although Standing Orders require meeting papers to be published 10 days in advance; and • Furthermore, the Health Board's website noted a start time of 11.30am[4] for the Special Meeting of the Board on 30 June 2022, 30 minutes later than the actual start time of 11am and in accordance with the agenda.[5] We note that this meeting was live streamed, but could be accessed retrospectively.	Potential risk of: Reduced transparency and accountability of governance arrangements.
Recommendation 2	**Priority**
To address the governance observations highlighted through our review of the IMTP development and scrutiny process, the following should be addressed: • The accessibility of the information presented to public meetings, including the Strategy and Delivery Committee and the Board; • Adherence to the 10 day advance publication of meeting papers in accordance with Standing Orders; and • The timing of meetings should be correctly stated on the Health Board's website, particularly when being live streamed.	**Medium**

[4] https://cavuhb.nhs.wales/about-us/governance-and-assurance/board-meetings/2022-23/
[5] https://cavuhb.nhs.wales/files/board-and-committees/board-2022-23/2022-06-30-special-board-v5pdf/

Agreed Management Action 2	Target Date	Responsible Officer
a) Agreed. In future the Corporate Governance Team will request that documents are not embedded within covering reports and other paperwork, but are provided by the report authors as separate documents which can then be published as separate documents/appendices to the main paperwork and/or covering reports. We will update our Standard Operating Procedure (SOP) to reflect this. b) Generally the Corporate Governance Team publishes Board meeting papers at least 10 clear days before the meeting. This was not possible on this occasion due to the process to finalise the draft IMTP, which included discussions with Welsh Government before the financial elements of the draft IMTP could be agreed. The Corporate Governance Team received the IMTP papers 2 days before the Board meeting, hence the delay in publishing these papers. In future, where the Corporate Governance Team is aware that Board papers will be published late, we will publish a statement on our website to notify the Public that the paperwork will be published late. c) Noted and the Corporate Governance team will carry out a further check to ensure that the Board and Committee timings are correctly listed on the Health Board's website. This further check will be built into our SOP.	Immediately (July 2022)	Marcia Donovan, Head of Corporate Governance

Matter Arising 3: Lessons learnt reviews (Design)		**Impact**
Currently, no formal lessons learnt exercises are undertaken of the planning process. Given this is a cyclical process, there would be benefit of taking stock and reflecting on any learning that could inform future planning periods. We do note the iterative nature of the planning process, and this would need to be considered when determining the opportune time to consider any learning to take forward. We are also cognisant that the requirements of the Welsh Government Planning Framework do evolve year on year.		Potential risk of: Beneficial lessons may not be identified and implemented.
Recommendation 3		**Priority**
Consideration should be given to building in a lessons learnt exercise into the planning timeline, to take forward any future learning and to build into the cyclical process.		**Low**
Agreed Management Action 3	**Target Date**	**Responsible Officer**
As this audit notes The Strategy Development and Delivery Group is a key management forum for overseeing the development of the IMTP as such it is also appropriate that this group should take a leadership role in reflecting on the processes which its runs - Gathering feedback and taking learning where appropriate. A mechanism will be established within this forum to ensure there is ongoing periodic time to reflect and learn lessons regarding the IMTP process which it oversees on behalf of the UHB.	By September 2022	Jonathan Watts, Head of Strategic Planning

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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Stock Management – Neuromodulation Service (Specialist Services Clinical Board)

Final Internal Audit Report

August 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

Contents

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Executive sign-off:	Hannah Evans, Managing Director for Non-Acute Services
Distribution:	Sarah Lloyd, Interim Director of Operations Mathew Price, Directorate Manager of Neurosciences Craig Coggins, Finance Business Partner
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 audit was to evaluate and determine the adequacy of the systems and controls in place within the Neurosciences Directorate in relation to neuromodulation equipment stock management.

Overview

We have issued reasonable assurance on this area.

The outcome of our review builds on the improvements instigated by management, working with finance, to strengthen the stock management arrangements within the Neurosciences Directorate.

We have made recommendations under each of the five objectives of our review, the most notable, is a high priority recommendation to address missing stock, to the value of £75,000.

At the time of closing our audit fieldwork, the stock remained unaccounted for. The implementation of the recommendations from this review will strengthen the control environment, which should mitigate the risk of future financial losses due to missing stock.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Neuromodulation stock procedures	Reasonable
2	Security and accessibility of stock	Reasonable
3	Stock records and reconciliations	Reasonable
4	Ordering and receipt of stock	Reasonable
5	Management information of stock	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Standard Operating Procedures	1	Design	Medium
2	Storage and Security of Stock	2	Operation	Medium
3	Outcome of June 2022 Stock Count	3	Operation	Medium
4	Goods Receipting Process	4	Operation	Medium
5	Missing Stock	5	Operation	High

1. Introduction

1.1 The review of the 'Stock Management-Neuromodulation Service' was completed at the request of the Specialist Services Clinical Board. The review is an addition to the Cardiff and Vale University Health Board's Internal Audit Plan 2022/23, approved by the Audit Committee.

1.2 The Cardiff Neuromodulation unit is the tertiary referral centre for Wales and forms part of the remit of the Neurosciences Directorate, based in the University Hospital of Wales. Neuromodulation is technology that acts directly upon nerves. It is the alteration or modulation of nerve activity by delivering electrical (spinal cord stimulation) or pharmaceutical agents directly to a target area.

1.3 Neuromodulation devices are advanced medical tools that can increase or decrease the activity of the nervous system and can, in most cases, be considered as high value items for financial accounting purposes.

1.4 An Internal Audit proposed by a Clinical Board requires executive approval from the Chief Operating Officer (COO). During the interim period, and in advance of the COO commencing in role, the Managing Director of Non-Acute Services is the lead for this review.

Audit Risks

1.5 The potential audit risks considered in this review are as follows:

- Stock control procedures fail to adequately direct the management of stock, which compromises the supply and physical security of stock; and
- Financial loss to the Health Board due to the loss or misappropriation of stock.

2. Detailed Audit Findings

Objective 1: Procedures are in place for the management of neuromodulation equipment stock.

2.1 The Directorate Manager of Neurosciences developed a Standard Operating Procedure (SOP) for the management of neuromodulation stock in May 2022. A review of the SOP noted that the document only sets out a flow diagram of the process and does not provide sufficient detail to direct the process. *(Matter Arising 1 – Medium Priority)*

Conclusion 1: The Standard Operating Procedure, whilst helpful should be strengthened to enhance the controls currently in place for the management of neuromodulation stock. (Reasonable Assurance)

Objective 2: Stock is securely held in a manner that maximises the efficiency of the storage facilities

2.2 To ascertain the arrangements for the physical storage of stock we conducted a visit to the neuroscience's secretaries' office and neurosurgery theatres on the 30th June 2022.

2.3 We were able to confirm that there are designated storage cabinets for storing the neuromodulation stock utilised by the neurosurgery staff. The cabinets are situated outside the neurosurgery theatres. Storage cabinets are locked at all times and the keys are held by the Neurosurgery Consultants and are only provided to selected members of staff upon reasonable request. Theatre staff require access to the stock to prepare for upcoming surgeries and neurosciences staff require access to the cabinets to replenish the stock and/or perform monthly stock counts.

2.4 During our visit to the neurosciences office we identified that consumable neuromodulation stock, managed by the neurosciences secretary and issued directly to patients was being kept on a desk and not securely stored away. *(Matter Arising 2 – Medium Priority)*

Conclusion 2: We were able to confirm that the majority of neuromodulation stock is securely locked away in storage cabinets. However, we identified that some stock was being held in the secretaries' office. (Reasonable Assurance)

Objective 3: Transactions are recorded, stock movements are appropriate and authorised, and stock reconciliations are undertaken.

2.5 The Directorate has been historically performing monthly stock counts. The stock count was carried out intermittently throughout the pandemic, stock counts have not been undertaken as regularly due to lockdown restrictions within main theatres at UHW, and temporary suspensions of non-urgent surgeries.

2.6 Following the year end stock count reconciliation in March 2022, the Finance Team and the Directorate identified a number of issues with the neuromodulation stock management process. The following improvements to the process have been instigated by management:

- It appeared that stock movements were not being recorded for all transactions – Consumables issued directly to patients by the neurosciences secretary were not being reported to Finance. As of May 2022 a new process has been put in place to record all information, and to communicate this to Finance. We can confirm that this has been taking place in a timely manner.
- Item expiry dates were not being considered as part of the storage process and this led to inefficiencies in the use of stock. As of May 2022, colour coded stickers have been added to stock to highlight the expiration date. During our visit we were able to confirm that the process is in place and is working effectively.

- No reporting had been taking place for items that had been accidentally damaged, had expired and were obsolete, or were missing. Discussions with the Finance Business Partner confirmed that as of May 2022, this information has been reported by the Directorate following each monthly stock count.
- The Directorate did not have any standard operating procedures to document the stock management process. As stated under objective 1, the Directorate developed a stock management procedure in May 2022.

2.7 During our visit, we shadowed the Neurosciences Directorate Support Manager performing the monthly stock count for June 2022, which presented issues that require addressing. *(Matter Arising 3 – Medium Priority)*

Conclusion 3: We recognise the recent improvements that have been made to the stock management process, but there is room for further improvements, which require communicating to all staff who have access to the stock. (Reasonable Assurance)

Objective 4: Appropriate processes are in place for ordering and physically receiving the equipment.

2.8 The Neuromodulation Team identify the need for new stock and liaise with the neurosurgery secretaries who are responsible for placing orders through the financial system Oracle. The Directorate holds information on upcoming planned patient treatments and order additional equipment based on trends and to meet future demands up to a period of four to six weeks.

2.9 As part of the procurement process, the majority of the stock is shipped to the Health Board's Lakeside Stores. When new stock is received, Lakeside Stores staff should notify the Directorate and arrange to deliver these items.

2.10 A review of the procurement process for a sample of four completed orders noted that further controls could be instigated to proactively ensure that all orders are received by the Neurosciences Directorate. *(Matter Arising 4 – Medium Priority)*

Conclusion 4: The Directorate has processes in place for identifying the need of new neuromodulation stock and for placing orders accordingly, but further controls should be instigated to enhance the oversight and receipt of order placed. (Reasonable Assurance)

Objective 5: Management information is available which is accurate, timely and relevant

2.11 The Health Board has a funding arrangement in place with the Welsh Health Specialised Services Committee (WHSSC) for the provision of the Neuromodulation Service. As per the terms of the agreement, the Health Board can request funding from WHSSC for neuromodulation equipment that has been utilised for treating patients. The Directorate maintains a Patient Level Data (PLD) spreadsheet to document this.

2.12 The PLD spreadsheet is an internal document held by the Directorate and is updated on a monthly basis and shared with finance staff at month end. The document lists all of the neuromodulation treatments which have taken place, records patient name, NHS number, date of treatment and serial numbers of stock used.

2.13 As part of the budgetary control arrangements, the Directorate is supported by the Finance Team and meet on a monthly basis to discuss the financial position and the variances identified from the monthly reconciliation of neuromodulation stock versus the PLD spreadsheet. We can confirm that budgetary control meetings between Finance and the Directorate have been taking place in a timely manner, but the most recent presented a variance due to missing stock. *(Matter Arising 5 – High Priority)*

Conclusion 5: The Directorate holds adequate stock management information which is readily available and is relevant for decision making purposes. At the time of the audit, management working with Finance have identified missing stock to the value of £75,000. At the closure of our audit fieldwork the issue remained unresolved, which highlights the need to strengthen the control environment. (Limited Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Standard Operating Procedures (Design)	**Impact**
Whilst the Directorate has developed a Standard Operating Procedure for the management of neuromodulation stock, we have identified gaps within the procedure which could be strengthened: • There is no introduction to stock management and the Directorate's objectives for implementing an effective and efficient stock management process; • A lack of clarity of defined roles and responsibilities, and the importance of segregation of duties throughout the process; • No reference to key documentation and the system of controls in place to ensure that the processes are working effectively; • There is a lack of detail regarding storage and security of stock, the requirement to perform regular stock counts and the actions to be taken when issues arise; and • The process for identifying and reporting on damaged, obsolete and/or missing stock.	Potential risk of: Stock control procedures fail to adequately direct the management of stock, which compromises the supply and physical security of stock.

	Recommendation	**Priority**
1	The Standard Operating Procedure for the management of neuromodulation stock should be enhanced, to take on board our observations, which if addressed would strengthen the procedure.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	A standard operating procedure (SOP) has been created following the audit. The SOP explains objectives for managing neuromodulation stock, defining all roles and ensuring the stock management process is understood effectively. It outlines how the process should operate, with efficiency; and the stock control procedures are detailed to ensure the stock is appropriately managed and remains uncompromised.	1st October 2022	Sophie Griffiths – Neurosurgery Service Manager

	The SOP will be reviewed and ratified by the Directorate Management Team, then communicated across applicable staff groups. The SOP will be reviewed in March 2023 to ensure efficient working practices.		

Matter Arising 2: Storage and Security of Stock (Operation)			**Impact**
During our visit to the neurosurgery secretaries' office, we identified that consumable stock was being held on a secretary's desk and that there was no designated storage facility for securely storing this type of stock. At the time of the visit, there were other neurosurgery secretaries in the office, and we obtained confirmation that the office is locked when staff are not present. We had no immediate concerns for the security of the stock at the time of our visit, however stock management best practice would encourage that stock is kept secure at all times.			Potential risk of: Stock control procedures fail to adequately direct the management of stock, which compromises the supply and physical security of stock.
Recommendation			**Priority**
2	In line with stock management best practice, stock should be stored securely at all times. The facilities available to securely store the stock should be reviewed.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	In line with the above comments and lessons learnt following the review, the directorate has now ensured that all stock is appropriately counted and securely stored in two locations (main theatres or secure cabinet within secretary's office) to ensure we avoid losses and damages.	Complete	Sophie Griffiths – Neurosurgery Service Manager

Matter Arising 3: Outcome of June 2022 Stock Count (Operation)			**Impact**
During our visit, we shadowed the Neurosciences Directorate Support Manager performing the monthly stock count for June 2022. Upon reviewing the contents of the theatre cabinets, we identified that three items were missing outer packaging and had no identifiable reference / serial numbers. The Service Manager was not aware of these items, or why the packaging was missing. We were since informed that this was due to an operational issue, and the stock could still be used at a later date. The issue presented can lead to poor stock management practices and impact on the Directorate's ability to perform accurate stock counts.			Potential risk of: Financial loss to the Health Board due to the loss or misappropriation of stock.
Recommendation			**Priority**
3	In conjunction with recommendation 1, expansion of the Standard Operating Procedure for the management of neuromodulation stock should confirm how issues identified during the month end stock count are to be resolved.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Standard Operating Procedure for the management of neuromodulation stock includes details of how to manage stock issues, such as cancelled procedures which occurred during this audit period.	1st October 2022	Sophie Griffiths – Neurosurgery Service Manager

Matter Arising 4: Goods receipting process (Operation)	**Impact**
A review of the procurement process for a sample of four completed orders noted that there are instances whereby the goods receipting (within the finance system) is completed either by the neuromodulation medical secretary or by staff at the Lakeside Stores. We were advised that if goods are receipted within the Oracle system by the stores staff, the Directorate lose visibility of the orders placed. The Directorate does not have a process for tracking the delivery status of all orders placed, for instance, where orders have been goods receipted by lakeside stores, which are yet to be delivered to the Directorate, there is no process for tracking the goods.	Potential risk of: Financial loss to the Health Board due to the loss or misappropriation of stock.

	Recommendation	**Priority**
4	The Neurosciences Directorate should instigate a process to proactively track orders placed, until goods are delivered to the neuroscience's office. Any issues which arise should be addressed.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4	The Service Manager will liaise with procurement colleagues at Lakeside stores to set up a process to ensure all stock is delivered to the Neurosciences Directorate Office and receipted by a nominated directorate colleague. The aim being that all receipting of goods being completed on delivery to the Neurosciences Directorate Office. Receipting goods in a timely manner will assist with order tracking to prevent loss, increase visibility of outstanding orders avoiding financial loss due to misplaced / undelivered goods. This will require support from procurement colleagues to ensure process is sound and is undertaken as required by the All Wales Policy or guidance. This practices adopted by the DMT has been incorporated into the current SOP. Further changes may be required once the process has been firmed up with Lakeside stores colleagues.	1st November 2022	Mathew Price, Directorate Manager – Neurosciences

Matter Arising 5: Missing stock (Operation)	**Impact**
We note that Directorate Management, working with the Finance Team have identified a variance of £75,000, relating to missing stock, which was captured in their meeting notes taken in July 2022. The variance was identified from comparing the Patient Level Data spreadsheet, to the stock count undertaken in June 2022. At the time of closing our audit fieldwork the five items, amounting to £75,000 remained unaccounted for, but it was highlighted that the month end stock count for July 2022 may improve the position. Both the Finance Team and the Directorate highlighted that timing issues do emerge where goods have been receipted by Lakeside Stores, but are yet to reach the department.	Potential risk of: Financial loss to the Health Board due to the loss or misappropriation of stock.

Recommendation		**Priority**
5	To address the missing stock the Directorate need to undertake the following: - Note the outcome of the July 2022 stock count; - If the variance remains, to investigate and attempt to locate the missing stock; - Depending on the outcome, implement suitable controls to ensure that this issue does not re-occur; and - Engage with central finance over the value of the missing stock. ** The implementation of the previous recommendations made within this report will strengthen the control environment.*	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	Following the July stock take there is still missing stock. Attempts are ongoing to find the missing stock with stores, theatres, directorate and the product supplier. The final variance with the potential missing stock will take two to three months to work through the system, due to timely receipting/delivery of products.	31st October 2022	Mathew Price, Directorate Manager - Neurosciences

	Finance colleagues are sighted on volume of missing stock. The directorate and finance colleagues have a monthly finance meeting scheduled to review the neuromodulation stock variance in detail in order to finalise the position. The SOP sets out the processes and systems in place to track all stock from ordering to implantation/return to supplier.		

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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Waste Management
Proposed Final Internal Audit Report

July 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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Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities Nicola Foreman, Director of Corporate Governance Stephen Gardiner, Head of Estates and Facilities Ian Fitsall, Interim Head of Estates Gareth Simpson, Interim Head of Operations (UHB wide) Jennifer Williams, Waste Manager
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.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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

The audit was undertaken to assess the UHB's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Reasonable assurance has been issued in this area.

A number of areas of good practice were evidenced during the audit, noting particularly the development and implementation of an internal audit management system for the planning, delivering, and monitoring of a range of estates compliance audits, including waste.

The significant challenges faced by Estates & Facilities in the last two years in responding to the Covid pandemic are recognised (e.g., increased volumes of clinical waste from testing centres).

The matters requiring management attention included:

- the need to review and update the existing waste management policy and associated procedural guidance;
- the preparation of a training needs assessments;
- the need to address operational issues identified at site testing, particularly the adequacy of bin signage and cleanliness of site compounds; and
- Other recommendations are within the detail of the report.

Positive action in addressing the matters arising was being demonstrated at the time of the issue of this final 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	Policy & Procedures	Reasonable
2	Governance & Management	Reasonable
3	Contractual Arrangements	Reasonable
4	Operational Practice	Reasonable
5	Monitoring & Reporting	Substantial

[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	Policy & Procedures should be appropriately updated	1	Design	Medium
3	Risk escalation processes should be defined (*actioned since audit fieldwork*)	2	Design	Medium
4	Training requirements should be needs focussed (*actioned since audit fieldwork*)	2	Design	Medium
5	Key Performance Indicators should be applied to contractual arrangements	3	Design	Medium
6	Operational issues should be effectively addressed including enhanced signage and waste storage within main yards	4	Operation	Medium

1. Introduction

1.1 Welsh Health Technical Memorandum (WHTM) 07-01: '*Safe Management of Healthcare Waste'* provides a framework for best practice waste management, to help healthcare organisations meet legislative requirements as well as identify opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.

1.2 Effective waste management also requires compliance with the requirements of various regulatory regimes, including environment and waste, controlled drugs, infection control, health and safety and transport.

1.3 Noting that waste arising from Covid-19 patients is designated as infectious clinical waste, specific guidance has additionally been developed in the last year ('*Covid-19 waste management standard operating procedure'*).

1.4 The Welsh Government's waste reduction targets were set out in its '*Towards Zero Waste*' strategy, first published in 2010 – with a target of 70% recycling / recovery rate by 2025, and for zero waste by 2050 ('Beyond Recycling', Welsh Government 2021).

1.5 This audit assessed Cardiff and Vale University Health Board's (the UHB) compliance with the relevant legislation and guidance, and progress towards agreed national and local waste reduction targets.

1.6 The potential risks considered in the review were as follows:

- Safety of UHB staff, patients, visitors, and contractors.
- Environmental damage.
- Non-compliance with legislation, risking financial penalties or prosecution.
- Failure to achieve mandated waste reduction targets.
- Reputational damage associated with negative publicity.
- Failure to achieve value for money for the UHB.

2. Detailed Audit Findings

2.1 In undertaking this audit and presenting the findings within this report, we acknowledge the significant challenges faced by the UHB and its Estates & Facilities and Hotel Services teams during the last two years in responding to the Covid pandemic. These challenges have impacted waste management in a number of areas including performance of the clinical waste contract, delivery of waste training and operational compliance with established processes. Despite this unprecedented situation, the audit has identified a small number of areas for management action (as set out below), which management have assured will be straight forward to address as the UHB moves out of the pandemic and returns to business as usual.

Policy & Procedures: To ensure an appropriate Waste Management Policy and supporting procedures were in place.

2.2 The UHB's Waste Management Policy (version 4), as approved by the Health & Safety Committee was in date at the time of current review and being refreshed in accordance with its stipulated period for review.

2.3 The audit review undertaken of the UHB's Waste Management Policy identified the need for the enhancement of some of the information contained within the same to ensure full compliance with the WHTM requirements and best practice including:

- roles and responsibilities;
- risk control;
- training requirements;
- financial and budgetary processes; and
- waste reduction.

2.4 There was similarly a need for a corresponding update, and cross referencing to the supporting Waste Management Procedures. Both the Policy and some supporting procedures also required update at the intranet. Noting the same, at the time of the issue of the final report, progress in addressing the issues identified was being demonstrated (**MA 1**).

2.5 Noting the currency of the both the waste management procedures, whilst updating was required to fully reflect WHTM and best practice, **reasonable assurance** has currently been determined.

Governance & Management: To ensure an appropriate governance structure was operating, budgets were appropriately monitored, risks recorded, monitored, and escalated, and training appropriately delivered.

2.6 The Executive Director of Planning was responsible for waste management within the UHB. Operational management and compliance reporting was provided by the Director of Capital, Estates and Facilities, the Interim Head of Operations/Estates Manager and the Waste and Compliance Manager respectively. However, the management structure chart within the Policy, required update to reflect these arrangements (**MA 1**).

2.7 The UHB attended the All-Wales Clinical Waste Consortium, which shares best practice across Wales. The Environmental Management Steering Group (EMSG) was the dedicated forum for oversight of waste management. Briefings were also provided to the Health & Safety Committee, and by exception to the Executive Team, when significant issues required escalation. However, at the time of the review, these arrangements were not well reflected within the terms of reference of the EMSG) (**MA 1**).

2.8 Whilst noting the additional pressures on the management of clinical waste during the Covid pandemic, expenditure was managed within available budgets. However, while detailed budgetary monitoring was undertaken, the associated processes were not defined within existing procedures e.g., for query resolution (**MA 2**).

2.9 Similarly, while risk monitoring was actively operated, there was need to confirm risk escalation processes e.g., reporting of top risks etc. (**MA 3**).

2.10 The UHB provided a rolling programme of waste management training with associated recording and monitoring of compliance. However, training needs assessments would provide a more tailored approach (**MA 4**). Training needs should also be reflected within waste management procedures (**MA 1**).

2.11 While recognising the above issues, the UHB has benefitted from effective budgetary control. Risk management and training processes were being operated, and operational responsibilities were identified. Accordingly, **reasonable assurance** has been determined in respect of governance and management.

2.12 It is recognised that positive action in addressing the matters arising was being demonstrated at the time of the issue of this final report. The updates made to key controls/processes will be reflected within the updated waste management policy and associated procedural documents.

Contractual arrangements: Assurance that waste contracts have been appropriately procured and were monitored against agreed performance targets. That appropriate controls operated in the payment of invoices.

2.13 The UHB's contractual arrangements for clinical waste recycling were managed via the All-Wales Clinical Waste Consortium. At the time of this review. this contract was in year four of five, and an extension of a further three years had recently been negotiated.

2.14 Clinical waste contract performance (including delivery against KPIs) was monitored at the All-Wales Clinical Waste Consortium. There had been an increased focus on performance during the past 24 months, to manage the service through the Covid pandemic. Continuing issues (NHS Wales-wide) with capacity and performance, which fall outside the agreed performance targets, were being discussed between the key parties at the time of review, with the potential for financial penalties to be imposed under the contract.

2.15 General waste/recycling and confidential waste services had been procured via national frameworks. The UHB is planning to join the forthcoming All-Wales contract for general waste and recycling arrangements, which is scheduled to be tendered by NWSSP Procurement Services in 2022

2.16 Key Performance Indicators were monitored in relation to internal targets (e.g., recycling). However, they remained to be set for external parties and reflected in contracts (e.g., at penalty clauses etc) (**MA 5**).

2.17 There was also a need to define financial control processes to determine appropriate operation e.g., routine, or periodic audit checks of invoiced tonnage to weighbridge records (**MA 1**). However, as previously noted, detailed financial monitoring of budgetary variances was observed.

2.18 **Reasonable assurance** has been determined recognising the ongoing challenges associated with significant increase in clinical waste requiring removal, associated with the ongoing Covid-19 pandemic.

Operational Practice: A review of operational arrangements in key areas such as segregation, storage, safe handling, transfer etc. and associated record keeping, to assess compliance with the UHB's policy and procedures, WHTM 07-01 and relevant legislation. A review of waste reduction initiatives pursued by the Trust.

2.19 Operational practice was reviewed through a site visit to University Hospital Wales, to view a sample of areas within the hospital. The areas included, the main waste yard (outside the Estates department), Theatres, Coronary Care Unit, Ward B2, and at Y Gegin canteen.

2.20 Good practice was observed in a number of these areas, including:

- the appropriate provision of suitably located bins and storage areas to safely dispose of waste;
- appropriate frequency of removal of waste from source to central holding areas, to prevent build-up of waste;
- secure external waste areas; and
- appropriate labelling and packaging of waste in accordance with WHTM 07-01 requirements.

2.21 However, several operational site issues were identified including:

- inadequate bin classification signage;
- clinical waste bins within the Theatres waste area were obstructed by a theatre light; and
- an unkempt main storage yard, causing potential slippage and contamination risks, inadequate waste segregation **(MA 6)**.

The audit identified periodic audits undertaken by the UHB, including the review of the above issues. However, the most recent review of the main yard was undertaken in April 2021. Key Performance Indicators for internal waste management detailed only the number of audits undertaken, rather than the nature of the issues identified. It is recognised that general reporting of waste management issues was in place (see monitoring & reporting section).

2.22 For a sample reviewed, waste consignment notes had been completed correctly and retained for the required period.

2.23 Details of waste reduction initiatives were provided to audit, for example, WARP IT scheme, to recycle/reduce waste.

2.24 It is recognised that the clinical waste volumes (rather than tonnage) increased significantly across NHS Wales (including at the UHB) during the Covid pandemic, due to the inclusion of Personal Protective Equipment (PPE) etc. as infectious clinical waste. NWSSP: Specialist Estates Services (SES) have published updated guidance (*'Covid-19 waste management standard operating procedure,'* June 2021*)* stating that organisations should comply with the requirements of WHTM 07-01 i.e., disposal of non-infectious PPE in the domestic or offensive waste streams where appropriate.

2.25 The audit found appropriate provision of tiger stripe bins across the sampled areas. Whilst noting the same, safeguards against ongoing / over-use of tiger stripe and clinical waste bins were not identified,

2.26 The UHB does not currently include their approach to waste minimisation within their Policy (**MA 1** & **7**).

2.27 Noting good practice across the range of areas under consideration, and limited exceptions, a **reasonable assurance** has been determined in this area.

Monitoring & Reporting: That appropriate arrangements were in place to record, monitor and report waste management activities, including incidents, compliance audits, costs and performance against agreed targets. That reporting was appropriately directed at both operational and executive level.

2.28 Appropriate arrangements were in place for the recording and investigation of waste-related incidents, notably via Datix. Of fifteen Datix incidents recorded January - September 2021, nine resulted in no harm, and five were described as minor. However, one further case was logged as more significant injury (from slippage at the waste compound). However, this was not classified together with the other fourteen incidents at Datix. There was therefore a need to confirm appropriate coding of incidents (**MA 8**). This incident also highlights the significance of issues raised within this report relating to slippage risks within the storage yard.

Management advised that subsequent to the audit fieldwork, the UHB has moved Datix to DCIQ which is powered by SharePoint and far more user friendly. Therefore, similar coding issues should not arise in future.

2.29 The UHB has developed an internal audit management system (I-Auditor), for the planning, delivering, and monitoring of a range of estates compliance audits, including waste. The system facilitates the management of the following:

- "ISO14001 Environmental System external audit;
- Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises); and also
- undertakes its own internal site inspections.

Audit recommendations were tracked through the I-Auditor system.

2.30 Waste management monitoring and reporting included:

- **Environmental Management Steering Group**: the primary forum for oversight reporting of including risks, budget management, and ISO14001 non-conformities;
- **Capital, Estates and Facilities Board**: received waste management updates, compliance audits/ISO14001, risk updates and information on new waste initiatives of interest (Green Health Wales);
- **Health & Safety Committee**: This group received detailed waste compliance reports, and reviewed key waste related matters by exception; and
- **Executive briefings**: as required, by exception

2.31 As previously noted (at the governance section), UHB staff also attended the All-Wales Clinical Waste Consortium.

2.32 Findings from the monthly internal site inspections were reported to the relevant Site Manager for action, recognising the lower-level nature of these issues (not resulting from formal external audits).

2.33 While recognising issues both within this section, and assessed elsewhere within this report, noting the range of monitoring, and reporting arrangements, a **substantial assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)	**Impact**
Welsh Health Technical Memorandum (WHTM) 7.1: '*Safe Management of Healthcare Waste,*' requires: "access *to an appropriate healthcare waste policy that identifies who is responsible … and .. instructions on how it should be managed."* (6.2) The Waste Management Policy, as approved by the Health & Safety Committee was in date at the time of audit, and being refreshed in accordance with its stipulated period for review. However, a review of the policy identified a need for enhancement including: • roles, responsibilities, reporting, and communications including the waste-contractor and structure charts; • budgetary and monitoring arrangements (**MA 2**); • risk control (**MA 3**); • training requirements (**MA 4**); • financial processes (e.g., routine or periodic audit checks of invoiced tonnage to weighbridge records); • waste minimisation (**MA 7**); • non-compliance, tracking, and summary record/processes; • business continuity arrangements including of testing and assurances; • dissemination of the Policy including intranet update;	Potential risk of: • inappropriate guidance

• improvement programmes and monitoring progress (e.g., against baseline figures for number of waste/ disposal routes, waste contract or legal requirements); and • cross referencing to supporting information & help. There was also a need for enhanced clarity in relation to committee responsibilities. The Terms of Reference for the Environmental Management Steering Group require it only to *"develop Environmental Objectives and Targets for specific specialist disciplines including but not limited to: Energy, Waste, Air Emissions"*. Similarly, linkage and reporting to the Health and Safety Committee was not defined. The UHB had developed a range of supporting procedural documents, providing guidance on for example, Food Waste, TUG Operation, and Removing Waste (on wards), and Spillages. Whilst comprehensive, these were last updated in 2017 and therefore required review to ensure information remains relevant to current UHB operations. The UHB's intranet site also contained some out-of-date and superseded policy and procedural documents, which should also be reviewed for currency or removed as appropriate.	

Recommendations	Priority
1.1. Waste management policies and procedures should be updated for currency / removed, in accordance with best practice guidance, and appropriately ratified.	**Medium**
1.2 The Environmental Management Steering Group terms of reference should be updated to appropriately reflect its waste governance responsibilities and linkage to the Health and Safety Committee.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1.1 Agreed. Update waste policy and procedures (ref MA1) to also include waste minimisation (ref MA7). Progress has been made in addressing a number of the above issues since the issue of the draft report i.e. an updated	September 2022	Interim Head of Estates Operations

	management structure, training needs and risk management processes have been drafted for inclusion within the above (ref MA1). The updated will be ratified at relevant board.		
1.2	Agreed and actioned since audit fieldwork - the Environmental Management Steering Groups Terms of Reference has been updated to appropriately reflect its waste governance responsibilities and linkage to H&S Committee	Actioned Since Audit Fieldwork	N/A

Matter Arising 2: Budget Management (Design)	**Impact**
The Waste Management Procedure specifies the need for appropriate waste budgeting by the UHB. Whilst noting the additional pressures on the management of clinical waste during the Covid pandemic, both budget and risks were managed within existing operational remits and / or available Covid recovery monies. Detailed budgetary monitoring was undertaken including reporting of top categories for expenditure variances. However, while much of the process was evident from practice, as noted at **MA 1** it did not benefit from full definition including assigned roles and responsibilities (e.g., whether verification checks are the responsibility of finance or the waste department). A query raised by the Waste & Compliance manager to the Finance Department on 9th December 2021 (relating to five non-waste staff charged to the waste budget), remained un-answered at the conclusion of audit (March 2022). While the resolution process was not defined, it is recognised that this was indicative of detailed monitoring, and appropriate interactions.	Potential risk that: • the budget is not appropriately controlled.

Recommendations	**Priority**
2.1 Budget processes should be defined, including cost allocation, query, and escalation mechanisms.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. Process map finance - budget allocation, issues, errors etc., to be detailed (ref **MA2**). Some areas have already been mapped out since the completion of the audit fieldwork.	August 2022	Interim Head of Estates Operations/ Waste and Compliance Manager

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Matter Arising 3: Risk Management (Design)	**Impact**
The Waste Management Policy recognised the need to control risks (notably injury / harm), and accordingly referenced supporting documents e.g., those relating to infection control, and radioactive waste. Accordingly, risk assessments were identified in relation to specific matters. Datix and RIDDOR returns were also being utilised to recording incidents. Health and Safety reports, inclusive of risk updates were presented to the Capital, Estates and Facilities Department, Health and Safety meeting. A presentation was also produced to cascade information to staff. However, an assessment/reporting of the key risks associated with waste management (and their associated mitigation/management arrangements) was not identified.	Potential risk that: • Risks are not properly identified, assessed, reported/escalated, mitigated, and managed.

Recommendations	**Priority**
3.1. The UHB should confirm appropriate risk reporting and escalation arrangements, notably to the Environmental Management Steering Group.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Agreed. Process maps required for Risk Management (ref **MA3**) and particularly escalation arrangements to Environmental Management Steering Group *Note: The "RISK MANAGEMENT PROCESS – CAPITAL ESTATES AND FACILITIES" has been defined and will be included within the updated Waste Management Policy.*	Actioned since audit fieldwork	N/A

Matter Arising 4: Training (Design)	**Impact**
WHTM 07.01 (6.33) highlights the importance of waste management training: *"all healthcare staff should be aware of the policy/procedures and that the policy is implemented by trained and competent people;"* and that *"a training record will readily enable line managers to identify members of staff who are not receiving the appropriate level of training, and where such training should be focused."* Waste management training was provided via Induction, Line Manager/Toolbox Talks, supported by several Operational Procedures. Training was recorded and monitored using a Training Matrix, a Waste spreadsheet, and a Compliance spreadsheet. However, there was limited information in respect of targeted coverage, oversight, and monitoring processes/actions within operating procedures (**MA 1**). Additionally, limited information was available re the training of wider staff groups e.g., not all the staffing groups identified within the WHTM 07 01 guidance for example were stated i.e., Pharmacists, Infection Control, Medical Doctors. Recognising the same, a wider reach of environmental awareness / recycling training would support the achievement of UHB/national waste reduction targets and the UHB's Waste Strategy.	Potential risk that: • Staff do not receive appropriate training to minimise risks and optimise waste handling. • Non-compliance with WHTM 07-01 requirements
Recommendations	**Priority**
4.1a The UHB should undertake training needs assessments to inform tailored training programmes encompassing all relevant UHB staff groups to determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling and include additional training provided due to COVID).	**Medium**

4.1b Management should investigate options to provide waste management/recycling/green agenda training to all UHB staff. Including the engagement of appropriate departments / forums to present the benefits of wider awareness/recycling training across the UHB		
Agreed Management Action	**Target Date**	**Responsible Officer**
4.1a Agreed, a training needs assessment matrix has been developed for all relevant Estates and Facilities staff. The matrix will be included within the updated Waste Management Policy (ref **MA1**).	Actioned Since Audit Fieldwork	N/A
4.1b Agreed, however, wider support needed from L&D to roll out across HB. Waste Manager currently sitting on a number of 'Teams' channels to deal with Waste queries as they arise.	September 2022	Waste and Compliance Manager

Matter Arising 5: Key Performance Indicators (Design)	**Impact**
WHTM 07.01 notes: *"performance should be measurable"* and recommends as best practice "*publication of a bespoke report regarding the performance."* Key Performance Indicators (KPIs) were monitored in relation to internal targets (e.g., recycling). A clinical waste issues log was also maintained (recording 18 incidents from January – September 2021 including, removal of tags; over-charging; out of hours collection – diverting medical staff; short / missed collections; and failure to supply bins). At the time of audit KPIs remained in formulation in respect of contracted parties. Accordingly, while contracts contained basic requirements such as anticipated tonnage, locations and frequency of collections, formal monitoring of performance was not in place via this mechanism (e.g., collections missed, cleanliness, spillages, or billing accuracy). It is noted that such monitoring could be linked to contractual penalty clauses and incentives at future contracts.	Potential risk that: • Performance is not appropriately monitored • Performance is not optimised.

Recommendations	**Priority**
5.1 The UHB should conclude the formulation and operation of Key Performance indicators in respect of contracted parties to complement contractual arrangements.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts are currently going through procurement, there is therefore an opportunity to now build these in.	August 2022	Waste and Compliance Manager

Matter Arising 6: Operational Practice (Operation)	**Impact**
WHTM 07-01 requires healthcare waste to be appropriately segregated and securely and appropriately stored (e.g., to prevent contamination or infection). Operational practices were reviewed at the University Hospital Wales site. This found waste separated into coded bags and stored in secure areas (excepting limitations of access to ward sub-store areas due to Covid restrictions). However, noting the need to correctly identify waste, issues noted included: • **Inadequate signage** - In some cases signage was absent (CCU), handwritten, or above the wrong bins (e.g., as for electrical equipment at the main waste yard); • **Contamination risk** - the main waste yard had spilled / broken bags. This also reduced available workspace, increased the risk of injury through trips etc. and potentially posed a risk of incorrect waste segregation. Ward B2, and Theatre's storerooms were visited as part of testing. Of these, the Theatre's storeroom access was obstructed by a large lamp on the floor. However, it is recognised that this may have been an isolated and temporary matter.	Potential risk of: • Waste areas presents a health and safety risk • Breach of guidance
Recommendations	**Priority**
6.1 Waste signage at storage locations should be reviewed and improved to ensure clear, accurate instructions are provided for waste segregation and disposal. 6.2 Waste yards should be maintained to an appropriate standard and ensure that waste is correctly stored and segregated	**Medium**

Agreed Management Action	Target Date	Responsible Officer
6.1 Agreed, a review of all bin signage/labelling (ref MA6), will be undertaken.	August 2022	Waste and Compliance Manager
6.2 Agreed.	August 2022	Waste and Compliance Manager

Matter Arising 7: Waste Minimisation (Design)	**Impact**
WHTM 07-01 (5.3) sets out that: *"The best financial and environmental option is not to produce waste in the first place. This is because whether waste goes for recovery, recycling, or disposal, it is still a product that the organisation has usually bought, handled, and is then having to pay for disposal of. Avoiding producing the waste at all reduces both buying costs and disposal costs;"* and *"Waste policies should include a programme to critically review the volume and types of waste that are produced, and to identify and implement practical steps to reduce waste volumes."* Whilst some examples of good practice in waste minimisation were provided by management, it was not evident that a UHB-wide critical review has been undertaken in recent years. It is fully recognised that 2020-2021 has been focused on managing the Covid response, and time for such a review would not have been feasible and may not be for some time. However, the potential to undertake this work, in targeted areas, should be considered as part of future work programmes.	Potential risk that: • Waste is not minimised at source.

Recommendations	**Priority**
7.1 A critical review of waste volumes and types across the UHB should be considered, to identify potential for waste minimisation in accordance with WHTM 07-01 (5.3 - 8).	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 Agreed. A critical review of waste volumes and types across the UHB will be considered to identify potential for waste minimisation. This is currently in progress.	December 2022	Waste and Compliance Manager

Matter Arising 8: Incidents (Operation)	**Impact**
The Waste Management Procedure requires that: *"Given the risks associated with the handling of waste, any accidents/injuries involving waste must be reported immediately in accordance with the Organisation's policy for the reporting of accidents and untoward incidents, utilizing the appropriate Incident Reporting Procedure".* Of 14 incidents recorded January - September 2021, nine resulted in no harm, and five were described as minor. One RIDDOR incident (over 7 days incapacitation) was also logged - caused by slippage at a bin store. While it was stated as recorded on Datix (noting its assigned Datix reference within RIDDOR), it was not recorded within the Datix extract of waste incidents (as required), indicating an issue of classification. This would represent a 15th Datix incident.	Potential risk that: • Waste related incident reporting is incomplete.

Recommendations	**Priority**
8.1 The relation between coding classifications of RIDDOR and Datix incident recording should be reviewed to ensure appropriate reporting.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
8.1 Agreed, however superseded since audit fieldwork. Management advised that subsequent to the audit fieldwork, Datix has moved over to DCIQ which is powered by SharePoint and far more user friendly and coding issues should not arise.	Actioned Since Audit Fieldwork	N/A

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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Waste Management
Final Internal Audit Report

August 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

Contents

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Executive sign-off:	Catherine Phillips, Executive Director of Finance
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities Nicola Foreman, Director of Corporate Governance Stephen Gardiner, Head of Estates and Facilities Ian Fitsall, Interim Head of Estates Gareth Simpson, Interim Head of Operations (UHB wide) Jennifer Williams, Waste Manager
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.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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

The audit was undertaken to assess the UHB's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Reasonable assurance has been issued in this area.

A number of areas of good practice were evidenced during the audit, noting particularly the development and implementation of an internal audit management system for the planning, delivering, and monitoring of a range of estates compliance audits, including waste.

The significant challenges faced by Estates & Facilities in the last two years in responding to the Covid pandemic are recognised (e.g., increased volumes of clinical waste from testing centres).

The matters requiring management attention included:

- the need to review and update the existing waste management policy and associated procedural guidance;
- the preparation of a training needs assessments;
- the need to address operational issues identified at site testing, particularly the adequacy of bin signage and cleanliness of site compounds; and
- Other recommendations are within the detail of the report.

Positive action in addressing the matters arising was being demonstrated at the time of the issue of this final 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	Policy & Procedures	Reasonable
2	Governance & Management	Reasonable
3	Contractual Arrangements	Reasonable
4	Operational Practice	Reasonable
5	Monitoring & Reporting	Substantial

[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	Policy & Procedures should be appropriately updated	1	Design	Medium
3	Risk escalation processes should be defined (*actioned since audit fieldwork*)	2	Design	Medium
4	Training requirements should be needs focussed (*actioned since audit fieldwork*)	2	Design	Medium
5	Key Performance Indicators should be applied to contractual arrangements	3	Design	Medium
6	Operational issues should be effectively addressed including enhanced signage and waste storage within main yards	4	Operation	Medium

1. Introduction

1.1 Welsh Health Technical Memorandum (WHTM) 07-01: '*Safe Management of Healthcare Waste'* provides a framework for best practice waste management, to help healthcare organisations meet legislative requirements as well as identify opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.

1.2 Effective waste management also requires compliance with the requirements of various regulatory regimes, including environment and waste, controlled drugs, infection control, health and safety and transport.

1.3 Noting that waste arising from Covid-19 patients is designated as infectious clinical waste, specific guidance has additionally been developed in the last year ('*Covid-19 waste management standard operating procedure'*).

1.4 The Welsh Government's waste reduction targets were set out in its '*Towards Zero Waste*' strategy, first published in 2010 – with a target of 70% recycling / recovery rate by 2025, and for zero waste by 2050 ('Beyond Recycling', Welsh Government 2021).

1.5 This audit assessed Cardiff and Vale University Health Board's (the UHB) compliance with the relevant legislation and guidance, and progress towards agreed national and local waste reduction targets.

1.6 The potential risks considered in the review were as follows:

- Safety of UHB staff, patients, visitors, and contractors.
- Environmental damage.
- Non-compliance with legislation, risking financial penalties or prosecution.
- Failure to achieve mandated waste reduction targets.
- Reputational damage associated with negative publicity.
- Failure to achieve value for money for the UHB.

2. Detailed Audit Findings

2.1 In undertaking this audit and presenting the findings within this report, we acknowledge the significant challenges faced by the UHB and its Estates & Facilities and Hotel Services teams during the last two years in responding to the Covid pandemic. These challenges have impacted waste management in a number of areas including performance of the clinical waste contract, delivery of waste training and operational compliance with established processes. Despite this unprecedented situation, the audit has identified a small number of areas for management action (as set out below), which management have assured will be straight forward to address as the UHB moves out of the pandemic and returns to business as usual.

Policy & Procedures: To ensure an appropriate Waste Management Policy and supporting procedures were in place.

2.2 The UHB's Waste Management Policy (version 4), as approved by the Health & Safety Committee was in date at the time of current review and being refreshed in accordance with its stipulated period for review.

2.3 The audit review undertaken of the UHB's Waste Management Policy identified the need for the enhancement of some of the information contained within the same to ensure full compliance with the WHTM requirements and best practice including:

- roles and responsibilities;
- risk control;
- training requirements;
- financial and budgetary processes; and
- waste reduction.

2.4 There was similarly a need for a corresponding update, and cross referencing to the supporting Waste Management Procedures. Both the Policy and some supporting procedures also required update at the intranet. Noting the same, at the time of the issue of the final report, progress in addressing the issues identified was being demonstrated (**MA 1**).

2.5 Noting the currency of the both the waste management procedures, whilst updating was required to fully reflect WHTM and best practice, **reasonable assurance** has currently been determined.

Governance & Management: To ensure an appropriate governance structure was operating, budgets were appropriately monitored, risks recorded, monitored, and escalated, and training appropriately delivered.

2.6 The Executive Director of Planning was responsible for waste management within the UHB. Operational management and compliance reporting was provided by the Director of Capital, Estates and Facilities, the Interim Head of Operations/Estates Manager and the Waste and Compliance Manager respectively. However, the management structure chart within the Policy, required update to reflect these arrangements (**MA 1**).

2.7 The UHB attended the All-Wales Clinical Waste Consortium, which shares best practice across Wales. The Environmental Management Steering Group (EMSG) was the dedicated forum for oversight of waste management. Briefings were also provided to the Health & Safety Committee, and by exception to the Executive Team, when significant issues required escalation. However, at the time of the review, these arrangements were not well reflected within the terms of reference of the EMSG) (**MA 1**).

2.8 Whilst noting the additional pressures on the management of clinical waste during the Covid pandemic, expenditure was managed within available budgets. However, while detailed budgetary monitoring was undertaken, the associated processes were not defined within existing procedures e.g., for query resolution (**MA 2**).

2.9 Similarly, while risk monitoring was actively operated, there was need to confirm risk escalation processes e.g., reporting of top risks etc. (**MA 3**).

2.10 The UHB provided a rolling programme of waste management training with associated recording and monitoring of compliance. However, training needs assessments would provide a more tailored approach (**MA 4**). Training needs should also be reflected within waste management procedures (**MA 1**).

2.11 While recognising the above issues, the UHB has benefitted from effective budgetary control. Risk management and training processes were being operated, and operational responsibilities were identified. Accordingly, **reasonable assurance** has been determined in respect of governance and management.

2.12 It is recognised that positive action in addressing the matters arising was being demonstrated at the time of the issue of this final report. The updates made to key controls/processes will be reflected within the updated waste management policy and associated procedural documents.

Contractual arrangements: Assurance that waste contracts have been appropriately procured and were monitored against agreed performance targets. That appropriate controls operated in the payment of invoices.

2.13 The UHB's contractual arrangements for clinical waste recycling were managed via the All-Wales Clinical Waste Consortium. At the time of this review. this contract was in year four of five, and an extension of a further three years had recently been negotiated.

2.14 Clinical waste contract performance (including delivery against KPIs) was monitored at the All-Wales Clinical Waste Consortium. There had been an increased focus on performance during the past 24 months, to manage the service through the Covid pandemic. Continuing issues (NHS Wales-wide) with capacity and performance, which fall outside the agreed performance targets, were being discussed between the key parties at the time of review, with the potential for financial penalties to be imposed under the contract.

2.15 General waste/recycling and confidential waste services had been procured via national frameworks. The UHB is planning to join the forthcoming All-Wales contract for general waste and recycling arrangements, which is scheduled to be tendered by NWSSP Procurement Services in 2022

2.16 Key Performance Indicators were monitored in relation to internal targets (e.g., recycling). However, they remained to be set for external parties and reflected in contracts (e.g., at penalty clauses etc) (**MA 5**).

2.17 There was also a need to define financial control processes to determine appropriate operation e.g., routine, or periodic audit checks of invoiced tonnage to weighbridge records (**MA 1**). However, as previously noted, detailed financial monitoring of budgetary variances was observed.

2.18 **Reasonable assurance** has been determined recognising the ongoing challenges associated with significant increase in clinical waste requiring removal, associated with the ongoing Covid-19 pandemic.

Operational Practice: A review of operational arrangements in key areas such as segregation, storage, safe handling, transfer etc. and associated record keeping, to assess compliance with the UHB's policy and procedures, WHTM 07-01 and relevant legislation. A review of waste reduction initiatives pursued by the Trust.

2.19 Operational practice was reviewed through a site visit to University Hospital Wales, to view a sample of areas within the hospital. The areas included, the main waste yard (outside the Estates department), Theatres, Coronary Care Unit, Ward B2, and at Y Gegin canteen.

2.20 Good practice was observed in a number of these areas, including:

- the appropriate provision of suitably located bins and storage areas to safely dispose of waste;
- appropriate frequency of removal of waste from source to central holding areas, to prevent build-up of waste;
- secure external waste areas; and
- appropriate labelling and packaging of waste in accordance with WHTM 07-01 requirements.

2.21 However, several operational site issues were identified including:

- inadequate bin classification signage;
- clinical waste bins within the Theatres waste area were obstructed by a theatre light; and
- an unkempt main storage yard, causing potential slippage and contamination risks, inadequate waste segregation **(MA 6)**.

The audit identified periodic audits undertaken by the UHB, including the review of the above issues. However, the most recent review of the main yard was undertaken in April 2021. Key Performance Indicators for internal waste management detailed only the number of audits undertaken, rather than the nature of the issues identified. It is recognised that general reporting of waste management issues was in place (see monitoring & reporting section).

2.22 For a sample reviewed, waste consignment notes had been completed correctly and retained for the required period.

2.23 Details of waste reduction initiatives were provided to audit, for example, WARP IT scheme, to recycle/reduce waste.

2.24 It is recognised that the clinical waste volumes (rather than tonnage) increased significantly across NHS Wales (including at the UHB) during the Covid pandemic, due to the inclusion of Personal Protective Equipment (PPE) etc. as infectious clinical waste. NWSSP: Specialist Estates Services (SES) have published updated guidance (*'Covid-19 waste management standard operating procedure,'* June 2021*)* stating that organisations should comply with the requirements of WHTM 07-01 i.e., disposal of non-infectious PPE in the domestic or offensive waste streams where appropriate.

2.25 The audit found appropriate provision of tiger stripe bins across the sampled areas. Whilst noting the same, safeguards against ongoing / over-use of tiger stripe and clinical waste bins were not identified,

2.26 The UHB does not currently include their approach to waste minimisation within their Policy (**MA 1** & **7**).

2.27 Noting good practice across the range of areas under consideration, and limited exceptions, a **reasonable assurance** has been determined in this area.

Monitoring & Reporting: That appropriate arrangements were in place to record, monitor and report waste management activities, including incidents, compliance audits, costs and performance against agreed targets. That reporting was appropriately directed at both operational and executive level.

2.28 Appropriate arrangements were in place for the recording and investigation of waste-related incidents, notably via Datix. Of fifteen Datix incidents recorded January - September 2021, nine resulted in no harm, and five were described as minor. However, one further case was logged as more significant injury (from slippage at the waste compound). However, this was not classified together with the other fourteen incidents at Datix. There was therefore a need to confirm appropriate coding of incidents (**MA 8**). This incident also highlights the significance of issues raised within this report relating to slippage risks within the storage yard.

Management advised that subsequent to the audit fieldwork, the UHB has moved Datix to DCIQ which is powered by SharePoint and far more user friendly. Therefore, similar coding issues should not arise in future.

2.29 The UHB has developed an internal audit management system (I-Auditor), for the planning, delivering, and monitoring of a range of estates compliance audits, including waste. The system facilitates the management of the following:

- "ISO14001 Environmental System external audit;
- Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises); and also
- undertakes its own internal site inspections.

Audit recommendations were tracked through the I-Auditor system.

2.30 Waste management monitoring and reporting included:

- **Environmental Management Steering Group**: the primary forum for oversight reporting of including risks, budget management, and ISO14001 non-conformities;
- **Capital, Estates and Facilities Board**: received waste management updates, compliance audits/ISO14001, risk updates and information on new waste initiatives of interest (Green Health Wales);
- **Health & Safety Committee**: This group received detailed waste compliance reports, and reviewed key waste related matters by exception; and
- **Executive briefings**: as required, by exception

2.31 As previously noted (at the governance section), UHB staff also attended the All-Wales Clinical Waste Consortium.

2.32 Findings from the monthly internal site inspections were reported to the relevant Site Manager for action, recognising the lower-level nature of these issues (not resulting from formal external audits).

2.33 While recognising issues both within this section, and assessed elsewhere within this report, noting the range of monitoring, and reporting arrangements, a **substantial assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)	**Impact**
Welsh Health Technical Memorandum (WHTM) 7.1: '*Safe Management of Healthcare Waste,*' requires: "access *to an appropriate healthcare waste policy that identifies who is responsible … and .. instructions on how it should be managed."* (6.2) The Waste Management Policy, as approved by the Health & Safety Committee was in date at the time of audit, and being refreshed in accordance with its stipulated period for review. However, a review of the policy identified a need for enhancement including: • roles, responsibilities, reporting, and communications including the waste-contractor and structure charts; • budgetary and monitoring arrangements (**MA 2**); • risk control (**MA 3**); • training requirements (**MA 4**); • financial processes (e.g., routine or periodic audit checks of invoiced tonnage to weighbridge records); • waste minimisation (**MA 7**); • non-compliance, tracking, and summary record/processes; • business continuity arrangements including of testing and assurances; • dissemination of the Policy including intranet update;	Potential risk of: • inappropriate guidance

• improvement programmes and monitoring progress (e.g., against baseline figures for number of waste/ disposal routes, waste contract or legal requirements); and • cross referencing to supporting information & help. There was also a need for enhanced clarity in relation to committee responsibilities. The Terms of Reference for the Environmental Management Steering Group require it only to *"develop Environmental Objectives and Targets for specific specialist disciplines including but not limited to: Energy, Waste, Air Emissions"*. Similarly, linkage and reporting to the Health and Safety Committee was not defined. The UHB had developed a range of supporting procedural documents, providing guidance on for example, Food Waste, TUG Operation, and Removing Waste (on wards), and Spillages. Whilst comprehensive, these were last updated in 2017 and therefore required review to ensure information remains relevant to current UHB operations. The UHB's intranet site also contained some out-of-date and superseded policy and procedural documents, which should also be reviewed for currency or removed as appropriate.	

Recommendations	Priority
1.1. Waste management policies and procedures should be updated for currency / removed, in accordance with best practice guidance, and appropriately ratified.	**Medium**
1.2 The Environmental Management Steering Group terms of reference should be updated to appropriately reflect its waste governance responsibilities and linkage to the Health and Safety Committee.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1.1 Agreed. Update waste policy and procedures (ref MA1) to also include waste minimisation (ref MA7). Progress has been made in addressing a number of the above issues since the issue of the draft report i.e. an updated	September 2022	Interim Head of Estates Operations

	management structure, training needs and risk management processes have been drafted for inclusion within the above (ref MA1). The updated will be ratified at relevant board.		
1.2	Agreed and actioned since audit fieldwork - the Environmental Management Steering Groups Terms of Reference has been updated to appropriately reflect its waste governance responsibilities and linkage to H&S Committee	Actioned Since Audit Fieldwork	N/A

Matter Arising 2: Budget Management (Design)	**Impact**
The Waste Management Procedure specifies the need for appropriate waste budgeting by the UHB. Whilst noting the additional pressures on the management of clinical waste during the Covid pandemic, both budget and risks were managed within existing operational remits and / or available Covid recovery monies. Detailed budgetary monitoring was undertaken including reporting of top categories for expenditure variances. However, while much of the process was evident from practice, as noted at **MA 1** it did not benefit from full definition including assigned roles and responsibilities (e.g., whether verification checks are the responsibility of finance or the waste department). A query raised by the Waste & Compliance manager to the Finance Department on 9th December 2021 (relating to five non-waste staff charged to the waste budget), remained un-answered at the conclusion of audit (March 2022). While the resolution process was not defined, it is recognised that this was indicative of detailed monitoring, and appropriate interactions.	Potential risk that: • the budget is not appropriately controlled.

Recommendations	**Priority**
2.1 Budget processes should be defined, including cost allocation, query, and escalation mechanisms.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. Process map finance - budget allocation, issues, errors etc., to be detailed (ref **MA2**). Some areas have already been mapped out since the completion of the audit fieldwork.	August 2022	Interim Head of Estates Operations/ Waste and Compliance Manager

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Matter Arising 3: Risk Management (Design)	**Impact**
The Waste Management Policy recognised the need to control risks (notably injury / harm), and accordingly referenced supporting documents e.g., those relating to infection control, and radioactive waste. Accordingly, risk assessments were identified in relation to specific matters. Datix and RIDDOR returns were also being utilised to recording incidents. Health and Safety reports, inclusive of risk updates were presented to the Capital, Estates and Facilities Department, Health and Safety meeting. A presentation was also produced to cascade information to staff. However, an assessment/reporting of the key risks associated with waste management (and their associated mitigation/management arrangements) was not identified.	Potential risk that: • Risks are not properly identified, assessed, reported/escalated, mitigated, and managed.

Recommendations	**Priority**
3.1. The UHB should confirm appropriate risk reporting and escalation arrangements, notably to the Environmental Management Steering Group.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Agreed. Process maps required for Risk Management (ref **MA3**) and particularly escalation arrangements to Environmental Management Steering Group *Note: The "RISK MANAGEMENT PROCESS – CAPITAL ESTATES AND FACILITIES" has been defined and will be included within the updated Waste Management Policy.*	Actioned since audit fieldwork	N/A

Matter Arising 4: Training (Design)	**Impact**
WHTM 07.01 (6.33) highlights the importance of waste management training: *"all healthcare staff should be aware of the policy/procedures and that the policy is implemented by trained and competent people;"* and that *"a training record will readily enable line managers to identify members of staff who are not receiving the appropriate level of training, and where such training should be focused."* Waste management training was provided via Induction, Line Manager/Toolbox Talks, supported by several Operational Procedures. Training was recorded and monitored using a Training Matrix, a Waste spreadsheet, and a Compliance spreadsheet. However, there was limited information in respect of targeted coverage, oversight, and monitoring processes/actions within operating procedures (**MA 1**). Additionally, limited information was available re the training of wider staff groups e.g., not all the staffing groups identified within the WHTM 07 01 guidance for example were stated i.e., Pharmacists, Infection Control, Medical Doctors. Recognising the same, a wider reach of environmental awareness / recycling training would support the achievement of UHB/national waste reduction targets and the UHB's Waste Strategy.	Potential risk that: • Staff do not receive appropriate training to minimise risks and optimise waste handling. • Non-compliance with WHTM 07-01 requirements
Recommendations	**Priority**
4.1a The UHB should undertake training needs assessments to inform tailored training programmes encompassing all relevant UHB staff groups to determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling and include additional training provided due to COVID).	**Medium**

4.1b Management should investigate options to provide waste management/recycling/green agenda training to all UHB staff. Including the engagement of appropriate departments / forums to present the benefits of wider awareness/recycling training across the UHB		
Agreed Management Action	**Target Date**	**Responsible Officer**
4.1a Agreed, a training needs assessment matrix has been developed for all relevant Estates and Facilities staff. The matrix will be included within the updated Waste Management Policy (ref **MA1**).	Actioned Since Audit Fieldwork	N/A
4.1b Agreed, however, wider support needed from L&D to roll out across HB. Waste Manager currently sitting on a number of 'Teams' channels to deal with Waste queries as they arise.	September 2022	Waste and Compliance Manager

Matter Arising 5: Key Performance Indicators (Design)	**Impact**
WHTM 07.01 notes: *"performance should be measurable"* and recommends as best practice "*publication of a bespoke report regarding the performance."* Key Performance Indicators (KPIs) were monitored in relation to internal targets (e.g., recycling). A clinical waste issues log was also maintained (recording 18 incidents from January – September 2021 including, removal of tags; over-charging; out of hours collection – diverting medical staff; short / missed collections; and failure to supply bins). At the time of audit KPIs remained in formulation in respect of contracted parties. Accordingly, while contracts contained basic requirements such as anticipated tonnage, locations and frequency of collections, formal monitoring of performance was not in place via this mechanism (e.g., collections missed, cleanliness, spillages, or billing accuracy). It is noted that such monitoring could be linked to contractual penalty clauses and incentives at future contracts.	Potential risk that: • Performance is not appropriately monitored • Performance is not optimised.

Recommendations	**Priority**
5.1 The UHB should conclude the formulation and operation of Key Performance indicators in respect of contracted parties to complement contractual arrangements.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts are currently going through procurement, there is therefore an opportunity to now build these in.	August 2022	Waste and Compliance Manager

Matter Arising 6: Operational Practice (Operation)	**Impact**
WHTM 07-01 requires healthcare waste to be appropriately segregated and securely and appropriately stored (e.g., to prevent contamination or infection). Operational practices were reviewed at the University Hospital Wales site. This found waste separated into coded bags and stored in secure areas (excepting limitations of access to ward sub-store areas due to Covid restrictions). However, noting the need to correctly identify waste, issues noted included: • **Inadequate signage** - In some cases signage was absent (CCU), handwritten, or above the wrong bins (e.g., as for electrical equipment at the main waste yard); • **Contamination risk** - the main waste yard had spilled / broken bags. This also reduced available workspace, increased the risk of injury through trips etc. and potentially posed a risk of incorrect waste segregation. Ward B2, and Theatre's storerooms were visited as part of testing. Of these, the Theatre's storeroom access was obstructed by a large lamp on the floor. However, it is recognised that this may have been an isolated and temporary matter.	Potential risk of: • Waste areas presents a health and safety risk • Breach of guidance
Recommendations	**Priority**
6.1 Waste signage at storage locations should be reviewed and improved to ensure clear, accurate instructions are provided for waste segregation and disposal. 6.2 Waste yards should be maintained to an appropriate standard and ensure that waste is correctly stored and segregated	**Medium**

Agreed Management Action	Target Date	Responsible Officer
6.1 Agreed, a review of all bin signage/labelling (ref MA6), will be undertaken.	August 2022	Waste and Compliance Manager
6.2 Agreed.	August 2022	Waste and Compliance Manager

Matter Arising 7: Waste Minimisation (Design)	**Impact**
WHTM 07-01 (5.3) sets out that: *"The best financial and environmental option is not to produce waste in the first place. This is because whether waste goes for recovery, recycling, or disposal, it is still a product that the organisation has usually bought, handled, and is then having to pay for disposal of. Avoiding producing the waste at all reduces both buying costs and disposal costs;"* and *"Waste policies should include a programme to critically review the volume and types of waste that are produced, and to identify and implement practical steps to reduce waste volumes."* Whilst some examples of good practice in waste minimisation were provided by management, it was not evident that a UHB-wide critical review has been undertaken in recent years. It is fully recognised that 2020-2021 has been focused on managing the Covid response, and time for such a review would not have been feasible and may not be for some time. However, the potential to undertake this work, in targeted areas, should be considered as part of future work programmes.	Potential risk that: • Waste is not minimised at source.

Recommendations	**Priority**
7.1 A critical review of waste volumes and types across the UHB should be considered, to identify potential for waste minimisation in accordance with WHTM 07-01 (5.3 - 8).	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 Agreed. A critical review of waste volumes and types across the UHB will be considered to identify potential for waste minimisation. This is currently in progress.	December 2022	Waste and Compliance Manager

Matter Arising 8: Incidents (Operation)	**Impact**
The Waste Management Procedure requires that: *"Given the risks associated with the handling of waste, any accidents/injuries involving waste must be reported immediately in accordance with the Organisation's policy for the reporting of accidents and untoward incidents, utilizing the appropriate Incident Reporting Procedure".* Of 14 incidents recorded January - September 2021, nine resulted in no harm, and five were described as minor. One RIDDOR incident (over 7 days incapacitation) was also logged - caused by slippage at a bin store. While it was stated as recorded on Datix (noting its assigned Datix reference within RIDDOR), it was not recorded within the Datix extract of waste incidents (as required), indicating an issue of classification. This would represent a 15th Datix incident.	Potential risk that: • Waste related incident reporting is incomplete.

Recommendations	**Priority**
8.1 The relation between coding classifications of RIDDOR and Datix incident recording should be reviewed to ensure appropriate reporting.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
8.1 Agreed, however superseded since audit fieldwork. Management advised that subsequent to the audit fieldwork, Datix has moved over to DCIQ which is powered by SharePoint and far more user friendly and coding issues should not arise.	Actioned Since Audit Fieldwork	N/A

Mohamed.Sarah
06/09/2022 09:09:15

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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