Audit and Assurance Committee Meeting

Tue 05 July 2022, 09:00 - 12:30

Agenda

1. Welcome and Introductions

John Union

2. Apologies for Absence

John Union

3. Declarations of Interest

John Union

4. Minutes of the Committee meetings held on 12 May 2022 and 14 June 2022

John Union

04 Draft Public Audit Minutes -12.5.22 IV MD NF. JU.pdf (7 pages)
04 Draft Special Public Audit Minutes - June MD.NF. JU.pdf (11 pages)

5. Action log following meetings held on 14 June 2022

John Union

05 Draft Public Action Log - June MD.pdf (3 pages)

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

John Union

7. Items for Review and Assurance

7.1. Internal Audit Progress Report

Ian Virgil

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

7.2. Temporary Staffing Department (Nurse Bank) Internal Audit Report Update

Rachel Gidman / Jonathan Pritchard

- 7.2 Temporary Staffing Department (Nurse Bank) Internal Audit Report.pdf (2 pages)
- 7.2a Nurse Bank Updated Report Cover.pdf (2 pages)
- 7.2b Nurse Bank_Final Internal Audit Report (Inc. Mgt. Responses).pdf (20 pages)

7.3. IT Service Management Update (Verbal)

David Thomas

7.4. Audit Wales Update

Wales Audit

Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response

- 7.4 C&VUHB AC Update (July 2022).pdf (12 pages)
- 7.4 Audit Wales - Review of Quality Governance Arrangements - C&VUHB (Final).pdf (30 pages)
- 7.4(a) Review of Quality Governance Arrangements - CVUHB Management Response 27.06.2022 - FINAL.pdf (17 pages)

7.5. Ultrasound Clinical Governance Position

Fiona Jenkins / Paul Rogers

- 7.5 USCGG - Exec Summary.pdf (3 pages)
- 7.5a US Clinical Governance-USCGG-ToRs.pdf (13 pages)
- 7.5b Ultrasound Governance (CDT CB).pdf (16 pages)

7.6. Declarations of Interest, Gifts and Hospitality Report

Nicola Foreman

- 7.6 Declarations of Interest Gifts and Hospitality Tracking Report July 2022.pdf (4 pages)
- 7.6 - Declarations of Interest Apr 20 to Present.pdf (4 pages)

7.7. Internal Audit Tracking Report

Nicola Foreman

- 7.7 - Internal Audit Tracking Report July 2022.pdf (4 pages)
- 7.7(a) Appendix 1 - Internal Audit Tracker July 2022.pdf (14 pages)
- 7.7a2 Appendix 1 - Internal Audit Tracker July 2022 Not Rated.pdf (3 pages)
- 7.7b Appendix 2 - Internal Audit Summary Tables - July 2022.pdf (3 pages)

7.8. Audit Wales Tracking Report

Nicola Foreman

- 7.8 - Audit Wales Recommendation Tracker July 2022.pdf (3 pages)
- 7.8b - Audit Wales Recommendation Tracker - Recommendation Table (July 2022).pdf (1 pages)
- 7.8c - Audit Wales Tracker.pdf (4 pages)

7.9. Regulatory Tracking Report

- 7.9 Regulatory Compliance Tracking Report July 2022.pdf (5 pages)
- 7.9(a) Regulatory Tracker - July 2022.pdf (2 pages)

7.10. Review Risk Management

Nicola Foreman

- 7.10 - Risk Management Review.pdf (3 pages)

7.11. Procurement Compliance Report - Single Tender Actions

Catherine Phillips

- 7.11 Procurement Compliance Report - Single Tender Actions.pdf (6 pages)

7.12. Counter Fraud Progress Report

Catherine Phillips / Gareth Lavington

- 7.12 Counter Fraud Progress Report Cover Paper.pdf (2 pages)
- 7.12a Counter Fraud Progress Report.pdf (12 pages)
- 7.12a(i) - Fraud Alert - Mandate Fraud.pdf (1 pages)
- 7.12a(ii) - Fraud Alert - Telephone Scam.pdf (1 pages)
- 7.12a(iii) - Fraud Alert - ESR Phishing Email.pdf (1 pages)
- 7.12a(iv) - Fraud Alert - Counter Fraud Newsletter.pdf (2 pages)

8. Items for Approval / Ratification

8.1. Draft Management of Policies, Procedures and Other Written Control Documents Policy

Nicola Foreman

- 8.1 Controlled Documents Policy_Report.pdf (2 pages)
- 8.1a UHB 001 POLICY ver 6_draft_TD.pdf (3 pages)
- 8.1b UHB 242 PROCEDURE v3_draft_AF.pdf (28 pages)

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgil

9.1.1. Recovery of services and Delivery of the Annual Plan 2021 – 2022 Final Report – Substantial Assurance

- 9.1a Delivery of Annual Plan and Recovery.pdf (12 pages)

9.1.2. Risk Management Final Internal Audit Report – Reasonable assurance

- 9.1b Risk Management Report.pdf (13 pages)

9.1.3. Performance Reporting (Data Quality) Final Report – Reasonable Assurance

- 9.1c Performance Reporting (Data Quality).pdf (15 pages)

9.1.4. ChemoCare IT System Final Report – Limited Assurance

- 9.1d Chemo Care System Final Report.pdf (23 pages)

10. Agenda for Private Audit and Assurance Committee

John Union

i. Counter Fraud Progress Report (Verbal)
ii. Workforce and Organisational Development Compliance Report

11. Any Other Business

John Union

12. Review and Final Closure

12.1. Items to be deferred to Board / Committee

John Union

12.2. To note the date, time and venue of the next Committee meeting:

Tuesday 6 September 2022 at 9am via MS Teams

13. Declaration

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 Meeting
Held On 12 May 2022 at 09:00
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
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
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Sian Harries	SH	IM&T Audit Manager
Mark Jones	MJ	Audit Wales
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
David Thomas	DT	Director of Digital & Health Intelligence
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Andrew Crook	AC	Head of People Assurance & Experience
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People & Culture
Charles Janczewski	CJ	UHB Chair
Darren Griffiths	DG	Audit Wales

Item No	Agenda Item	Action
AAC 12/05/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 12/05/002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 12/05/003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 12/05/004	**Minutes of the meeting held on 5th April 2022** **The Committee resolved that:** a) The draft minutes of the meeting held on 5th April 2022 were held as a true and accurate record of the meeting.	

AAC 12/05/005	**Action Log - following meeting held on 5th April 2022** The Head of Internal Audit (HIA) commented that AAC 22/5/4/ 018 was still in progress and would be reported at a later committee meeting. **The Committee resolved that:** a) Subject to the above amendment, the Action Log was up to date.	**Action log**
AAC 12/05/006	**Any other urgent business:** To agree any additional items of urgent business that may need to be considered during the meeting **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 12/05/007	**Compliance with the Corporate Governance Code** The Director of Corporate Governance (DCG) stated that it showed the Health Boards (HBs) compliance with the UK Corporate Governance Code. The DCG added that there were some areas where the HB did not need to comply due to the level and status of the corporate governance, however, where the HB did not feel that they were compliant they would need to explain this. It was completed annually as a self-assessment and fed into the annual report through the annual governance statement. **The Committee resolved that:** a) The assessment of compliance against the UK Code of Corporate Governance for April 2021-March 2022 was noted. b) The self-assessment of compliance against the UK Code of Corporate Governance for inclusion in the Accountability Report for 2021-2022 was approved.	
AAC 12/05/008	**Board and Committee Effectiveness Surveys 2021-22** The DCG stated that it was a requirement of the standing orders to undertake an effectiveness review of all the committees of the Board. It was completed through a monkey survey and it was noted that a different tool may be used next year.	

	The individual results of the committees and the Board were included. An action plan which provided areas that required improvement was also included. It was noted that this year the survey was broadened to committee members and also attendees to increase response rates. The DCG added that the HB would be looking at its strategic objectives and aligning those with the strategic objectives of the committees of the Board. Therefore, the structure of the committees could change over the next 12 months. **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2021-2022, and the action plan for 2021-2022, to be progressed via Board Development sessions were noted. b) The completed actions within the Board Committee Effectiveness Action plan 2020-2021 were noted. c) The results of the Annual RATS Committee Effectiveness Survey 2021-2022, and the action plan for 2021-2022 attached as Appendix 1, to be progressed via Board Development sessions were noted.	
AAC 12/05/009	**Counter Fraud Progress Report (Verbal)** The Lead Local Counter Fraud Specialist (LLCFS) advised the Committee on the following: • Most of the activity taken place had been in relation to building the infrastructure that was required. • This included creating infrastructure for awareness, education and reporting routes. **The Committee resolved that:** a) The Counter Fraud Progress Report Verbal Update was noted.	
AAC 12/05/010	**Internal Audit Progress Report** The HIA presented the Internal Audit Progress Report (the Report) and highlighted the following – • There were two limited assurance reports. One was with the Executive Director of People and Culture and the other was with the Director of Digital & Health Intelligence. • Section 2 highlighted that 4 audits were planned to be delivered for this committee. Two were at the draft stage. Outcomes of those reports would feed into the Head of Internal Audits opinion. Details of the report would be brought to the July committee meeting.	**IV**

	• Section 3 highlighted that 8 reports had been finalised. Four received substantial assurance, two received reasonable assurance and two received limited assuranc • Summaries were included in section 6 of the report. • Section 4 highlighted the delivery of the 2021/22 plan. 24 final audits have been delivered. A further 2 were in draft and 5 were in progress. It was noted that a piece of work to validate actions recorded as complete within the tracker had started. They were waiting on responses from management to confirm the position. The outcome would feed into the Head of Internal Audit opinion at the June meeting but the outcome would go to the July meeting. The CC queried how the sample was decided. The HIA responded that Internal Audit looked at all the actions recorded as complete and took a sample from those which were a high and medium priority. It was noted that section 6 detailed the executive summaries of the 8 final reports. The full reports were under section 9 of the papers. The first four reports were substantial assurance. The HIA presented the Development of Genomics Partnership Wales report and highlighted the following: • A reasonable assurance was given - This reflects that there were robust project teams operating and appropriate engagement with stakeholders and users. • The key matters arising related to: A need for improved contractual management arrangements at all stages of the project; and Weaknesses in the approvals process in relation to the accelerated approach. An action plan had been agreed to allow management to address the issues. The Deputy Head of Internal Audit (DHIA) presented the Nurse Rostering: Children's Hospital for Wales report and highlighted the following; • It was completed in readiness to allow transition across to the new HB rostering system. • Reasonable assurance was provided. • The health roster project team had confirmed that the new system would address issues identified and gave a demonstration of controls. • Management had accepted the recommendation and the HB would be one of the earlier adopters of the new roster system. The DHIA presented the Nurse Bank report and highlighted the following:	

	• A number of issues were encountered. • Management agreed with the findings. • High priority issues were identified. Most which related to the structure of the temporary staffing department and how they could best support the nurse bank and how the HB could make the best use of agencies to support them. • The health roster would also have an impact on the temporary staffing department. The Head of People Assurance and Experience (HPAE) stated that the service was inherited from corporate nursing. The plan was to work through all the action points and come back with a detailed report to ensure the bank works to full effect. Mark Jones (MJ) from Audit Wales commented that Audit Wales did not always take assurance from Internal Audit however, they would need to speak to the HIA to understand the report in relation to auditing the accounts. The CC queried how this would be reported back to the committee. MJ responded that unless there was a material issue, it could be picked up in their meeting on 14th June. The IM&T Audit Manager presented the NIS Directive and highlighted the following: • They had reviewed the implementation of the network and information system directive. It was a core piece of legislation related to cyber security with the intention to increase the levels of security and resilience to key systems. • The review found that an appropriate plan was in place to complete the cyber assessment. • Concluded limited assurance. • Management immediately dealt with the high priority recommendation. The Independent Member for ICT (IMI) queried the audit process. The IMI stated he was concerned of the high priority recommendation where a section had been missed in the final assessment which carried through to the audit report and now the meeting. The HIA responded that initial findings were discussed with management. However, the reports needed to reflect the situation at the time of completing the audit. The Director of Digital & Health Intelligence (DDHI) highlighted the following:	**EDPC**

	• Action 1 had been taken on board and accepted the 600 questions posed by the cyber resilience unit. Need to have a mechanism to maintain it. • There was an oversight on one of the questions. This had been completed. • They were now actively recruiting a dedicated cyber team. • The risk register had been updated and reflected the NIS situation. • A detailed response on NIS and the cyber element would be discussed in the private part of the Digital committee meeting in June. The HIA stated that the meeting papers included the advisory work on the mental health arrangements which came to the last audit meeting. It did not include the management responses. It was noted that the responses were included under section 9.1. The DCG stated that she wanted to make sure the tracker included the advisory report recommendations and noted that it had also gone to the Mental Health committee. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered.	
	Items for Approval / Ratification	
AAC 12/05/011	**Counter Fraud Annual Plan** The LLCFS presented the Counter Fraud Annual Plan and highlighted the following: • Proposed work for 2022/23. • It looked slightly different from previous years. This was due to changes in the NHS counter fraud authorities' standards. They were mandatory from next year onwards. • 12 requirements needed to be worked to. • It measured 3 levels of compliance – green, red and amber. • The HB should be able to achieve green ratings in the upcoming year. • The annual plan is expected to be flexible and broad. **The Committee resolved that:** a) The Counter Fraud Annual Plan 2022 – 2023 was discussed and approved.	
AAC 12/05/012	**The Counter Fraud Annual Report 2021/22** It was noted that the main part of the report formed the summary of compliance.	

	The HB was listed as green in all areas but improvements needed to be made in fraud awareness, education and reporting routes. The Executive Director of Finance (EDF) stated it was a progress report and it had been reviewed by the team. **The Committee resolved that:** a) The report as an accurate assessment of the work undertaken during the year and a measure of compliance with the standards set out by the NHS CFA was discussed and approved.	
	Items for Information and Noting	
AAC 12/05/013	i) COVID-19 Vaccination Programme - Phase 3 delivery Final Report (Substantial Assurance) ii) Health & Safety Final Report (Substantial Assurance) iii) Wellbeing Hub at Maelfa Final Report (Reasonable Assurance) iv) Development of Genomics Partnership Wales Final Report (Reasonable Assurance) v) Network and Information Systems (NIS) Directive Final Report (Limited Assurance) vi) Welsh Risk Pool Claims (Substantial Assurance) vii) Nurse Rostering: Children's Hospital for Wales, Children and Women's CB (Reasonable Assurance) viii) Nurse Bank (Limited Assurance). Otherwise Approved. ix) Delivery of Mental Health Services – Advisory Report	
	Any Other Business No other business was discussed.	
	Review and Final Closure	
AAC 12/05/014	**Items to be deferred to Board / Committee** Nothing further was added.	
	Date & time of next Meeting To note date, time and venue of the next Committee meeting: **Tuesday 14th June 2022 (Special Meeting) at 9am**	

Draft Minutes of the Special Audit and Assurance Committee Public Meeting
Held on Tuesday 14th June 2022 at 9.30am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
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
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Mark Jones	MJ	Audit Wales
Marcia Donovan	MD	Head of Corporate Governance
Robert Mahoney	RM	Interim Deputy Director of Finance
Rachel Pressley	RP	Workforce Governance Manager
Helen Lawrence	HL	Head of Financial Accounts and Services
Timothy Davies	TD	Head of Corporate Business
Observers:		
Natalie Painter	NP	Audit Wales Graduate Trainee
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People & Culture
Suzanne Rankin	SR	Chief Executive Officer
Meriel Jenney	MJ	Executive Medical Director
Charles Janczewski	CJ	UHB Chair

Item No	Agenda Item	Action
AAC 14/6/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 14/6/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 14/6/22 003	**Declarations of Interest** **The Committee resolved that:**	

	a) No Declarations of Interest were noted.	
AAC 14/6/22 004	**Any other urgent business** The CC thanked the Finance and Corporate Governance teams for getting the papers ready in time for the meeting.	
	Items for Approval / Ratification	
AAC 14/6/22 005	**Report of the Losses and Special Payment Panel** The Interim Deputy Director of Finance (IDDF) presented the Report of the Losses and Special Payment Panel paper and advised the Committee on the following: • The Losses and Special Payments Panel last met on 10th May 2022 to consider the 6-month period from 1st October 2021 to 31st March 2022. • The report informed the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval. • The minutes of the 10th May Panel were previously discussed in the Private session of the Audit Committee on held earlier on 14 June 2022. • The figures have been approved by the Losses and Special Payment Panel and have now been incorporated into the Annual Accounts. **The Committee resolved that:** a) The write offs outlined in the Key Issues Section of the report were approved.	
AAC 14/6/22 006	**Introduction to Annual Report and Accounts 2021-22** The Head of Financial Accounts and Services (HFAS) presented the Introduction to the Annual Report and Accounts 2021-22 and advised the Committee on the following: • The report set out the key changes identified between the draft and final version of the draft Annual Report. • In accordance with the agreed deadlines, the 2021/22 Draft Annual Accounts, Draft Performance Report and Draft Accountability Report were completed and forwarded to the Welsh Government and Audit Wales.	

	• With regards to its role in providing advice to the Board, the Audit and Assurance Committee, in accordance with its Terms of Reference, had responsibility to specifically comment upon the accounting policies, the Accounts, the Annual Report of the organisation and the Letter of Representation.The Audit and Assurance Committee also has a key role in reviewing the ISA 260 report from Audit Wales. • The Annual Report contains the Annual Accounts and the Remuneration Report which were the key financial statements. • The Draft Performance Report, Draft Accountability Report, Draft Annual Accounts and associated documents were reviewed in detail by the Audit and Assurance Committee at its workshop held on 12th May 2022. • Assurance on the accuracy of the Annual Report and Accounts could be taken by: - The programme of work and review that the Audit and Assurance Committee had undertaken throughout 2021/22 and the process it followed to verify and sign off the Annual Report and Accounts. - The work completed by Audit Wales and presented to the Audit and Assurance Committee in their ISA 260 Report; - The response given to the Audit Enquiries to those Charged with Governance and Management and the Letter of Representation that would be sent to Audit Wales. - Assurance could also be taken from the programme of work undertaken by the Audit and Assurance Committee, the work completed by Audit Wales, the response given to the Audit Enquiries with those Charged with Governance and the Letter of Representation sent to Audit Wales. - Assurance could also be taken from the work carried out by Internal Audit, Counter Fraud and the opinion issued by the Head of Internal Audit. • This year attention was drawn to the ISA260 Report regarding the regularity opinion qualification. The financial statements included a provision (and corresponding expenditure) of £2.193 million. That related to the Health Board's estimated liability arising from a Ministerial Direction in 2019. The Direction instructed payments to be made to Clinical staff, if claimed,	

	to restore the value of their pension benefits packages. • For NHS Clinicians who opted to claim the financial offer to settle their annual allowance tax charges arising from their 2019-20 NHS pension savings, their NHS employers would meet the impact of those personal tax-charges on their pension when they retire. • Claims that were submitted by the deadline of 31 March 2022 were accounted for as expenditure within the 2021-22 Financial Statements. That expenditure was irregular and material by its nature. • An unqualified Audit opinion was given on the 2021-22 Financial Statements, with the exception of the above-mentioned regularity opinion. <u>Changes to the Draft Annual Report and Accounts</u> • Audit Wales had reviewed the Draft Performance Report and Draft Accountability Report and provided feedback on a number of minor narrative changes which were incorporated within the Annual Report. • The Accountability Report had also been amended to include the Head of Internal Audit Opinion where reasonable assurance had been provided. • There were small number of changes made to the Draft Accounts. Those however, did not impact on the reported financial performance of the Health Board and the £232,000 surplus remained against the revenue resource limit. Those amendments were mentioned on pages 2 and 3 of the Committee papers and include: - £17.685m PFI disclosure had been added to PFI note 25.2. That referenced note 11 and the capital value included within the PFI scheme. It was a disclosure adjustment because the PFI was correctly included within the body of the draft accounts. - Within note 18 there was a £9.48m reclassification of capital creditors that was previously misclassified within the revenue creditors. - Within note 22 the capital commitment disclosure was reduced. It was purely a disclosure adjustment and capital adjustment expenditure occurred was correctly reflected within the drafts account.	

	- Within note 3.3 it was identified that the depreciation charges were understated by £349,000. As depreciation was funded by Welsh Government (WG), the revenue resource limit was reviewed and increased by £349,000 in line with the increased expenditure. The revenue resource performance had been updated to reflect that. As a result of the increased expenditure allocated by WG there were no changes to the bottom line. - Staff note 9.6.1 showed that disclosure amendments were made adjusting the pay banding for the Chief Executive Officer and the highest paid Director. Salaries were correctly included in the accounts and note 9 was amended to be consistent with the Remuneration Report. - Two amendments were made to note 30. Welsh Wound Centre amounts owed to related party were increased by £2k. Cardiff Council expenditure to related party was decreased by £3.412m. They were correctly included in the accounts but not the disclosure notes. - In comparison to previous audits, the adjustments were small. - The following adjustments were made to the Remuneration Report. Firstly, the pay bands for three senior officers were amended to a different pay band. - A column had been added to the remuneration table to disclose the full-year-equivalent salaries of the senior officers. The CC queried how many Health Boards would have had the same qualification. The HFAS replied that it would have been consistent across all the Health Boards. Clinicians who had applied for the payment would have had the comparable regularity qualification. Mark Jones (MJ) responded it was all Welsh Health Bodies except 3 (Health Education and Improvement Wales (HEIW), Welsh Ambulance Service Trust (WAST) and Digital Health and Care Wales). They either did not have senior Clinicians or did not put in any claims. The HFAS stated the changes made to the Draft Accounts and Remuneration Report were set out in Appendix 4 of the ISA 260 Report.	

	Uncorrected misstatements There was only one non-trivial uncorrected misstatement which related to land and building assets. The District Valuer (DV) had issued its indexation reports on an all-Wales basis, and supplied its 2021-22 report in August 2021. It stated that building asset values should be uprated by 5% for 2021-22. However that was further updated in March 2022 by the DV to 7%. It was noted that following Welsh Government discussions and in-line with other Welsh Health Boards that increased indexation had not been amended for in the accounts. If the Health Board had applied the 7% indexation instead of 5%, it would result in: - an increase of £10.280 million in the value of land and buildings in respect of indexation, as at 31 March 2022; - an increase in depreciation of £331,000 for 2021-22; - a reversal of past impairments of £8.184 million for 2021-22; and. - an increase in the revaluation reserve of £2.096 million, as at 31 March 2022. The CC queried if there would be opportunity to catch up at the end of the current financial year. The HFAS responded that they would be accurately revalued during this financial year. The Executive Director of Finance (EDF) stated that the volatility of indexation and resource allocation was not previously discussed by the Audit Committee. It had a material impact on the accounts and the Committee should be aware of that in the account preparation. If there were material errors, then materiality was substantially used by the non-adjustment that the Committee was not aware of. Overview of financial performance 2021-22 • The National Health Service Finance Act 2014 placed two financial duties on the Health Board:	

	– A duty under Section 175 (1) to ensure that its expenditure did not exceed the aggregate of the funding allocated to it over a period of 3 years. - A duty under Section 175 (2A) to prepare and obtain approval from the Welsh Ministers for a plan which achieved the first duty above (ie Section 175(1)), while also improving the health of the people for whom the Health Board was responsible and improving the healthcare provided to them. It was noted that the Health Board had an approved Integrated Medium-Term Plan (IMTP) covering the years 2019-20 to 2021-22. The Health Board had therefore achieved its financial duty under Section 175 (2A). The approved IMTP was to achieve a year-end balanced out-turn position in each year of the plan. The financial performance for the year, as contained in the accounts was a year-end surplus of £0.232m for 2021/22. The Health Board had a surplus of £0.058m in 2019/20 and a surplus of £0.090m in 2020/21. That meant that over the three-year period the aggregated surplus was £0.380m. Thus, the Health Board had met its financial duty against its Revenue Resource Limit, both under Section 175 (1) and Section 175 (2A), over the three-year period 2019/20 to 2021/22. <u>Performance against its Capital Resource Limit</u> It was noted that the Health Board had effectively managed its considerable Capital programme during the year and the accounts had shown a small surplus of £0.041m against its Capital Resource Limit of £70.989m. It was noted that the Health Board had a surplus of £0.089m in 2019/20 and a surplus of £0.104m in 2020/21 against its Capital Resource Limit. That meant that over the three-year period the aggregated surplus was £0.234m. Thus, the Health Board had met its financial duty to break-even against its Capital Resource Limit over the three years 2019/20 to 2021/22. The CC stated it was good to meet the in-year revenue especially during the pandemic. The CC thanked all the teams involved. The CC said that the Committee would return to consider the proposed recommendations set out in the report once all of the agenda items have been presented to the Committee.	

AAC 14/6/22 007	**The Head of Internal Audit Opinion and Annual Report for 2021-22** Ian Virgil (IV) presented the Head of Internal Audit Opinion and Annual Report for 2021-22 and highlighted the following: • The majority of the final document was the same as the draft presented in the Audit Workshop in May. • The HIA Opinion for 21/22 was that 'The Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively'. • It was a positive Opinion overall and consistent with the draft report. • 29 audits were completed within 2021-22. That included 7 Substantial Assurance, 12 Reasonable Assurance, 7 Limited Assurance and 3 advisory or non-opinion. • The only difference from the draft document was that they had anticipated 32 audits but 3 were still "work in progress" and had not been included in the Opinion. However, those would be included in this year's audits. The Independent Member for ICT (IMI) queried the data analytics and system development audit. It is was an area that the Health Board could improve. It would be interesting to look at the report. IV responded that he would forward the documents to the IMI. The CC stated that the 3 of the limited assurance reports were in the IT area and the Director of Digital Health Intelligence had given assurance to the Committee. The CC thanked Internal Audit for all their work. **The Committee resolved that:** a) the Head of Internal Audit Opinion and Annual Report for 2021/22 was recommended to the Board to agree and endorse.	IV

AAC 14/6/22 008	**Audit Wales ISA 260 Report** Mark Jones (MJ) presented the Audit Wales ISA 260 Report and highlighted the following: • The Audit Wales Report discharged responsibility before the accounts were considered for approval and signed. • Unqualified audit opinion was given except for regularity opinion and that related to scheme pay and tax issues. • There was accrued expenditure in the accounts. • Corrections that were done were low in number in comparison to previous years. A follow up report would go to the September Audit meeting. MJ thanked the Finance team and all those involved for their help in completing this. **The Committee resolved that:** a) The Audit Wales ISA 260 Report was noted.	AW
AAC 14/6/22 009	To receive and consider the following for 2020-21: a) The Letter of Representation included within the ISA 260 report (see item 7.4) The EDF stated that it was a standard document. It was the Health Board's letter back to the Auditor General. An indexation was inserted into the letter. It detailed that the Health Board had chosen not to amend the misstatements. It reflected that it was the Health Board's choice not to amend the accounts. b) The response to the Audit Enquiries to those charged with Governance and Management It was noted that this was a standard process by Audit Wales. It was presented to the Committee for completeness. The CC stated that he received and signed it prior to the Audit Workshop.	

c) The CVUHB Annual Report 2021-2022 including the Annual Accountability Report, Performance report and the Financial Statements

The Director of Corporate Governance (DCG) stated that the draft Performance Report had been approved by Audit Wales and WG with only minor changes. The changes to the Remuneration Report were also mentioned by the HFAS.

MJ stated that the audit was open until the accounts were certified by WG. On Friday morning the EDF would have to state that she would still sign the accounts.

The DCG stated that there would be an abridged version for the AGM that would pick up on the more interesting points.

The Committee returned to the recommendations set out in the report for agenda item 7.2 above.

The Committee resolved that:

a) The reported financial performance contained within the Annual Report and Accounts and that the Health Board had met its statutory financial duties in respect of revenue and capital expenditure, were noted.
b) The changes made to the Draft Annual Report and Accounts were noted.
c) The ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the Audit Enquiries to those charged with Governance and Management, and the Annual Report and Accounts, were reviewed.
d) The ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the Audit Enquiries to those charged with Governance and management were recommended to the Board to agree and endorse.
e) The Annual Report and Accounts for 2021/22 were recommended to the Board for approval.

AAC 14/6/22 010	**Any Other Business** No other business was discussed.	
AAC 14/6/22 011	**Items to be deferred to Board / Committee** No other items were deferred to Boards or Committees.	
	Date & time of next Meeting Tuesday 5th July 2022 at 9am via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
12th May 2022
(For the Meeting 5th July 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 22/2/8/023	Meeting with Audit Wales	Independent Members to meet with Audit Wales virtually.	Nicola Foreman	5/7/2022	Complete Meeting between the Committee IMs and Audit Wales scheduled to take place on 5 July 2022.
AAC 22/5/4/007	IT Service Management Report	David Thomas to provide an update on the IT service Management Report actions.	David Thomas	5/7/2022	Complete On July agenda – item 7.5
AAC 12/05/005 AAC 22/5/4/ 018	Internal Audit Tracking Report	Internal Audit to give further assurance to the Committee on the accuracy of the information on the tracker.	Internal Audit	5/7/2022	Complete On July agenda (7.1)
AAC 12/05/010	Nurse Bank	Update to be provided on the nurse bank once actions from Internal Audits report have been put into place.	Rachel Gidman	5/7/2022	Complete On July agenda - item 7.2
AAC 12/05/010	Internal Audit Progress Report	4 Audits will be delivered to the Committee.	Internal Audit	5/7/2022	Complete On July agenda- item – 9.1
AAC 12/05/010	Internal Audit Tracking Report	A piece of work to validate actions recorded as complete within the Tracker had started.	Internal Audit	5/7/2022	Complete Please refer to action AAC 22/5/4/ 018

AAC 12/05/010	Auditing the accounts	Audit Wales would speak to HIA to understand the nurse bank report in relation to auditing the accounts.	Internal Audit Audit Wales	13/5/2022	Complete Discussion took place on 13 May 2022
AAC 12/05/010	Cyber update	A detailed response on NIS and the cyber element would be discussed in the private part of the Digital Committee meeting in June.	David Thomas	7/6/2022	Complete It was discussed at DHIC meeting in June
Actions in Progress					
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	In progress 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-pay expenditure and return to the Audit Committee in September 2022 with a further update.	Claire Salisbury/Catherine Phillips	6/9/2022	In progress Update to be provided at the September meeting.
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	In progress Update to be provided at the September meeting.
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	28/7/2022	In progress To be shared at the Board meeting in July 2022 (added to Board Forward Plan).

Report Title:	**Internal Audit Progress Report**				Agenda Item no.	7.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	05/07/22	
			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 following four audit reports from the 2021/22 plan have been finalised since the May 22 meeting of the Committee:

- Recovery of services and Delivery of the Annual Plan 2021 – 2022 (Substantial Assurance)
- Risk Management (Reasonable Assurance)
- Performance Reporting (Data Quality) (Reasonable Assurance)
- Chemocare IT System (Limited Assurance)

Although these reports were not finalised in time for submission to the May Committee, the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2021/22.

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

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed adjustments to the 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 July 2022

NWSSP Audit and Assurance Services

Partneriaeth Cydwasanaethau
Cydwasanaethau 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. Outcomes from Completed Audit Reviews

A number of 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.

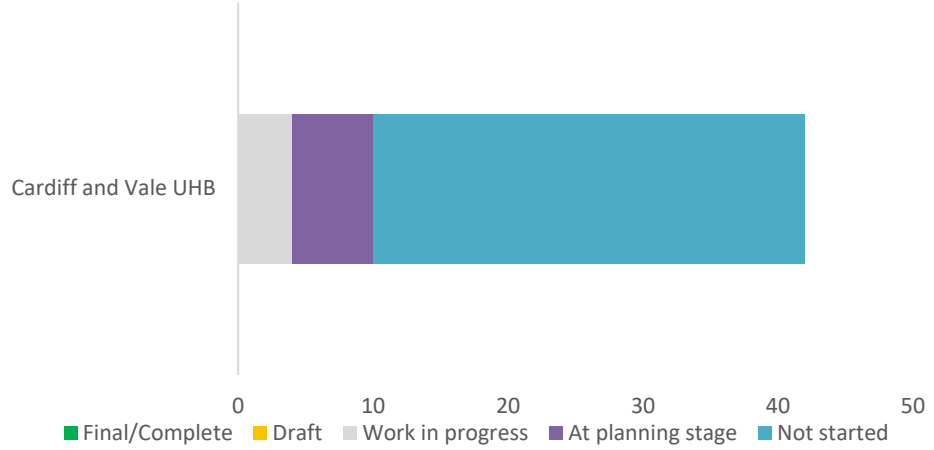
All but one of the audits have now been finalised, as detailed in the table below. The Executive Summaries from the final reports are provided in Section six. The full reports are included separately within the Audit Committee agenda for information.

The Audit of Waste Management is still to be finalised and will be reported to the September meeting of the Committee.

FINALISED AUDIT REPORTS (2021/22 Opinion)	ASSURANCE RATING	
Recovery of services and Delivery of the Annual Plan 2021 - 2022	Substantial	
Risk Management	Reasonable	
Performance Reporting (Data Quality)		
Chemocare IT System	Limited	

3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 41 reviews included within the 2022/23 Internal Audit Plan, and overall progress at this early stage of the year is summarised below.



From the illustration above it can be seen that there are four audits that are currently work in progress with a further six 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.

4. Changes to the 2022/23 Plan

The plan that was agreed by the Committee in April 22 included details of the proposed quarters in which each of the identified audits would be undertaken.

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 – Move from Q1 to Q2
- Reporting of Covid Deaths – Move from Q3 to Q2
- Financial Plan / Reporting – Move from Q2 to Q3
- Performance Reporting – Move from Q3 to Q4

5. Assurance on Recommendation Tracking

Since September 2019 the Corporate Governance team have been developing an Internal Audit Recommendation Tracker. The Tracker has advanced in maturity and provides the Audit Committee with information on the current progress that has been made towards the implementation of outstanding Internal Audit Recommendations. The information within the Tracker is based on responses provided by Health Board management confirming the current progress.

It was agreed that Internal Audit would introduce a process for reviewing a sample of the entries within the tracker, in order to validate the stated position and provide additional assurance to the Audit Committee.

Appendix B provides detail of the entries from the Tracker that we attempted to validate implementation.

Our audit sample focused on the recommendations reported to the Audit Committee through 2021/22 as complete. From a total of 56 recommendations reported as complete, we selected a third (18) to form our sample across the following split of committees; April 2021 (5), July 2021 (2), September 2021 (5), November 2021 (2), and February 2022 (4).

The overall outcome of the 18 recommendations sampled can be summarised as follows:

- The majority were verified as complete (11);
- An Internal Audit follow up noted partially complete recommendations, but these had been superseded by further recommendations made through the follow up (2);
- We were unable to validate a small number of recommendations due to the absence of evidence presented by management, which remains outstanding (3); and
- In the instance of one audit, there had been a change in staff which impacted the ability to provide evidence, although assurance was offered of a forward look in nature (2).

The exercise has highlighted that the Audit Committee can be reasonably assured that the progress information detailed within the Tracker for 2021/22 is accurate, although further efforts are required to obtain complete assurance from management.

6. Final Report Summaries

6.1 Recovery of services and Delivery of the Annual Plan 2021 - 2022

Purpose

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 2021/22'.

Overview

We have issued an overall rating of substantial assurance on this area and are also able to provide substantial assurance for each of the individual objectives, as detailed within the Assurance Summary table.

Our report makes two low priority recommendations, which are forward looking given the review focused on 2021/22 arrangements. The recommendations can be taken forward to 2022/23 and relate to:

- The transparency of reprofiling recovery funding; and
- The timeliness of information contained within the Board Assurance Framework.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate governance arrangements have been established which provide effective oversight	Substantial
2	Deliverables outlined within the Addendum to the 2021/22 Annual Plan are regularly monitored	Substantial
3	The Board Assurance Framework adequately highlights the risk of delivery of the Annual Plan 2021/22	Substantial

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

Key Matters Arising

There are no key matters arising to report on this occasion.

6.2 Risk Management

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 the risk management arrangements.

Overview

We have issued reasonable assurance on this area.

For three of the five objectives reviewed we have offered reasonable assurance, largely due to the continued efforts required by Clinical Boards and Corporate Departments to enhance their risk registers, as highlighted in the key matter arising below.

We also note that the tools available to management are lacking, in that risk registers are currently held in spreadsheets, which limits the visibility of risks and the ability to profile and aggregate risks across the Health Board. We make no recommendation in this area given an all-Wales solution is being developed but highlight the position, and the impact on the assurance we can offer against Objective 3.

Our report makes two further low priority recommendations, which are best practice in nature to support the Health Board's risk maturity.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⟺ 2020/21

Assurance summary[1]

	Assurance objectives	Assurance
1	Up to date Risk Management Strategy and Procedures.	Substantial
2	Risks are managed effectively at Clinical Board/Corporate Department level.	Reasonable
3	Risks are profiled and aggregated where possible.	Reasonable
4	Risks are consistently captured, scored and mitigated (where applicable).	Reasonable
5	Progress with internal audit recommendations from 2020/21 Risk Management audit.	Substantial

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

Key Matter Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
2	Enhancements required to Clinical Board and Corporate Department Risk Registers	2 & 4	Operation	Medium

6.3 Performance Reporting (Data Quality)

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 Performance Reporting (Data Quality).

The review specifically focused on the 'Integrated Performance Report' and the processes in place for its production and reporting.

Overview

We have issued reasonable assurance on this area.

We have made two medium priority recommendations which require management attention, both fall within objective two of this review and focus on the robustness of systems and processes to capture and validate the data within the Integrated Performance Report, specifically the Balanced Scorecard.

Whilst we found no fundamental data quality issues within our sample, we did note the absence of data completely for one indicator. The recommendations proposed, once implemented would enhance the clarity and completeness of the report.

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

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate governance arrangements for effective reporting of the Integrated Performance Report	Substantial
2	Robustness of systems and processes to capture and validate the data required to produce the Integrated Performance Report	Reasonable
3	Timely compilation of the Integrated Performance Report	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
2	Data accuracy and completeness of the Balanced Scorecard	2	Operation	Medium
4	Further enhancements to develop the Balanced Scorecard	2	Operation	Medium

6.4 ChemoCare IT System

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

ASSIGNMENT STATUS SCHEDULE

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

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
Clinical Audit (Follow-up)	17	Medical Director	Q2		Planning		November
Estates Assurance – Decarbonisation (Deferred from 21/22)	15	Finance	Q2				November
IT Strategy	21	Digital & Health Intelligence	Q2				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				November
Mental Health CB – Administration Services	29	Chief Operating Officer	Q2				November
Specialist Services CB – Community Patient Appliances	33	Chief Operating Officer	Q2				February
CD&T CB – Medical Records Tracking	34	Chief Operating Officer	Q2				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				April
Financial Plan / Reporting (Deferred from 21/22)	12	Finance	~~Q2~~	Q3			February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Charitable Funds	13	Finance	Q3				February
Medical Staff Additional Sessions	16	Medical	Q3				February
New IT Service Desk Tool	22	Digital & Health Intelligence	Q3				February
PCIC CB – GMS Access (Deferred from 21/22 plan)	30	Chief Operating Officer	Q3				February
Medicine CB – QS&E Governance Framework (Deferred from 21/22 plan)	31	Chief Operating Officer	Q3				February
Surgery CB – Consultant Job Plans	32	Chief Operating Officer	Q4				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				February
Risk Management	01	Corporate Governance	Q4				April
Core Financial Systems	02	Finance	Q4				February
Management of Health Board Policies	04	Corporate governance	Q4				May
Inclusion & Equality Team	08	People & Culture	Q4				April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Capital Systems	14	Finance	Q4				April
Performance Reporting	19	Digital & Health Intelligence	~~Q3~~	Q4			April
Data Warehouse	23	Digital & Health Intelligence	Q4				April
Recovery of Services	27	Chief Operating Officer	Q3				May
Women & Children's CB – Management of Locum Junior Doctors	35	Chief Operating Officer	Q4				April
Cyber Security	24	Digital & Health Intelligence	TBC				April
Shaping Our Future Hospitals Programme	40	Strategic Planning	Q1-4		Ongoing		n/a
Development of Integrated Audit Plans	41	Strategic Planning	Q1-4		Ongoing		n/a

ASSURANCE ON RECOMMENDATION TRACKER

Audit Information			Validation process	
Audit Title	**Recommendation**	**Rating**	**Internal Audit validation result**	**Basis of validation**
Internal Audit Follow Up (1) Consultant Job Planning (CVU 1920-41) Final Report Issued: 07/01/20 Audit Rating: Limited Assurance	1. Annual Job Plans	High	Complete	Internal Audit Follow Up (2) Consultant Job Planning (CVU 2021-37) Final Report issued: 29/04/21 Audit Rating: Reasonable Assurance
	2. Job Planning Documentation	High	Complete	
Data Quality Performance Reporting - Single Cancer Pathway (CVU 2021-10) Final Report Issued: 27/05/21 Audit Rating: Reasonable Assurance	2. Operational Procedures	Medium	**Validation incomplete** A meeting was held with the Interim Lead Cancer Services Manager who confirmed the change in procedures and processes, however the supporting evidence remains outstanding.	Evidence requested from the Interim Lead Cancer Services Manager to confirm completion.
	4. Accuracy and validation of SCP data	Medium		
Mental Health Outpatient Clinic Cancellations (CVU 2021-31) Final Report issued: 13/01/21 Audit Rating: Limited Assurance	1. Written procedures	High	Complete and supplementary follow up recommendation made - Low Priority	Internal Audit Follow Up Cancellation of Outpatient Clinics: Mental Health Clinical Board (CVU 2122-29) Final Report issued: 16/08/21 Audit Rating: Reasonable Assurance
	2. Lack of evidence to support cancellations	Medium	Partially Complete but superseded by supplementary follow up recommendation - Medium Priority	
	3. Authorisation of clinic cancellations	Medium	Partially Complete but superseded by supplementary follow up recommendation - Medium Priority	

Audit Information			Validation process	
Audit Title	**Recommendation**	**Rating**	**Internal Audit validation result**	**Basis of validation**
	4. PARIS is used inconsistently between Mental Health Directorates	Medium	Complete	
	5. Monitoring of Outpatient Clinic Cancellations	High	Complete - Supplementary Medium Priority Recommendation made	
Claims Reimbursement (CVU 2021-04) Final Report issued: 19/03/21 Audit Rating: Substantial Assurance	1. Central Repository for Claims Reimbursement Documentation	Medium	Complete	Internal Audit of Welsh Risk Pool Claims (CVU 2122-04) Final Report issued: 28/04/22 Audit Rating: Substantial Assurance
Core Financial Systems (CVU 2021-13) Final Report issued: 23/03/21 Audit Rating: Reasonable Assurance	2. Asset Verification Review	High	**Validation incomplete** Evidence remains outstanding	Evidence requested from Head of Financial Accounts and Services, and Head of Financial Services to confirm completion
	3. Bank reconciliation	Medium	Complete - Evidence received from Head of Financial Services	
Environmental Sustainability Report (CVU 1920-44) Final Report issued: 16/08/19 Audit Rating: Reasonable Assurance	1. Accuracy Check & Sign Off	Medium	Whilst information was provided to support completion of the recommendations, the narrative was forward looking, given a change in staff since the initial audit.	Evidence requested from the Trust Energy Advisor to confirm completion.
	2. Guidance Document	Medium		
Integrated Health Pathways (CVU 2021-20) Final Report issued: 25/02/21 Audit Rating: Reasonable Assurance	5. User Feedback on Health Pathways	Medium	Complete	Evidence requested from the Primary Community and Intermediate Care Clinical Board, which the Assistant Director of Operations – Planning & Delivery provided.
	6. Performance Metrics and Reporting	Medium	Complete	

Audit Information			Validation process	
Audit Title	**Recommendation**	**Rating**	**Internal Audit validation result**	**Basis of validation**
Risk Management (CVU 2021-03) Final Report issued: 24/03/21 Audit Rating: Reasonable Assurance	2. Aggregation and visibility of risk across the Health Board	Medium	Complete – although a risk was highlighted in the 2021/22 audit.	Risk Management (CVU 2122-01) Final Report issued: 9/06/22 Audit Rating: Reasonable Assurance
	4. Risk Management Maturity	Medium	Complete	

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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Report Title:	Temporary Staffing Department (Nurse Bank) Internal Audit Report					Agenda Item no.	7.2
Meeting:	Audit Committee		Public	X		Meeting Date:	5 July 2022
			Private				
Status *(please tick one only):*	Assurance	√	Approval			Information	
Lead Executive:	Executive Director of People and Culture						
Report Author (Title):	Assistant Director of People Resourcing						

Main Report
Background and current situation:

This report is to provide assurance to the Audit Committee in respect of the Audit of the Temporary Staffing Department (TSD) where issues of 'limited assurance' were reported.

The People and Culture department commenced their accountability and management of the TSD in October 2021. An internal Audit was subsequently requested to identify any issues that needed to be addressed. An Audit report was received on 10 May 2022. The report highlighted 2 objectives which had only 'limited' assurance and 3 recommendations which were rated as 'high' priority which are as follows:

1. Inadequate structure within the TSD (Design)
2. Lack of resilience of the TSD (operation)
3. Range of agency usage (operation)

In response to the Audit, the Assistant Director of People Resourcing and the Senior Nurse developed an action plan to address all recommendations within the report including those that were rated as a 'medium' priority.

A number of the actions have already been implemented and the remainder will be undertaken within the timescales indicated with the audit report.

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

One of the key issues within the report was the lack of resilience in processing invoices if the Senior Nurse was absent. Two other members of staff have been trained to ensure this process continues however, as the function has now moved to self-billing, this will not be an issue for the department moving forward.

As the new Allocate Health rostering system is phased in over the UHB, some of the functions of the department will become more automated and the roles of the staff working within the team will change to focus more on expanding the numbers working on the bank and also increasing the range of professions being supplied. The roll-out of Allocate should be completed by March 2023.

Recommendation:

The Board / Committee are requested to:

- Note the contents of this report.

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
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 department has improved its resilience by reviewing and documenting all processes to ensure that if a member of the team is absent, there are clear processes in place for someone else to undertake. Staff are also in the process of being trained on different processes and job rotation is being tested.

Safety: No

Financial: No

Workforce: Yes

Changes to the structure were recommended within the report to include appointing a deputy to the senior nurse. This can be done within the existing workforce and will be cost neutral.

Legal: No

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Mohamed,Sarah
06/07/2022 13:17:46

Report Title:	**Nurse Bank Internal Audit Report - Update**				Agenda Item no.	7.2	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	05/07/22	
			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 Final Limited Assurance Internal Audit Report on the Nurse Bank (Temporary Staffing Department) was presented to the Audit Committee in May 2022 but did not include any management actions.

The management actions have since been provided and agreed, and are included within the updated final report which is presented to the Committee for information and assurance.

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

The agreed management actions are included within Appendix A of the updated final Nurse Bank (Temporary Staffing Department) report.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider and note** the management actions within the updated final report.

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:

Nurse Bank (Temporary Staffing Department)

Final Internal Audit Report

May 2022

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

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:	CVU-2122-13
Report status:	Final Report
Fieldwork commencement:	26 January 2022
Fieldwork completion:	23 March 2022
Debrief meeting:	6 April 2022
Draft report issued:	12 April 2022
Management agreement received	25 April 2022
Final report issued:	28 April 2022 (without management responses) 26 May 2022 (with management responses)
Auditors:	Lucy Jugessur, Internal Audit Manager Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
Distribution:	Jonathan Pritchard, Assistant Director of Workforce Resourcing Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce
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.

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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 the Nurse Bank.

Overview

We have issued limited assurance on this area.

We have made a number of high and medium priority recommendations which require management attention that relate to the structure and operation of the Temporary Staffing Department, which holds the Nurse Bank.

There is a lack of resilience within the current structure, which is impacting the recruitment to the Nurse Bank, payment to agencies, and a general lack of engagement with service users, whether that be ward management or bank staff themselves.

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Policy, procedures and guidance.	Reasonable
2	Structure and operation of the Temporary Staffing Department.	Limited
3	Verification and authorisation of bank and agency shifts.	Limited
4	Accurate and timely reports on bank usage and costs.	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	Lack of Temporary Staffing Guidance	1	Design	Medium
2	Inadequate structure within the Temporary Staffing Department	2	Design	High
3	Resilience of the Temporary Staffing Department	2 & 3	Operation	High
4	Roles and responsibilities for Bank recruitment	2	Operation	Medium
5	Lack of engagement with service users	2 & 4	Operation	Medium
6	Operational management of the Temporary Staffing Department	2	Operation	Medium
7	Range of agency usage	3	Operation	High
8	Ward verification of agency shifts	3	Operation	Medium

1. Introduction

1.1 The review of the Nurse Bank (Temporary Staffing Department) was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 The Health Board are reliant on the use of bank and agency staff to fill vacant shifts on hospital wards. Staff that are registered on the Bank, through the Health Board's Temporary Staffing Department can find available shifts through the Health Board's website[1], Facebook page or by telephoning the Temporary Staffing team.

1.3 The Temporary Staffing Department has experienced some organisational changes through 2021, previously within the remit of the Executive Nurse Director, Workforce Resourcing took over responsibility in September 2021, within the Executive Director of People and Culture's portfolio.

1.4 The Board Assurance Framework (BAF) refers to Workforce as a key risk, noting that across the UK and in Wales there are increasing workforce challenges for healthcare professionals. In the context of the Nurse Bank, the BAF refers to the impact of the new Nurse E-Rostering System, to be rolled out in 2022/23, with improved Bank Application (App) functionality.[2]

1.5 The Board's Strategy and Delivery sub-committee routinely receives the People Dashboard of Workforce Key Performance Indicators report, which includes the trend of 'Whole Time Equivalent Permanent, Fixed-Term and Bank Staff in post numbers'. The Dashboard presented to the sub-committee on 16 November 2021 noted, "Nurse Bank usage remains fairly static, roughly equivalent to 400 WTE per month".[3]

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

Audit Risks

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

- Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff;
- The allocation and completion of bank shifts does not meet the priorities of the Clinical Boards;
- Financial loss due to unnecessary usage or incorrect payment of bank and agency staff; and
- Issues relating to bank and agency are not identified or addressed.

[1] https://www.cardiffandvalenursebank.co.uk/en/calendar
[2] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/
[3] https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2021-22/2021-11-16-audit-final-papers-v4-pdf/

Limitations to scope

1.8 At the time of audit fieldwork, given the pressures within the Health Board, our audit testing was limited to procedures, processes and documentation held by the Nurse Bank and did not extend to information held by the Clinical Boards.

2. Detailed Audit Findings

Objective 1: Health Board policy, procedures and guidance are in place to efficiently direct the use of bank and agency staff, which is appropriate and up to date.

2.1 The Health Board's Rostering Procedure for Nurses and Midwives (UHB 339 v2) highlights an objective to, *"Improve the utilisation of existing staff and reduce bank and agency spend by giving Ward Sisters/Charge Nurses/Departmental Managers, Lead/Senior Nurses and Midwives clear visibility of staff contracted hours."*[4] The procedure clarifies the circumstances where bank and temporary staffing can be utilised and the expectations placed on wards to communicate changes with the Temporary Staffing Department.

2.2 We are aware that the Health Board has commenced rolling out a new e-rostering system, HealthRoster (Allocate) to facilitate the rostering process, which will include bank and agency shifts. The revised arrangements will impact Health Board procedures and guidance in this area. Guidance to support the new system will include recording bank shift availability and self-booking of available bank shifts, which is a change in process, giving greater autonomy to bank staff.

2.3 We reviewed current procedures and guidance in place within the Nurse Bank, a Temporary Staffing Authorisation Flowchart (dated August 2018) details the process to follow for completion of rotas, which includes requesting bank or agency cover. The flowchart was sent to each Director of Nursing for the Clinical Boards for review and approval. However, whilst helpful, it was unclear from review of the document who owns and approved the flowchart. *(Matter Arising 1 – Medium Priority)*

2.4 At the time of the audit, the Nurse Bank recruitment guidance had been updated from a narrative description into a series of flowcharts, which were more succinct and easier to follow, which include:

- Temporary Staffing Students;
- Temporary Staffing Health Care Support Workers (HCSW) / Registered General Nurses / Registered Mental Health Nurse; and
- Temporary Staffing Fast Track.

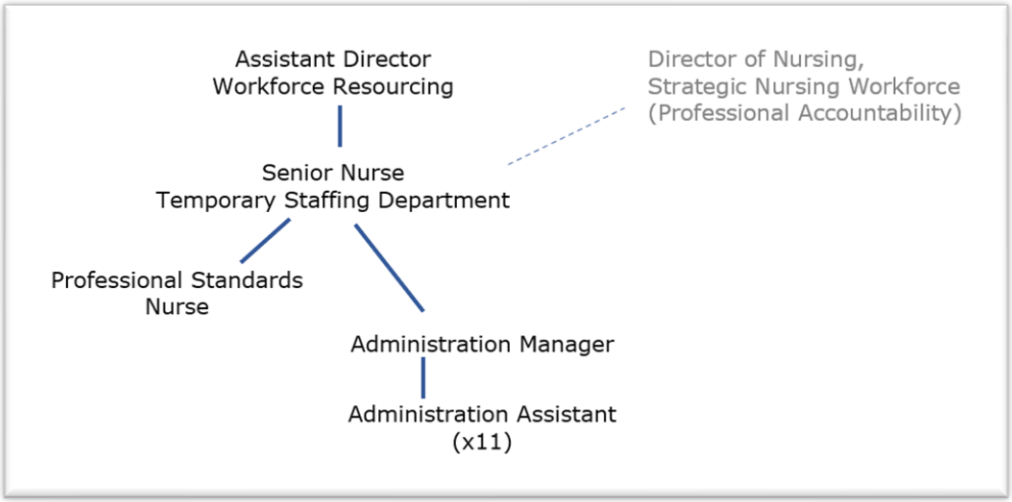
[4] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/workforce-and-od-policies/r-workforce-and-od/rostering-procdeure-for-nurses-and-mdiwves-final-v2-pdf/

2.5 We found no other process documents in place within the Temporary Staffing Department to cover areas such as, engaging with agencies or reviewing and actioning agency reports. *(Matter Arising 1 – Medium Priority)*

Conclusion 1: Whilst we found some procedural guidance in place to support the Temporary Staffing Department, there are gaps in the available guidance. Further guidance would enhance the resilience of the team. The control of guidance could also be improved, to clarify document approval. (Reasonable Assurance)

Objective 2: The Temporary Staffing Department is adequately structured and operating effectively to enable the robust and timely recruitment of bank and agency staff.

2.6 At the time of our review, we found the structure of the Temporary Staffing Department to be as follows:



2.7 The Temporary Staffing Department's establishment holds no vacancies, however, it was evident that staff within the department are not fully proficient with the different functions and processes, for example supporting recruitment and administering agency invoices. *(Matter Arising 2 – High Priority)*

2.8 We found the current structure of the Temporary Staffing Department to be inadequate and currently presents a resilience risk, where issues have materialised through 2021/22. *(Matter Arising 3 – High Priority)*

2.9 We were advised that the recruitment of Bank staff is currently being undertaken by several areas within Workforce, therefore we were unable to verify if the Temporary Staffing Department can operate effectively, to facilitate the timely recruitment to the Nurse Bank. *(Matter Arising 4 – Medium Priority)*

2.10 We questioned the effectiveness of the Nurse Bank through the lens of service users, particularly hospital wards. However, we found no engagement activities, such as surveys to validate user experience with the Bank, or for Ward Managers

to confirm if the Bank has been effective in obtaining adequate bank or agency staff to cover vacant shifts. *(Matter Arising 5 – Medium Priority)*

2.11 We considered the operational arrangements for managing the Temporary Staffing Department. In the first instance we reviewed the staff member's personal files, but these were found to be incomplete. We also selected a sample of sickness records from ESR to ensure that the appropriate documentation had been completed, but again found instances where these were incomplete. *(Matter Arising 6 – Medium Priority)*

Conclusion 2: The Temporary Staffing Department structure is inadequate, which impacts the operational effectiveness of the Nurse Bank. Due to current arrangements, we could not verify the ability of the Department to support the robust and timely recruitment to the Nurse Bank. There also seems to be a lack of engagement with hospital wards to obtain user feedback, although we note the COVID-19 pandemic has impacted face-to-face contact on hospital wards. (Limited Assurance)

Objective 3: All requests for bank and agency staff are supported by appropriate justification and authorisation, and all completed shifts are appropriately verified and authorised prior to payment at the correct rate.

2.12 We ascertained the process for requesting bank and agency cover. We were informed that the Ward Manager is required to record a reason for a vacant shift on Rosterpro, which confirms requirement for cover. The Temporary Staffing Department are responsible for contacting Bank workers to establish whether they can undertake a shift and they also contact the agencies to request cover.

2.13 The process will soon change as the Health Board migrates to HealthRoster and Bank staff will be able to book themselves onto a bank shift. Furthermore, the agencies will also be able to book their staff onto vacant shifts once they are released to them.

2.14 It was identified that the Health Board only utilises 36 out of an approximate 140 agencies that are on the All Wales framework to deploy agency staff. We reviewed the Bank and Agency staff report for the week commencing 27 February 2022, which noted challenging fill rates, for example 49% in the Specialist Services Clinical Board. There may be greater opportunities to deploy further agency staff, with specialist skills, when all other viable options have been exhausted to support hospital wards under pressure. *(Matter Arising 7 – High Priority)*

2.15 The Health Board implemented self-billing on 1 March 2022, which is directed by the 'Nurse Agency Self Billing - Standard Operating Procedure'. The process involves the Health Board preparing the agency's invoice and forwarding a copy to the agency with payment. As part of this process there is a reliance on ward managers to verify that agency shifts have been worked. However, it was evident during the review that the process needs to further embed amongst ward management. *(Matter Arising 8 – Medium Priority)*

2.16 The Senior Nurse within the Temporary Staffing Department spends a considerable amount of time reviewing and resolving issues on a weekly 'Invoices on Hold' report. The report includes invoices without a purchase order number, or instances where a shift has not been verified and requires action to enable the agencies to receive payment for the agency nurses deployed. *(Matter Arising 3 – High Priority)*

2.17 We identified that invoices are on hold for several reasons, examples include, staff on the wards failing to verify that an agency employee has worked a shift, the agency have provided an incorrect purchase order number, or the copy of a timesheet is illegible. Only two staff within the Temporary Staffing Department, aside from the Senior Nurse have been trained on the process for reviewing and actioning the 'Invoices on Hold' report, but both were absent from work at the time of the audit. *(Matter Arising 3 – High Priority)*

2.18 We requested reports on Bank usage and verification of shifts but at the close of audit fieldwork these had not been provided.

Conclusion 3: Following ward management approval, the Temporary Staffing Department is notified of unfilled shifts requiring bank and agency cover, through the RosterPro system. This process will move to HealthRoster once the roll out of the new system progresses. Our testing has identified issues with the verification of agency shifts worked, which if undertaken in a more timely manner would provide greater efficiencies to hospital wards and also the Temporary Staffing Department. Due to a lack of information provided, we were unable to evidence usage and verification of Bank staff. (Limited Assurance)

Objective 4: Accurate and timely reports on bank usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board. Reports are subject to effective scrutiny and actions are taken where required.

2.19 The Temporary Staffing Department produces a daily report showing all filled and unfilled shifts for the current day and the following day. This report is sent to all Lead and Senior Nurses within the Clinical Boards. In addition, the Temporary Staffing Administration Manager produces a report twice weekly showing the number of booked shifts and unfilled shifts for the week ahead. Once the Health Board has migrated to HealthRoster the Senior Nurses will be able to self-serve these reports.

2.20 The RosterPro Support and Training Co-ordinator produces a weekly bank and agency report which reports the weekly fill rates at different levels within the Health Board including the agency fill rate.

2.21 Although there are reports generated and circulated on nurse fill rates within the Health Board, through the lens of the Temporary Staffing Department, we were unable to evidence that these reports are scrutinised. We were also unclear what

action has been taken in response to the reports. *(Matter Arising 5 – Medium Priority)*

2.22 As noted in paragraph 2.18 we requested a report on Bank usage and verification, but we did not receive this.

2.23 We reviewed the reporting arrangements into the Committee structure, and we noted that the Strategy and Delivery Committee routinely receive a Workforce Key Performance Indicators report, which incorporates a graph on the WTE Permanent, Fixed-Term and Bank Staff in Post Numbers.

Conclusion 4: There are a number of reports produced showing the filled and unfilled shifts within the Health Board, but we were unable to verify the level of engagement, scrutiny and action taken in response to the reports, given the limited feedback within the Temporary Staffing Department. We also requested reports on Bank staff and usage, but did not receive these, for example how many are employed via the Nurse Bank, and when was a shift last worked. This information was not readily available, which is fundamental management information. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Lack of Temporary Staffing Guidance (Design)	**Impact**
We found procedural guidance within the Nurse Bank to be lacking, for instance there is no guidance in place to support key processes, such as engaging with agencies and managing the payment of agency invoices, through the 'Invoices on Hold' report. Where guidance is in place, there was a lack of clarity of approval and ownership, such as: • Temporary Staffing Authorisation Flowchart (dated August 2018); and • The recently introduced Nurse Bank Recruitment Flowcharts. We appreciate that given the imminent roll-out of HealthRoster through 2022/23, the systems and processes in the Nurse Bank will evolve and procedures and guidance will require updating.	Potential risk of: Procedures and guidance are not in place within the Bank to assist the Bank staff to manage the Nurse Bank adequately.
Recommendation 1	**Priority**
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.	**Medium**

Agreed Management Action 1	**Target Date**	**Responsible Officer**
1. Identify the full range of processes that will require guidance 2. Develop or improve existing guidance (this will include flowcharts) 3. Communicate all procedures within TSD team 4. Place all processes/flow charts onto shared folder with hard copies compiled on a file.	01/09/2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

Matter Arising 2: Inadequate structure within the Temporary Staffing Department (Design)	**Impact**
We were provided with a structure chart for the Temporary Staffing Department (see paragraph 2.6), we note the establishment, which currently holds no vacancies. Following consideration of the department's remit, we found the current structure to be lacking in terms of resilience and continuity for the following reasons: • The Senior Nurse who is responsible for managing the Nurse Bank does not have a deputy in place; • The Temporary Staffing Administration Manager is responsible for managing the administration staff within the Nurse Bank, but reports directly to the Senior Nurse, although we note the gap in pay bands. • In terms of pay bands, a further resource is placed between the two roles but does not act as a deputy or manage the Administration staff. They are responsible for professional standards and manage any complaints received about Bank and Agency staff. • Members of the team have not all been trained in the different operations within the Temporary Staffing Department. There are currently only two employees within the Department that undertake recruitment tasks for the Bank. • The Senior Nurse undertakes the review of the agency 'Invoices on Hold' report, rather than this being disseminated to the team.	Potential risk of: Issues relating to bank and agency are not identified or addressed
Recommendation 2	**Priority**
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.	**High**

Agreed Management Action 2	Target Date	Responsible Officer
1. Structure to be reviewed to include a Deputy post to the manager from within the existing structure (cost neutral). 2. Implement Deputy Role 3. Undertake a general review of the structure to ensure the roles match the changing requirements of the service and that the staff undertake the duties appropriate to their banding.	01/09/2022 01/01/2023 Dec 2022 – Jan 2023	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

~ Continued over page ~

Matter Arising 3: Resilience of the Temporary Staffing Department (Operation)	**Impact**
The Senior Nurse within the Temporary Staffing Department spends a considerable amount of time resolving issues with agency invoices that are listed on the 'Invoices on Hold' report, as referred to in matter arising 2. A period of absence of the Senior Nurse highlighted that this creates a lack of resilience as the report was not actioned during the period, which stopped payment. As a result, on return of the Senior Nurse the 'Invoices on Hold' report, dated 27 January 2022, reported a total invoice value of £1,280,149.06, with 2,374 line items of data. A subsequent report, dated 9 March 2022, reported a reduced value of £806,706.33, across 1,584 line items of data. We note that from 1 March 2022 the team's role in actioning the report should reduce given the introduction of agency self-billing, where greater reliance is placed on the wards to verify shifts.	Potential risk of: Issues relating to bank and agency are not identified or addressed.

Recommendation 3	**Priority**
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.	**High**

Agreed Management Action 3	**Target Date**	**Responsible Officer**
1. The implementation of Allocate/Health roster and change to incorporate self-billing will resolve the current issue of processing invoices. 2. Provide training to all of the team members to enable them to rotate into each other's roles. This will enable the ability for them to cross-cover when absences arrive and enrich their own roles.	December 2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

<table>
<tr><th colspan="2">Matter Arising 4: Roles and responsibilities for Bank recruitment (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">There is a lack of clarity of roles and responsibilities over the recruitment of bank staff. Recruitment is currently being undertaken by several departments, as noted below. We were therefore unable to verify if the Temporary Staffing Department can effectively operate to facilitate the timely recruitment to the Nurse Bank:
• The Nursing Hub is responsible for recruiting nurses and HCSWs to the Bank;
• The Workforce team is also undertaking recruitment on behalf of the Bank; and
• The Temporary Staffing Department are recruiting Students.
It has been proposed going forward that the recruitment of bank nurses will return to the Temporary Staffing Department. The Assistant Director of Workforce Resourcing has produced a spreadsheet to assess the effectiveness of the recruitment process, including time taken to recruit, and the numbers being recruited. If the process is undertaken in a timely manner, recruitment of bank nurses and HCSWs will return to the Temporary Staffing Department.
We acknowledge the impact the COVID-19 pandemic has had on recruitment arrangements and the need to onboard greater numbers of temporary staff at speed to support mass vaccination and testing centres.</td><td>Potential risk of:
Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff</td></tr>
<tr><th colspan="2">Recommendation 4</th><th>Priority</th></tr>
<tr><td colspan="2">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.</td><td>Medium</td></tr>
<tr><th>Agreed Management Action 4</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>1. Training has already been provided on Trac recruitment system to the team and recruitment of Registered Nurses has taken place.
2. HCSW recruitment (much higher volume) will commence with the TSD from 1st June going forward.
3. From this time all recruitment for the bank will be undertaken by the TSD.</td><td>June 2022</td><td>Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce</td></tr>
</table>

Matter Arising 5: Lack of engagement with service users (Operation)		**Impact**
We found that there is currently a lack of engagement with hospital wards to ascertain if the Nurse Bank is meeting the needs of service users and therefore operating effectively. Similarly, we found that no satisfaction surveys are being undertaken with Bank staff. We note that reports are circulated by the Temporary Staffing Department on nurse fill rates, but we were unclear on the level of engagement and action following dissemination. The administrative tasks currently undertaken by the Senior Nurse hamper the available time to engage with hospital wards and key nursing contacts within the Health Board. We note that the COVID-19 pandemic has reduced face to face contact amongst staff. Although in such instances, surveys are a useful mechanism to seek feedback, but we were unable to evidence any such alternative means of ascertaining effectiveness.		Potential risk of: Issues relating to the Nurse Bank are not identified or addressed.
Recommendation 5		**Priority**
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.		**Medium**
Agreed Management Action 5	**Target Date**	**Responsible Officer**
1. Develop an engagement plan for our key stakeholders which will include:- bank staff, ward managers 2. Implement engagement plan.	January 2023 February 2023	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

Matter Arising 6: Operational management of the Temporary Staffing Department (Operation)	**Impact**
To ascertain the operational arrangements for managing the Temporary Staffing Department we requested all personal files. We selected a sample of staff who have had instances of sickness absence and we reconciled these to the relevant personal files and electronic records available, to establish if the relevant documentation had been completed correctly, in accordance with the Managing Attendance at Work Policy. We identified that: • We were unable to locate a personal file for the Professional Standards Nurse and therefore we were unable to establish if return to work interviews and forms had been completed. • For further members of the department we found two instances whereby Return to Work (RTW) forms were not completed. In addition, there was one instance of the RTW form being completed a month following the employees return to work.	Potential risk of: Personal files are not being retained appropriately for staff. Sickness is not being managed correctly.
Recommendation 6	**Priority**
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.	**Medium**

Agreed Management Action 6	**Target Date**	**Responsible Officer**
1. Personal files to be reviewed and updated to include all relevant staff information. 2. Administration manager to receive appropriate training in sickness management and relevant management training	July 2022 31/09/2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

Matter Arising 7: Range of agency usage (Operation)	**Impact**
We were provided with the most recent report for Bank and Agency staff fill rates and the overall fill rate for the Health Board week commencing 27 February 2022 was 66%. We reviewed the Clinical Board fill rate report, and the fill rate was 99% within CD&T whilst in Specialist Services the fill rate was 49%, with 412 requests being made and 200 shifts being filled. The low fill rate within Specialist Services is a result of the Clinical Board's requirement for specialist Nurses in Cardiac Services and Neurosciences. We were provided with the Agency 2021 Framework with all the agencies recorded, which amounted to just over 140 agencies, but currently the Temporary Staffing Department only request agency nurses from 36 agencies. More shifts could potentially be filled if the Department utilised a greater number of agencies, particularly those of a specialist nature.	Potential risk of: Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff.

Recommendation 7	**Priority**
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.	**High**

Agreed Management Action 7	**Target Date**	**Responsible Officer**
Undertake a review of agencies currently not used who are on the Welsh Framework to identify if there are further agencies that could provide appropriate numbers of staff.	31/03/2023	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

Matter Arising 8: Ward verification of agency shifts (Operation)	**Impact**
The Health Board implemented self-billing on 1 March 2022, which places a greater reliance on ward management to verify agency shifts worked. The 'Invoices on Hold' report dated 9 March 2022, included invoices on hold with an invoice date from 1 March 2022 onwards, which totalled £95,068.04. At the time of the audit, the Senior Nurse in the Temporary Staffing Department circulated an email to all Senior and Lead Nurses requesting them to remind Ward Managers of the need to verify the shifts for the agency to receive payment.	Potential risk of: Agencies are not being paid in a timely manner

Recommendation 8	**Priority**
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.	**Medium**

Agreed Management Action 8	**Target Date**	**Responsible Officer**
1. Present reports on the failure to verify shifts by clinical boards to Nurse Directors for them to ensure compliance within the areas they are accountable for.	June 2022 and then monthly until health roster is fully embedded	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

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: July 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 2021-22 Performance Report, Accountability Report, and Financial Statements on 17 June. He provided unqualified audit opinions except for a qualified regularity opinion. Members of the Audit and Assurance Committee considered our Audit of Accounts Report on 14 June and are therefore aware of the audit findings.

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit and Assurance Committee
Review of Quality Governance Arrangements	To be considered in July 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 differently as the service looks to	Current status: Report drafting Planned date for consideration: September 2022

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
	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 Estates: Follow-up of Recommendations Executive Lead – Executive Director of Finance	In 2017, we undertook a review of estates. The work examined the Health Board's strategic approach to estates management, and its approach for delivering an economical, efficient, and effective estates service. We made a number of recommendations to the Health Board. This work will follow-up progress against these recommendations.	Current status: Report drafting Planned date for consideration: September 2022
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	Blog and data tool published in April 2022 Project brief to commence detailed work to be issued in June / July 2022 Planned date for consideration: TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
	appropriate for their unscheduled care needs.	

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. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	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 In response to the COVID-19 pandemic, we have established a COVID-19 Learning Project to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to prompt some thinking and support the exchange of practice. Two years into the pandemic, we have been engaging with a wide range of external colleagues to capture their perspectives on the impact of the pandemic on public services in Wales and how learning is being taken forward. We will be sharing these conversations via our YouTube channel.

6 Details of future events are available on the GPX website.

NHS-related national studies and related products

7 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.

8 **Exhibit 5** 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.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Tackling the Planned Care Backlog in Wales The key messages are summarised in **Appendix 1**	May 2022
Unscheduled Care (Blog and Data Tool)	April 2022

Appendix 1 – Key messages from recent national publications

Tackling the Planned Care Backlog in Wales (May 2022)

9 Our Planned Care review describes the significant challenges facing NHS Wales both in terms of shorter-term recovery and the need for longer term sustainable planned care services. There were clearly issues in some key areas about the balance of capacity and demand for services before the pandemic and is exacerbated significantly since.

10 In February 2022, there were nearly 700,000 patients waiting and numbers of waits continue to grow. Over half of the people currently waiting have yet to receive their first outpatient appointment, and across Wales over 100,000 patients are waiting over a year for their first outpatient appointment. This may mean their care cannot be effectively prioritised often because effective clinical prioritisation can only take place during outpatients and diagnosis.

11 The report highlights that referrals reduced during the pandemic and this suggests that there could be a pent-up demand for services which may result in higher than average or more complex and acute referrals in the short to medium term. If even half of those missing patient referrals emerge, this could mean that recovery of waiting lists to pre-pandemic levels could take seven years. Some specialties and services could recover more quickly, but others such as orthopaedics and eye care may take longer as these services have been under pressure for many years.

12 The Welsh Government made an extra £200 million available during 2021-22 to help recovery but NHS bodies could not use it all. They bid for and were allocated £146 million, but £12.77 million was returned to the Welsh Government at the end of March 2022. NHS bodies cited staff capacity, lack of physical space and limited private capacity to carry out planned care as barriers to spending the additional funding. While additional Welsh Government funding is going to be essential to tackle the backlog, this on its own, will not solve the problem. The NHS also needs to overcome some serious barriers, including the on-going impact of COVID on services, reducing the impact of emergency care on planned care service delivery and long-standing staff shortages and recruitment issues.

13 Our report makes five recommendations to the Welsh Government which focus on:

- Working with health bodies to set appropriately ambitious delivery targets;
- Producing a clear funding strategy including long term capital investment;
- Developing a workforce plan to build and maintain planned care capacity;
- Implementing system leadership arrangements to drive through the plan;
- Ensuring its arrangements focus on managing clinical risks associated with long waits, supporting patients while they wait, and delivering care efficiently and effectively.

14 While the recommendations are made to Welsh Government, health bodies across Wales also need to consider how they respond both to the issues identified in our report and locally required implementation of the recommendations. We are therefore seeking a written response from each health board and request that actions are tracked in routine recommendation monitoring arrangements and are reported to audit committees

15 Alongside our report, we've also published a waiting times data tool which sets out the different waiting times by health board.

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Review of Quality Governance Arrangements – Cardiff and Vale University Health Board

Audit year: 2019

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

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Cardiff and Vale University Health Board (the Health Board) carried out during 2021. To test the 'floor to board' perspective, we examined the arrangements for general surgical services.

Key messages

6 Overall, we found that the **Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement. Further investment is required to enable the Health Board to fully roll-out and embed planned quality and safety improvements.**

7 The Health Board has agreed quality and safety priorities at all levels of the organisation. There are reasonable corporate and operational arrangements in place for monitoring risk. Arrangements for monitoring mortality and morbidity are developing. The Health Board has effective arrangements to monitor and track progress with complaints, where it consistently achieves performance targets and arrangements to capture patient experience are reasonably effective. The Health Board has a well-established values and behaviour framework which is embedded in workforce processes. There is collective responsibility for quality and safety amongst Executive Leadership. Corporate and operational structures and processes for quality and safety are reasonably effective and the Health Board is taking steps to strengthen these further. Agendas for corporate and operational quality and safety meetings provide a wide coverage of quality and safety issues for discussion and there is sufficient information for scrutiny and assurance at both a corporate and clinical board levels and the Health Board's use of quality data is maturing.

8 However, we found poor alignment between corporate and operational quality and safety priorities and monitoring and reporting on their delivery needs strengthening. There is scope to ensure the corporate Quality, Safety, and Experience Committee maintains greater oversight of risks overseen by other committees where there is a clear quality and safety impact. Arrangements for clinical audit require significant improvement. The Health Board also needs to ensure that staff feel able to raise concerns. Whilst the departure of key clinical executives from the organisation potentially poses risks to rolling-out and embedding the new Quality, Safety and Patient Experience Framework; additional resources have been allocated to enable the Health Board to achieve this. There are opportunities for the agenda of corporate Quality, Safety and Experience Committee meetings to be more dynamic to reflect new and emerging quality risks and issues. Reporting on the four harms[1] associated with COVID-19 requires strengthening. Furthermore, reporting requires development at directorate level for services commissioned by the Health Board.

[1] The four harms are – (i) harm from COVID-19 itself; (ii) harm from overwhelmed NHS and social care system; (iii) harm from reduction in non-COVID-19 activity; and (iv) harm from wider societal actions / lockdown

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Quality and Safety Priorities R1 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.
Risk Management R2 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.
Clinical Audit R3 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

Recommendations

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.

Values and Behaviours

R4 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.

Personal Appraisal Development Reviews (PADRs)

R5 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.

Resources to support quality governance

R6 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 levels.

Recommendations

Monitoring and Reporting

R7 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.

Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **whilst the Health Board has agreed quality and safety priorities at all levels of the organisation, there is scope to ensure that operational priorities are better aligned to corporate priorities. Risks are managed appropriately at both a corporate and operational level, but opportunities exist to improve these arrangements further.**

Quality and patient safety priorities

12 The Health Board's 10-year strategy, 'Shaping our Future Wellbeing', sets outs its mission of "caring for people and keeping people well" and its vision that "a person's chance of leading a healthy lifestyle is the same wherever they live and whoever they are". To achieve its mission and vision, the Health Board has developed a strategy based on a "home first" approach which aims to avoid harm, waste, and variation; empower people; and deliver outcomes that matter to them. The Health Board's strategic objectives cover four key areas: population, service priorities, sustainability, and culture.

13 A key priority for the Health Board is to develop a patient safety and service quality culture to ensure quality improvement is a part of everyday practice. The 10-year strategy identifies several outcomes for the Health Board if it maintains a continued focus on patient safety, such as:

- zero tolerance of never events and hospital acquired infections;
- patient safety principles are embedded, owned, understood, and acted on by staff at all levels of the organisation; and
- recognised as a leading UK organisation for its work on patient safety initiatives and the application of improvement methodology.

14 To achieve these outcomes, the Health Board's strategy identifies several key actions which include:

- establishing governance processes that demonstrate learning from the depth and breadth of quality, safety, and patient experience sources; and
- investment in an expert specialist patient safety team who can support and work alongside teams to respond rapidly when things go wrong, supporting patient's, families, and staff and to ensure that actions are taken to prevent harm in the future.

15 The Health Board's Annual Plan 2021-22 outlines its commitment to "focus on quality, safety, and patient experience across all settings where healthcare is provided as we [the Health Board] look to be one of the safest organisations in the NHS". To achieve this, the quality, safety, and patient experience element of the plan identifies eight quality priority themes:

- Quality, Safety and Experience Framework 2021-2026 (see **paragraph 17**);
- Organisational safety culture;
- Leadership and the prioritisation of quality, safety, and experience;
- Patient experience and involvement in quality, safety, and experience;
- Patient safety learning and communication;
- Staff engagement and involvement in safety, quality, and experience,
- Patient safety, quality and experience data and insight;
- Professionalism of patient safety, quality, and experience.

16 The Health Board's headline activities and delivery timescales are designed to support the achievement of its quality priorities. However, there is no monitoring and reporting framework in place. As a result, we found limited assurance and scrutiny at the corporate Quality, Safety and Experience Committee (QSE Committee) on the key areas of delivery. This creates a risk that the Committee, and subsequently the Board, are not fully sighted on aspects where quality delivery aims are not being achieved or where there is limited progress. This was also a key finding in our 2021 Structured Assessment report[2], which resulted in a recommendation being made for the Health Board to strengthen its arrangements for monitoring and reporting on overall delivery of the 2021-22 Annual Plan and subsequent plans.

17 Our work found that the Quality, Safety, and Improvement Framework 2017-20 remained in place beyond its 2020 expiry date whilst the Health Board completed work on its new Quality, Safety, and Patient Experience Framework for the period 2021 to 2026. The framework, which was presented to the corporate QSE Committee in September 2021 for approval, focusses on eight key themes:

- Safety culture,
- Leadership and prioritisation,
- Patient experience and involvement,
- Patient safety, learning and communication,
- Staff engagement and involvement,
- Data and insight,
- Professionalism and
- Quality Governance.

18 The Health Board engaged stakeholders as part of the new framework development by seeking the views of clinical and non-clinical staff, patients and their families / carers, and other key external stakeholders and partners, such as the Community Health Council.

19 Both the Surgery Clinical Board and Surgical Services Directorate identify quality and patient safety priorities and monitor their progress. The Clinical Board and Directorate revised their priorities in response to the COVID-19 pandemic.

[2] https://www.audit.wales/sites/default/files/publications/cardiff_vale_health_board_structured_assessment_2021_phase_two_english_1.pdf

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. **(Recommendation 1)**

Risk management

20 The Health Board revised its risk management strategy, approach, and Board Assurance Framework (BAF) during 2021, and established a risk appetite for the safety, quality, and accessibility of care which it defines as 'open'[3] with the intention to move to 'seek'[4].

21 One of the ten principal risks to the Health Board as set out in the BAF relates to patient safety, which has been assigned to the clinical Executive Directors as leads responsible for managing the risk and to the corporate QSE Committee to seek and provide assurance that the Health Board is managing the risk appropriately. The BAF clearly outlines the current controls and assurances alongside any gaps and actions to address them.

22 Our observation of the corporate QSE Committee in February 2022 indicated that a brief presentation, discussion, and scrutiny took place on the BAF as well as the patient safety risk assigned to the committee.

23 There is scope to ensure the corporate QSE Committee maintains greater oversight of risks assigned to other committees where there is a clear quality and safety impact. For example, workforce risks are a consistent theme in the Surgery Clinical Board assurance report, the Corporate Risk Register (CRR), and the BAF. Whilst the strategic workforce risk is appropriately assigned to Executive Director of People and Culture as lead and to the Strategy and Delivery Committee for assurance purposes, the Health Board should consider how the corporate QSE Committee oversees and gains assurance on the wider workforce risks from a quality and safety perspective. **(Recommendation 2)**

24 The Health Board's CRR provides an overview of the key operational risks from the divisions and corporate directorates. Each risk is linked to a sub-committee of the Board for assurance purposes with any risks scoring 20 and above escalated onto the BAF as a principal risk to the Health Board. The CRR identifies several risks in relation to quality and safety.

25 At an operational level, the Health Board's Surgery Clinical Board and Surgical Services Directorate maintain and actively manage risk registers. They clearly articulate quality and safety risks at this level which are scored appropriately and

[3] Definition of 'open' risk appetite - "despite short term inherent risks it recognises potential for long term gain. The Health Board often challenges current clinical practices and pursues innovative treatment and care solutions. Confident in its risk control the Health Board allows non-critical decisions to be devolved to a low operational level."

[4] Definition of 'seek' risk appetite - "despite short term inherent risks it seeks potential for long term gain. The Health Board will routinely challenge current clinical practices and pursue innovative treatment and care solutions".

have appropriate controls. However, whilst the Clinical Board risk register identifies risk owners, the Surgical Services risk register does not. Risk also features on the agenda for both the Surgery Clinical Board and Surgical Services Quality, Safety, and Experience Committee meetings. Whilst operational processes for managing risk are reasonably effective, our discussions with staff found that risk management arrangements are developing. There is scope to improve the quality of risk information recorded on operational risks registers and the process of escalation and de-escalation of risks to / from the CRR to maintain the quality of the BAF and ensure the Board is appropriately sighted of key risks facing the organisation. We understand that the Health Board is currently addressing these issues.

Organisational culture and quality improvement

26 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

27 We found that **the Health Board has a dedicated Quality Improvement Team, but the COVID-19 pandemic has impacted on the support it provides to the Health Board. Arrangements for monitoring mortality and morbidity are developing, but arrangements for clinical audit require significant improvement. There is a well-established values and behaviours framework, but more work is required to develop an open and supportive culture to enable staff to raise concerns. The Health Board has effective arrangements to monitor and track progress with complaints, and consistently achieves performance targets. There are reasonable arrangements to capture patient experience, but more work is required to improve Board and Committee oversight of patient stories.**

Quality improvement

28 The Health Board's Quality Improvement (QI) Team consists of 2.6 Whole Time Equivalent (WTE) staff (4 headcount). The capacity of the team has recently increased through the reconfiguration of a previous role and securing 12 months' non-recurring funding for 1 WTE post.

29 Prior to the COVID-19 pandemic, the QI team delivered the Leading Improvement in Patient Safety (LIPS) Programme on a bi-annual basis to both clinical and non-clinical staff. However, the pandemic is limiting usual training activity. The Health Board's intention is to reinstate and refresh the programme during April and September 2022. However, the programme is under review as part of a wider review of the quality improvement process across the Health Board. The Health

Board was also able to secure a Health Foundation research grant for its Cardiff and Vale Quality Improvement (CAVQI) programme which aims to support departments across the organisation with data analysis and improvement. The Health Board has completed an evaluation of the programme which identified several positive outcomes, including the development of a dashboard to analyse incident report data in real-time. The Health Board intends to introduce the programme across the organisation.

30 The Health Board supports the Improving Quality Together Learning Programme; however, it did not provide data to demonstrate the proportion of staff that have completed the various levels of training.

Clinical audit

31 Clinical audit is an important way of providing assurance about the quality and safety of services. At the time of our review, the Health Board was developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to staffing challenges (long-term sickness) and awaiting confirmation from the Health Board on investment plans for clinical audit.

32 The Health Board categorises clinical audits into three tiers:

- Tier 1 – Mandatory national clinical audit;
- Tier 2 – All other national audits and local clinical audits undertaken to address the patient safety and quality agenda; and
- Tier 3 – Local clinical audit for any other reason including revalidation and continual professional development (CPD) purposes.

33 The Health Board approved its clinical audit plan for 2021-22 which includes all tier 1 and anticipated tier 2 audits. Whilst it does not include tier 3 audits, there are arrangements in place to ensure all tier 3 audits are scrutinised and are beneficial to the directorate and clinical board. At the time of our review, we found limited evidence that the Health Board has approved a clinical audit plan for 2022-23.

34 Both the Surgery Clinical Board and Surgical Services Directorate have a programme for national, local, and bespoke clinical audits, but have no system to track delivery. They provide progress updates to the corporate QSE Committee through the Clinical Board Assurance Reports. There are arrangements in place to share and discuss clinical audit findings, learning, and good practice across the Health Board's governance structure and with regional networks.

35 A corporate QSE Committee update in September 2021 highlighted the activity of the Clinical Effectiveness Committee (CE Committee) since December 2020. The report outlined the progress of tier 1 audits and highlighted several key messages issues, learning, and actions arising from the reviews to discuss at the committee. We also found evidence of verbal updates provided to the corporate QSE Committee during its subsequent meetings. We comment on the purpose of the Health Board's CE Committee in **paragraph 75**.

36 The CE Committee update highlighted capacity and IT system issues within the Clinical Audit Team which are impacting on the support available for local (tier 2) clinical audit activity, the quality of assurance around the development of improvement plans, and the progress being made in addressing audit recommendations. Results from our data collection survey found that corporate resources for clinical audit have reduced over the last 3 years to enable the Health Board to achieve cost reductions. The team currently comprises 6.21 WTE (7 headcount) and, at the time of our review, there was one vacancy. The Health Board's benchmarking exercise and review of current resources and team structure has also identified that clinical audit requires investment to deliver desired improvements. In addition to increasing the team's capacity, the Health Board has also invested in the AMaT[5] audit management system to better utilise clinical audit as a source of assurance and establishing a process for monitoring and reporting local (tier 2) clinical audits.

37 Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021. The review focussed on three areas: roles, responsibilities, and resources; programme planning and programme delivery; and board assurance. A limited assurance rating was given, and several key matters were identified in relation to the absence of a clinical audit strategy, policy, and procedures; inadequate resources and clinical audit IT system; absence of a clinical audit training plan; and limited oversight and scrutiny of local clinical audit activity. **(Recommendation 3)**

Morbidity and mortality

38 Mortality and morbidity review meetings provide a systematic approach for peer review of adverse events, complications, or mortality to reflect, learn from and improve patient care. We found that the processes around universal mortality reviews were recently superseded by the commencement of the Medical Examiner function.

39 The Health Board has established a bi-monthly multi-disciplinary Mortality (Learning from Deaths) Group. The Assistant Medical Director for Clinical Governance and Patient Safety chairs the group. Meetings have a balanced agenda encompassing a range of issues including: Covid-19 mortality; mortality reviews; divisional updates; and detailed reviews of mortality data. Meetings are well attended by clinical staff with good quality reports, presentations, discussion, and challenge.

40 Mortality and morbidity feature in the corporate QSE Committee's Quality Indicator report. The February 2022 update provides information on the implementation of the new process for mortality reviews and identifies emerging themes and actions within the Health Board. For example, the report identifies communication as a

[5] Audit Management and Tracking

recurring theme and, as a consequence, the Health Board is recruiting staff to ensure there is timely and regular communication with families.

41 At an operational level, mortality data analysis is a standing item on the agenda for the Surgery Clinical Board's Quality, Safety and Experience Committee. However, there is limited evidence of detailed discussion. Furthermore, results from our divisional and directorate data collection surveys suggest there were arrangements in place pre-pandemic to review mortality and morbidity through regular meetings, with learning and good practice shared outside the meetings via distribution of minutes and updates provided to the Surgery Clinical Board's Quality, Safety and Experience Committee. However, they have not been able to maintain these arrangements during the pandemic.

Values and behaviour

42 The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. It focuses on being kind, caring and respectful, and emphasises, integrity, and personal responsibility. The Health Board has embedded values and behaviours in workforce processes, such as recruitment, appraisals, and induction. However, the quality of induction for substantive and temporary staff appear to vary in quality. Of the staff who completed the Health Board's internal patient safety survey[6], only 36% agreed or strongly agreed that induction arrangements for new and temporary staff in their work area / department support safe and effective care.

43 Results from the Health Board's internal patient safety survey also revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns:

- 45% agreed or strongly agreed that when an event is reported, it felt like the person is being reported, not the problem.
- 36% agreed or strongly agreed when asked if they felt their mistakes are held against them.
- 46% agreed or strongly that they were worried that mistake's they make are kept in their personal file.
- 32% agreed or strongly agreed that staff are given feedback about changes put into place based on incident reports.
- 51% agreed or strongly agreed that staff are informed about errors that happen in their team / department.
- 57% agreed or strongly agreed that teams / department discuss ways to prevent errors from happening again.

[6] The Cardiff and Vale University Health Board's Patient Safety Staff Survey ran for a period of 4 weeks in 2021. The survey attracted responses from 988 staff. The findings are unlikely to be representative of the views of all staff across the Health Board. As a result, we have only used them to illustrate particular issues.

- 24% staff indicated a mistake is rarely or never reported if it is caught and corrected before affecting the patient.
- 21% staff indicated a mistake is rarely or never reported if it has no potential harm to the patient.
- 45% staff indicated a mistake is usually or always reported if a mistake could harm the patient. **(Recommendation 4)**

44 The most recent NHS Wales Staff Survey[7] showed a small but still significant proportion of staff expressing concerns relating to bullying, harassment, or abuse by another colleague, member of the public, or line manager over the past year (18.8%, 18.1% and 9.7% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff or a member of the public (40.3%). However, results from the Health Board's internal patient safety survey show that 67% of staff agreed or strongly agreed that people treat each other with respect in their team or department.

45 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. November 2021 figures show an overall organisational compliance of 72.26%[8]. Whilst this level slightly improved since September 2021, it is still below the target of 85%. The Health Board's internal patient safety survey found that 61.28% of staff disagreed or strongly disagreed that they have enough time at work to complete any statutory and mandatory training. The Surgery Clinical Board and Surgical Services Directorate have indicated that managers are allowing staff time to complete statutory and mandatory training, although this has been challenging over the last year due to pressures caused by the pandemic. Senior leadership and managers within the Surgery Clinical Board and Surgical Services Directorate encourage and monitor staff compliance through the appraisal process and revalidation events.

46 Personal Appraisal Development Review (now Values Based Appraisal) is a two-way discussion which helps staff understand what is expected of them in their role, become more engaged, and take responsibility for their own performance and development. Against a national target of 85%, the overall Health Board compliance rate for appraisals in November 2021 was 31.6% which has remained broadly consistent with the position reported in September 2021 of 31.9%. Compliance reported by the Surgery Clinical Board during our fieldwork was 27%. The Health Board reports that operational pressures are adversely affecting compliance. At an operational level, the Surgery Clinical Board are encouraging managers to use the Electronic Staff Record (ESR) system by enabling them to access training. However, enabling work has not delivered the level of

[7] The NHS Wales Staff Survey ran during November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 22%, compared to an all-Wales average of 19%.

[8] The Health Board is required to report compliance to the Welsh Government monthly and the target for compliance for all health boards is 85%.

improvement anticipated over the COVID-19 pandemic period. **(Recommendation 5)**

Listening and learning from feedback

Patient Experience

47 The Health Board's standalone Patient Experience Framework which expired in 2020, was replaced in 2021 by the new Quality, Safety and Patient Experience Framework for 2021 to 2026. The new framework identifies patient experience and involvement as one of its eight key themes and includes the development and implementation of a Patient Safety Partner (PSP) framework and a 'What Matters to You' campaign.

48 Our work found that Clinical Boards provide patient experience updates to the corporate QSE Committee via their Quality, Safety, and Experience Sub-group meeting minutes, Clinical Board Assurance Reports, and the quality indicators progress report. We also note a standalone patient experience update was provided to the February 2022 corporate QSE Committee. The report provides an overview of the role of the Patient Experience Team and how it operates under the recent Health and Social Care (Quality and Engagement) (Wales) Act 2020. It also highlights key achievements, and areas of risk or concern.

49 The Surgery Clinical Board and Surgical Services Directorate use short surveys, suggestion boxes, and 'Happy or Not' kiosks to capture patient experience information. There are also plans to install patient / visitor ward information boards at the entrance to all ward areas. They share the compliments or concerns raised by patients and their carers with staff to help them understand the patient's perspective of care received and any action to be taken where necessary.

50 During the pandemic, the Health Board withdrew its monthly feedback surveys and 'Happy or Not' kiosks and adapted its methods for gaining patient feedback by introducing a range of online surveys. The 'Happy or Not' kiosks have now been reintroduced to gather feedback from the Mass Vaccination Centres. The Health Board also issues surveys to patients and staff as part of bespoke studies across a range of different services.

51 The Health Board has a Complaints and Patient Advice and Liaison Service (PALS) that sits under the remit of the Executive Director of Nursing.

52 The Health Board is rolling out the Once for Wales Service User Feedback System that will introduce real-time feedback and 'ward to board' reporting functionality. This will ensure a consistent approach across the organisation and enable it to monitor actions and undertake more effective thematic analysis.

Concerns and Complaints

53 Against a national target of 75% of complaints responded to within 30-days, the Health Board achieved 77% as at January 2022 which represents a slight decrease in performance of 88% in December 2021. However, the Health Board consistently exceeds the national target through its Corporate Concerns Team, whose approach is to resolve as many concerns as possible under early resolution.

54 The Health Board uses information from concerns, complaints, serious incidents (known also as Nationally Reportable Incidents), and never events to identify themes and trends which it includes in its Quality Indicators Report. The top reported categories for serious incidents since June 2021 have been pressure ulcers, patient accidents / falls, unexpected deaths, delayed diagnostic processes / procedures, and delayed access / admission. The main themes in relation to concerns are waiting times, communication, care, and treatment.

55 The Surgery Clinical Board reported 812 concerns received between 1st September 2020 to 30th September 2021. It has embedded its arrangements for tracking concerns, with tracker meetings across all directorates aligned to an overarching Clinical Board tracker database. This enables effective monitoring of timelines in responding to concerns and supports the ability to take prompt action where there are delays. The effectiveness of these arrangements and the support received from the Corporate Concerns Team is reflected in the Surgery Clinical Board's performance, with 86% of concerns closed within the 30-day target for the period 1st September 2020 to 30th September 2021. The latest assurance report from the Surgery Clinical Board to the corporate QSE Committee in February 2022 identifies the main themes arising from concerns as: clinical treatment / assessment, appointments, communication issues, admissions, and attitude / behaviour. However, there was limited evidence within the report to demonstrate how the Clinical Board is learning and acting on the main concerns themes.

56 The Assistant Directors of Patient Experience and Patient Safety provide a report and presentation annually to the corporate QSE Committee which outlines the quality, safety, and experience themes and trends identified across the Health Board during the year. The 2020-21 report mainly focuses on the Health Board's work to adapt its reporting and working requirements across the organisation during the pandemic. However, the accompanying presentation identifies themes and trends in relation to key aspects of quality and safety, including patient safety incidents, concerns, redress, mortality reviews, COVID-19 investigations, and national clinical audit.

57 There appears to be a generally positive culture within the Health Board in relation to learning lessons and improving patient safety. Results from the Health Board's internal patient safety survey found that:

- 65% staff agreed or strongly agreed that they are actively doing things to improve patient safety.
- 58% staff agreed or strongly agreed that mistakes have led to positive change.

- 43% staff agreed or strongly agreed that after staff make changes to improve patient safety, and they evaluate their effectiveness.

Listening to staff concerns

58 The Health Board is committed to listening and learning from staff experiences and concerns. In December 2021, it reviewed and updated its Incident, Hazard, and Near Miss Reporting Procedure to reflect changes made by the NHS Wales Delivery Unit to the way NHS bodies report serious incidents. The procedure outlines a range of mechanisms for staff to raise concerns, including the 'freedom to speak up' initiative, 'safety valve' and whistleblowing policy. However, whilst the procedure references the 'safety valve' process as an option for raising concerns, the Health Board no longer uses it.

59 The Health Board's 'freedom to speak up' initiative aims to develop a culture of openness across the organisation. It supports and encourages staff to raise any concerns they may have. During June 2021, the Health Board updated its internet site and established a new communication plan to raise awareness across the organisation.

60 Whilst the Health Board regularly reports concerns to its corporate QSE Committee, it was unclear whether this includes concerns raised by staff. Subsequently, we could not assess the effectiveness of the arrangements.

61 The Health Board encourages staff to use Datix to report incidents. Whilst all staff within Corporate Services, the Surgery Clinical Board, and the Surgical Services Directorate appear to have access to the Datix system, the results from our data collection surveys suggest only some have received training or support to use the system to report concerns, near misses or run reports.

62 There is a mixed picture in relation to the culture around listening to staff concerns. Results from the Health Board's internal patient safety survey found 67% agreed or strongly agreed that staff will freely speak up if they see something that may negatively affect patient care, and 60% staff agreed or strongly agreed that their supervisor / manager seriously considers staff suggestions for improving patient safety. However, 41% agreed or strongly agreed that staff felt free to question the decision or actions of those with more authority and 27% agreed or strongly agreed that staff are afraid to ask questions when something does not seem right. **(Recommendation 4)**

Patient Stories

63 Patient stories feature on the agenda of meetings of the Board, corporate QSE Committee, other sub-committees of the Board such as the Mental Health Capacity and Legislation Committee, and the Clinical Board Quality, Safety and Experience Committees. Patient stories are regularly shared in public Board meetings using videos. The corporate QSE Committee note patient stories included in Clinical Board Assurance Reports and in the minutes of the Clinical Board Quality, Safety

and Experience Committees presented during the meeting. Learning and actions arising from patient stories are identified at Clinical Board level.

Patient Safety Walkarounds

64 Patient safety walkarounds provide Independent Members with an understanding of the reality for staff and patients, help make data more meaningful, and provide assurance from more than one source of information. The Health Board has re-commenced its programme of walkarounds having paused them during the pandemic. However, they are on a smaller scale whilst COVID-19 restrictions and considerations remain in place. Independent Members commented positively on the walkarounds. They indicated that the walkarounds help them to triangulate information, to gain a sense of staff morale, and to understand the day-to-day issues affecting staff. Reports arising from patient safety walkarounds are shared with the respective Clinical Board and reported to the corporate QSE Committee annually.

Internal / External Inspections

65 Our 2021 Structured Assessment work found that the Corporate Governance Directorate presents a legislative and regulatory tracker report to each Audit and Assurance Committee meeting. The update provides an overview of the Health Board's progress in implementing recommendations made by inspection and regulatory bodies, such as the Health and Safety Executive, Health Inspectorate Wales (HIW), and Community Health Council. The Corporate Governance Directorate has recently enhanced the content of the report to provide more robust assurance to the Audit and Assurance Committee, as well as to provide a commentary on the Health Board's management of Welsh Health Circulars, and Patient Safety Solutions. However, there are opportunities for the Audit and Assurance Committee to strengthen its role in seeking assurance from the corporate QSE Committee. Doing so might help provide a greater level of assurance to the Board that appropriate action is being taken to address and monitor external recommendations relating to quality and safety.

66 The corporate QSE Committee receives updates on HIW and CHC activity. Updates provided to the Committee meeting in February 2021, June 2021, and February 2022 provide an overview of CHC reports, and HIW local inspections and thematic and national reviews. All update reports gave sufficient information to ensure awareness amongst Committee members of all activity that could potentially impact on the Health Board.

Governance structures and processes

67 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

68 We found **strong collective responsibility for quality and safety amongst the Executive Leadership of the Health Board. However, the departure of key clinical Executives from the organisation potentially poses risks to rolling-out and embedding the new Quality, Safety and Patient Experience Framework. Corporate and operational structures and processes for quality and safety are reasonably effective and the Health Board is taking steps to strengthen these arrangements further. However, resources require further investment to enable the Health Board to fully roll-out and embed its planned quality and safety improvements.**

Organisational design to support effective governance

69 There is strong collective responsibility for quality and patient safety amongst the Executive Leadership of the Health Board, with the Executive Director of Nursing, Medical Director, and Director of Therapies and Health Sciences in particular providing visible leadership in this area. The Health Board's senior leadership is supported by a team of Assistant Directors who provide day-to-day leadership for a range of functions including quality and safety Improvement; patient safety; quality assurance; and clinical effectiveness. The Health Board's Director of Nursing is retiring in July 2022 and, therefore, the Health Board will need to recruit to this role. This potentially poses a risk to the Health Board, as both the Director of Nursing and previous Medical Director were instrumental in the development of the new Quality, Safety, and Patient Experience Framework and will have left the Health Board before it has been fully implemented and embedded across the organisation. Our review found that the Executive Management Board regularly discuss quality and safety as a standing agenda item at its twice weekly meetings.

70 Whilst there is collective responsibility and accountability for quality and safety at a corporate level, our work found that at an operational level there is evidence of 'silo' working and a lack of clarity among Clinical Directors around their responsibilities for quality and safety. We understand that the Health Board is addressing this through the job planning process.

Quality, Safety and Patient Experience Framework and Structures

71 We comment in **paragraph 17** on the Health Board's new Quality, Safety and Patient Experience Framework for 2021-26 which was approved by the corporate QSE Committee in September 2021. The framework articulates a structure which includes a range of committees and groups focussing on specific aspects of quality and safety. Each committee / group is required to provide assurance to the

corporate QSE Committee which, in turn, provides assurance to the Board via the quality, safety and experience dashboard and signals from noise data tool. It is expected that the committees / groups in the quality, safety, and experience structure will ensure an increased focus on key quality areas, reduce the workload of the corporate QSE Committee, and provide greater assurance to the Board. Key quality and safety exception reports such as, HIW reports, infection prevention and control reports and significant national quality, safety, and experience reports provide further assurance.

72 Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety, and how they align with the corporate structures to provide 'floor to board' quality and safety assurance. For example, each of the Health Board's Clinical Boards have a local Quality, Safety, and Experience Committee which are underpinned by directorate or site-based leadership Quality, Safety, and Experience groups. Clinical Boards provide assurance to the corporate QSE Committee through periodic assurance reports and the inclusion of minutes from the local meetings. The Health Board is still in the process of rolling out and embedding the new quality, safety and patient experience structure with some key committees and groups - such as the Organisational Learning Committee and Clinical Safety Group - yet to meet.

Corporate Quality, Safety, and Experience Committee

73 The corporate QSE Committee is responsible for providing assurance and advice to the Board in relation to quality and patient safety. The corporate QSE Committee considers and seeks assurance from a range of quality and safety information. As part of our work, we observed the committee on several occasions, and found them to be well-chaired with good quality discussion, scrutiny, and challenge from Independent Members. However, our recent structured assessment work highlighted some concerns expressed via the 2020-21 Board Effectiveness Survey regarding the length of the committee agendas.

74 The committee's arrangements for providing assurance on quality and safety matters has improved. The committee reviews and scrutinises a range of quality and safety indicators and provides an overview of the Health Board's performance at each Board meeting.

Clinical Effectiveness Committee

75 The monthly Clinical Effectiveness Committee (CE Committee) was established in December 2020 to provide a forum for senior clinicians to monitor the implementation of NICE[9] guidelines, to provide strategic direction for the Health Board's national and local clinical audit programme, and to receive reports from

[9] National Institute of Health and Care Excellence

sub-groups and escalate issues / provide assurance to the corporate QSE Committee and Board as appropriate. The committee has multidisciplinary membership and invites representatives from Clinical Boards to discuss items on its agenda.

Clinical Safety Group, Organisation Learning Committee, and Serious Incidents / Concerns Group

76 The Health Board intends to further strengthen its quality and safety arrangements by establishing a Clinical Safety Group and an Organisational Learning Committee.

77 The Clinical Safety Group's draft Terms of Reference indicates that its role will be to provide advice and assurance to the corporate QSE Committee by overseeing Health Board plans; considering external review / investigation reports and their implications on patient and citizen experience; considering outcomes for patient feedback; reviewing compliance with Health and Care Standards; and monitoring implementation of the Quality, Safety and Experience Framework. The committee will have multidisciplinary membership from nursing, medical, and corporate staff.

78 The Organisational Learning Committee's draft Terms of Reference indicate that its role will be to provide strategic direction and leadership to ensuring cross divisional learning from themes and trends. It will also be responsible for agreeing actions for improvement and monitoring the sharing of good practice. The committee will report to the corporate QSE Committee for assurance purposes. Whilst the proposed committee membership includes staff from a range of professional backgrounds, we do note a lack of nursing representation.

79 The role of the Serious Incident / Concerns Group is to provide oversight around the management of complaints, claims, serious incidents, patients experience, never events, inquests etc. We comment on the positive impact this group has had on the Health Board's concerns / complaints performance in **paragraph 53**. Our observations of several Serious Incident / Concerns meetings found there to be a positive culture around quality, safety, and patient experience. Meetings were well chaired with open and honest discussions amongst attendees. Clear actions were identified and agreed and assigned to responsible officers.

Clinical Board Quality, Safety and Experience Committees

80 The Quality, Safety, and Experience Committees within Clinical Boards are responsible for providing assurance and advice to the corporate QSE Committee. There are bi-monthly Surgery Clinical Board Quality, Safety, and Experience Committee meetings which are chaired by a Consultant Anaesthetist.

81 There is good multidisciplinary attendance at meetings from nursing, medical, and corporate staff. The structured meeting agenda aligns to the Health and Care Standards. There are also items relating to sharing feedback from the corporate QSE Committee and considering exception reports and escalation of key issues from Directorate Quality, Safety, and Experience Committees and specialties. This

ensures both ‘floor to board’ quality and safety assurance and enables sharing of key corporate quality and safety information down through the quality and safety structure.

Directorate Quality, Safety, and Experience Committees

82 The Directorate Quality, Safety, and Experience Committees are responsible for providing assurance and advice to the Clinical Board Quality, Safety, and Experience Committees. Monthly Surgical Services Directorate Quality, Safety and Experience committee meetings are held and chaired by the Lead Clinician responsible for quality and safety. Meetings are well chaired and have good multi-disciplinary attendance from nursing, medical, and corporate staff. There is good quality discussion among participants with sufficient time given to each item allowing everyone to contribute to the discussion.

Resources and expertise to support quality governance

83 There are several corporate teams working to support quality and safety issues across the Health Board. The Patient Experience Team and the Concerns Team report to the Executive Director of Nursing. This is in addition to the Quality Improvement, Clinical Audit, and Infection Prevention and Control Teams referred to in this report (see **paragraphs 28, 36, and 85**).

84 The Patient Experience Team (3.86 WTE, 4 headcount) provides a range of bespoke training to operational areas supporting staff, carers, and volunteers across the Health Board, alongside its more structured induction training for new staff. The Concerns Team (10.4 WTE, 14 headcount) provides training and support to operational staff in relation to early complaint resolution, breach of duty, putting things right, and other areas of bespoke training. Both the Patient Experience and Concerns Teams had no vacancies at the time of reporting. However, resources within the teams have reduced over the last three years to achieve cost reductions. Results from our data collection survey indicate that the Health Board does not have a corporate data analytics team.

85 The Health Board has a dedicated Infection Prevention and Control Team (7 WTE, 8 headcount), which provides formal and bespoke training and support to operational staff across the Health Board on matters relating to infection prevention and control. During the COVID-19 pandemic, the team worked in association with external / partner organisations and agencies such as Cardiff University, Cardiff Metropolitan University, Cardiff Council, and Vale of Glamorgan Council to provide PPE[10] and general infection prevention and control training and also ensured attendance at TTP[11] operational and board meetings. This has had a significant impact on the team’s capacity to provide both support to the immediate pandemic

[10] Personal Protective Equipment

[11] Test, Trace and Protect

response and to provide advice and training across the Health Board on its regular infection and prevention control work. The team had no vacancies at the time of reporting.

86 At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety such as: managing concerns, patient experience, infection prevention and control, quality improvement, risk management, Datix, and data analytics. However, we found that some designated leads do not have protected time to fulfil several of these roles, particularly at the directorate level.

87 Indeed, the lack of resources and capacity for quality and safety activity was a consistent theme during our interviews with Health Board staff. Furthermore, results from the Health Boards internal patient safety survey identify this as a significant issue:

- 67% of staff disagreed or strongly disagreed that there is enough staff to handle the workload.
- 43% of staff agreed or strongly agreed that staff in their team / department work longer hours than is best for patient care.

88 Corporate and operational resources for quality and safety, therefore, require further investment to enable the Health Board to fully roll-out and embed its planned quality and safety improvements. **(Recommendation 6)**

Arrangements for monitoring and reporting

89 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

90 We found that **corporate and operational agendas provide a wide coverage of quality and safety issues for discussion. There is sufficient information for scrutiny and assurance at both corporate and Clinical Board levels, and the Health Board's use of quality and safety data is maturing. However, there are opportunities for agendas to be more dynamic to reflect new and emerging quality risks and issues. Reporting on the four harms associated with COVID-19 requires strengthening. Furthermore, reporting requires further development at directorate level and around services commissioned by the Health Board.**

Information for scrutiny and assurance

91 The Board's integrated performance report and balanced scorecard provide performance information against the NHS Wales Delivery Framework measures including complaints, serious incidents, mortality, and falls. The report provides a detailed commentary on quality and safety performance and includes links to other papers that provide further information on specific aspects of quality and safety.

For example, the report provided to Board in January 2022 included a link to a separate paper on pressure damage reduction.

92 The Board introduced a 'COVID-19 Update Report' in November 2020 (which was renamed "Systems Resilience Update" in November 2021) to provide updates on key aspects of the Health Board's activities during the COVID-19 pandemic, including in relation to quality and safety. The quality and safety element of the report provides an overview of operational pressures and their impact, as well as some commentary in relation to people experience and investigations into hospital acquired COVID-19. However, 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. The Board also receives a range of separate quality and safety related reports around topics such as stroke performance, nurse staffing levels, and the Public Services Ombudsman's Annual Report.

93 In June 2020, the corporate QSE Committee agreed a range of quality indicators to routinely monitor at each meeting through a quality, safety, and experience dashboard. Although work on the dashboard is still progressing, the committee continues to provide oversight of quality indicators through its Quality Indicators Report which includes measures on nationally reportable incidents, pressure damage, COVID-19 related incidents, never events, concerns, patient experience, and falls. Whilst the corporate QSE Committee also receives reports from all Clinical Boards which assist in providing assurance across the breadth of the Health Boards services, there are opportunities to strengthen reporting on the quality and safety of services, including services commissioned by the Health Board.

94 Clinical Boards provide regular assurance reports to the corporate QSE Committee on the quality and safety of services at an operational level. The report from the Surgery Clinical Board is aligned to the Health and Care Standards and contains performance information on a range of quality metrics, including never events, healthcare acquired infections, incidents, concerns, and patient feedback. The report also highlights key risks and mitigating actions and work completed in response to COVID-19. However, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate QSE Committee. **(Recommendation 7)**

95 At an operational level, the Surgery Clinical Board's Quality, Safety, and Experience Committee reviews various presentations, performance reports, and dashboards including data around serious incidents, Datix management, mortality reviews, pharmacy prescribing, medication, patient experience, concerns, and infection control. We found that supporting papers were not provided for some agenda items, with verbal reports and updates provided instead. Whilst verbal reports and updates are appropriate in some cases, a lack of supporting information limits opportunities for attendees to review information in advance and provide sufficient scrutiny and challenge at meetings.

Coverage of quality and patient safety matters

96 The corporate QSE Committee's remit is clear in relation to providing oversight of quality and patient safety. Agendas are structured and include several standing items, such as Clinical Board Assurance Reports, Quality Indicators Report, reports on HIW activity, Primary Care updates, and review of the relevant Board Assurance Framework risks. The committee also receives exception reports and specific updates on key aspects of quality and safety such as pressure damage, regular review and approval of quality and safety related policies, and meeting minutes from all Clinical Board Quality, Safety, and Experience Committee meetings.

97 Whilst meeting agendas are structured, there are opportunities for them to be more dynamic to reflect new and emerging quality risks and issues. Furthermore, our work identified concerns around the size of agendas, presenting a risk that there is too much information to adequately scrutinise and seek assurance. However, as stated in **paragraph 71**, the establishment of additional committees and groups in the new quality, safety and experience structure should provide focus on key quality areas to provide assurance to the Corporate QSE Committee and, therefore, help to reduce the workload of the committee.

98 Operationally, the Quality, Safety and Experience committees within the Surgery Clinical Board and Surgical Services Directorate use standardised agendas which are aligned to Health and Care standards and cover key aspects of quality and safety such as: risk, patient stories, regulatory compliance and external accreditation, patient safety incidents, patient safety alerts, complaints, and infection control. However, the agendas for these meetings are also large which can result in meetings overrunning beyond their allocated time.

99 Results from our data collection surveys indicate that the COVID-19 pandemic did not impact the way in which the Surgery Clinical Board and Surgical Services Directorate monitors and reports quality and patient safety matters. They share minutes from meetings with the directorate, divisional and executive, management teams.

Appendix 1

Management response to audit recommendations

Exhibit [x]: 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
R1 AP recommendation text • AP recommendation bullet – AP recommendation sub-bullet	**Table text bold** Table text • Table bullet – Table sub-bullet	Table text	Table text

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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.

Management response

Report title: Review of Quality Governance Arrangements – Cardiff and Vale University Health Board

Completion date: 27/06/2022

Document reference: 2962A2022

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Quality and Safety Priorities** 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	Better alignment between operational and strategic quality and safety priorities.	Yes	Yes	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.	September 2022 September 2022	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

	strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.						

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	**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:	Quality, Safety and Experience Committee maintains greater oversight of all risks where there is a clear quality and safety impact. Strengthened risk management arrangements.	Yes	Yes	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,	October 2022	Director of Corporate Governance

	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.				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.	Underway and an ongoing requirement - March2023	

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	**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	Strengthened clinical audit arrangements.	Yes	Yes	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 -	October 2022 October 2022 Recruitment completed by September 2022	Head of Quality Assurance & Clinical Effectiveness

	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				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	Implementation completed by March 2023	

	implemented as a priority.						

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	**Values and Behaviours** 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	Better awareness and understanding of staff views on the arrangements for reporting errors, near misses, incidents, and for raising and listening to their concerns.	Yes	Yes	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	QSE Framework to 2026 May 2023 Project plan completion October 2022	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme

	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.				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.	Annual surveys to be undertaken	

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5	**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	improved performance in relation to PADRs at both corporate and operational levels.	Yes	Yes	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	50% compliance rate – March 2023 85% Compliance Rate – March 2024	Assistant Director of OD, Wellbeing and Culture

	performance in relation to PADRs at both corporate and operational levels.				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 VBAs on staff wellbeing, performance, motivation and quality.		

					A range of bite-size learning is also in development which will also provide employees with support in preparing for their VBA. Targeted intervention will support developments regarding pay progression.		

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6	**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.	Sufficient resource and capacity in place to support quality governance at both corporate and operational levels.	Yes	Yes	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.	May 2024 September 2022	Assistant Director of Patient Experience Executive Director of Nursing

	The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.				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	Completed October 22	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R7	**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	Greater monitoring and reporting of the four harms associated with COVID-19 by Clinical Boards and the Quality, Safety and Experience Committee.	Yes	Yes	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	August 22	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

	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.						

Report Title:	**C&V UHB Ultrasound Clinical Governance Group (USCGG)**			Agenda Item no.	7.5
Meeting:	**AUDIT AND ASSURANCE COMMITTEE**	Public	X	Meeting Date:	05/07/2022
		Private			
Status *(please tick one only):*	Assurance ☑	X	Approval	Information	
Lead Executive:	**Fiona Jenkins, Executive Director of Therapies and Health Science**				
Report Author (Title):	**Interim Assistant Director of Therapies and Health Science**				

Main Report
Background and current situation:

SITUATION
Following an internal audit of Ultrasound governance across the UHB, several shortcomings were identified. These centered around a lack of assurance of appropriate governance in the correct and safe use of ultrasound across the UHB and insufficient communication and escalation pathways.

BACKGROUND

The Ultrasound (US) audit report, published August 2021 (please see attached), found limited assurance for Ultrasound governance arrangements within C&V UHB. The two high priority recommendations were:

1. The design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.

2. Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services.

Be assured that the following actions have been taken to address the short fallings found in the August 2021 Ultrasound audit.

- Review of the Ultrasound Clinical Governance Group (USCGG) and new ToRs written and ratified by the EDoTH to cover Diagnostic and Therapeutic Ultrasound**. – Complete: Please see attached "USCGG ToRs v0.8".**
- Membership of the USCGG to be extended to include all areas of Diagnostic and Therapeutic US across the UHB. **– Complete: Please see attached "USCGG ToRs v0.8" for membership details**
- Suitable chair of the USCGG **- Complete: The Interim Assistant DoTH nominated. who will formally report into the Medical Equipment Group, chaired by the EDoTH.**
- Clear reporting pathway for USCGG ToRs **- Complete: Reporting into the Medical Equipment Group, chaired by the EDoTH, with reportable instances be directed to QSE, as per attached "USCGG ToRs v0.8".**
- Change of name for the Medical Ultrasound Risk Management Procedure and Policy to Ultrasound Clinical Governance Procedure and Policy. **– Complete: Request formally sent to rename and appropriately index both Policy and Procedure.**
- Arrange USCGG regular meetings **- Complete: The inaugural USCGG meeting took place on 23rd Feb 2022, with further meetings taking place at a minimum frequency of 3 months.**
- Requirements to appoint US roles of Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor within relevant Clinical Boards will be actioned as part of the formation of the new USCGG. **– Partially complete: information requested from all departments (https://forms.office.com/Pages/ResponsePage.aspx?id=uChWuyjjgkCoVkM8ntyPrrlXT-fm7LhNmeHyPODDv-ZUNUhINlNWUzFJSEUzUjdPSU1aTkpXQ1lwRi4u). Complete in Medical Physics, Critical Care and Physiotherapy. Pending in other areas.**

- Creation and implementation of the US Safety Training will be actioned and implemented as part of the formation of the new USCGG. **– In progress: Progress with LED. Courses to be up loaded initially to Learning@Wales (due live by 1st Sept) then subsequently to ESR (6-12month go live time scale). The work will involve creation of on-line mandatory Ultrasound safety training for all users with the responsibility of compliance lying with the relevant Clinical Boards who will report compliance into the USCGG.**
- An annual audit template will be developed by the membership of the USCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework. – **In progress – The USCGG has reviewed similar audit tools used by other services, including POCT. The draft audit tool will be shared and agreed at the next USCGG meeting (29/06/2022).**

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

The following lists the short fallings found in C&V UHB Ultrasound Governance:

From the Aug 2021 Ultrasound audit report:
Objective 1: Design and implementation of ultrasound governance arrangements.

i. Lack of awareness of revised C&V UHB Medical Ultrasound Risk Management Policy (https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/t-patient-safety/ultrasound-risk-management-policy-pdf/) and Medical Ultrasound Risk Management Procedure (https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/t-patient-safety/ultrasound-risk-management-procedure-pdf/)
ii. Consideration of how Clinical Boards will provide US Governance assurance to EDoTH.
iii. Creation of an abridged US procedure and renaming of both policy and procedure to align with US structure and governance.
iv. Out of date Ultrasound Clinical Governance Groups ToRs.
v. Unclear routine and embedded reporting arrangements in ToRs
vi. Charing of the USCGG fell short of the level of authority required.
vii. Poor attendance of USCGG

Objective 2: Roles and responsibilities.

i. No formal documentation of roles and responsibilities assigned to staff in certain US areas and appropriately documented within certain Clinical Boards.

Reasonable assurance was found in training, noting an ambition of the USCGG to create a mandatory e-learning module for Ultrasound Safety training for all relevant staff.

Recommendation:

The Board / Committee are requested to:

Note 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.

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 actions taken will greatly reduce the risk of staff not being adequately trained in Ultrasound use and the associated risk to patients from improper and unsafe use.
Safety: Yes/~~No~~
Improved patient safety by improving and controlling training compliance for staff.
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
Improving governance will also ensure appropriate alignment with Medical Device Regulations.
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

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

Mohamed,Sarah
06/07/2022 13:17:46

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

Cardiff and Vale UHB

Ultrasound Clinical Governance Group

Terms of Reference and Operating Arrangements

CARDIFF AND VALE UHB ULTRASOUND CLINICAL GOVERNANCE GROUP TERMS OF REFERENCE

INTRODUCTION

The UHB's Standing Orders provide that '*The Board may and, where directed by the Assembly Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*'.

The Ultrasound Clinical Governance Group (USCGG) will be responsible for defining the scope of Diagnostic and Therapeutic Ultrasound (US), taking into consideration the clinical need for Diagnostic and Therapeutic US, its financial implications, technical feasibility, and in ensuring that appropriate measures are in place to monitor the accuracy and quality of Diagnostic and Therapeutic US and reporting. This will ensure optimal health and experience outcomes and improve patient safety across all of the UHB's US activities. The USCGG will also provide system level and strategic oversight to image storage arrangements. The USCGG report to Cardiff and Vale UHB's Medical Equipment Group which is chaired by the Executive Director of Therapies and Health Science who holds Executive responsibility for clinical ultrasound governance. See Appendix 1 – Governance and Reporting Framework.

Within Cardiff and Vale University Health Board, the USCGG advises on procurement decisions as well as seeking assurance on equipment life cycle management including monitoring, maintenance, replacement and disposal of equipment. The establishment and maintenance of service standards including training, competence assessment, supervision, operational delivery and audit are also within the Group's remit.

Key guidance.

1. Ultrasound Clinical Governance
National Diagnostic Imaging Board, Department of Health, LONDON (2008)
http://www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Diagnostics/Imaging.

2. 'Ultrasound Training Recommendations for Medical and Surgical Specialties'
RCR REF BFCR(05)2 The Royal College of Radiologists LONDON (2005)

PURPOSE

The purpose of the **Ultrasound Clinical Governance Group** is to;

- receive assurance that all US services have adopted and are adhering to the general requirements for good US governance,
- receive assurance on the achievement and maintenance of appropriate levels of competence, performance and patient safety related to the use of US equipment,
- provide regular written highlight reports and meeting minutes to the Medical Equipment Group (MEG),
- to provide assurance to the EDoTHS on all aspects of US clinical aspects, and escalating issues where assurance cannot be provided,
- through regular programmed review to maintain and develop the Medical Ultrasound Risk Management Policy and Procedure to ensure that it incorporates all contemporaneous clinical, professional and safety guidance,
- To seek assurance from each Directorate involved in US that suitable and sufficient Clinical Lead Users, Speciality Lead Users and Educational Supervisors / Training Supervisors are available within the UHB to assure continuing safe delivery of US clinical services, and escalate as necessary.
- recommend systems to ensure data is recorded accurately and consistently and stored safely across the UHB,
- advise procurement on criteria for evaluation of bids for US equipment, inform and facilitate better decision making and good governance in the purchase and use of US equipment within Cardiff

and Vale UHB,

- To maintain a robust system level governance framework and supporting infrastructure which ensures that US practitioners are trained, competent and work within the limits of their competence, and ensure all US practitioners are exposed to sufficient volume and complexity of procedures to maintain their skills and knowledge base. This will be assessed by a digital audit programme to include the development of a dashboard of balanced US service quality performance metrics where applicable,

- To develop and maintain an e-learning module to support the consistent adoption of best practice linked to the US Governance Policy and Procedure,

- Direct programmes of work where necessary to establish baseline US activity, review scope of existing practice and make recommendations on service improvement.

- develop an annual work programme to support the continuous improvement of US services at both a clinical service level and a UHB system level.

DELEGATED POWERS AND AUTHORITY

The Group will, in respect of its assurance role, seek confirmation that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality and safe US services across Cardiff and Vale University Health Board.

To achieve this, the Group's work programme will be designed to ensure that, in relation to all aspects of US service delivery:

- There is clear, consistent strategic direction, strong leadership, good governance and transparent lines of accountability with Executive oversight in the delivery of US services.

- The USCGG has a citizen centred approach, putting patients and patient safety above all other considerations.

- The US services planned or provided across the UHB are consistently delivered, strategically aligned, based on sound evidence, compliant with relevant law, clinically effective and meet standards set by relevant professional, regulatory, external quality assurance and accreditation bodies.

- The UHB has the right systems and processes in place to deliver, from a patient's perspective, effective, efficient, timely and safe US services.

- The US workforce is appropriately selected, trained, supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained.

- There is an ethos of continual quality improvement and regular methods of updating the US workforce in the skills needed to demonstrate quality improvement throughout the UHB.

- There is good team working across US services, with effective collaboration and partnership assured to provide the best possible outcomes for all service users.

- US risks are effectively and robustly managed and appropriately escalated within Clinical Boards and the wider UHB in a timely manner.

- All reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies US services, and in particular that:

    - recommendations made by internal and external reviewers are considered and acted upon in a timely basis; and
    - lessons are learned and fully evidenced from patient safety incidents, complaints and claims and disseminated as appropriate across the Clinical Directorates and Clinical Boards.

- Advise the MEG and relevant Quality, Safety and Experience Sub-Committee on the adoption of a set of US service quality performance indicators which will be regularly monitored, assessed and reported on.

These will include the following:

Clinical Governance

- To support the implementation of the Clinical Governance Programme for Cardiff and Vale UHB.

- Monitor the co-ordination and implementation of Welsh Government's Health and Care Standards and other standards relevant to the delivery of US services.

- Contribute to the Annual Healthcare Standards Improvement Plan and monitor progress within the Clinical Boards who deliver US services.

- Receive and consider reports as appropriate from US clinical services, the MEG, the Decontamination Group, the Infection Prevention and Control Group, relevant Clinical Board Quality, Safety and Experience sub committees and Operational Health and Safety sub groups within the Clinical Boards. See Appendix 1 – Governance and Reporting Framework.

- Share and communicate US best practice and continuous quality improvement.

- To advise the Point of Care Testing (POCT) Group on the suitability of US POCT Devices.

- To receive exception reports from Clinical Boards, Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor which relate to the delivery of US services.

Patient Experience

- Review reporting trends in US service delivery relating to patient safety incidents with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of further incidents have been identified and consistently and uniformly taken across the UHB.

- Receive and review progress reports relating to the requirements identified for patient safety and clinical governance activity relating to the provision of US services.

- Review reporting trends relating to clinical negligence claims involving US services with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of further claims have been identified and taken.

Policies and Procedures

- Authorise that US Clinical Procedures are appropriate on behalf of the UHB, and provide a summary of these to the Executive Quality, Safety and Experience Committee.

Concerns/ NHS Redress, Compliments and Claims

- Receive reports from Clinical Boards on complaints, compliments and claims relating to US services and the reporting trends relating to the progress and outcome of the related processes, with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of a repeat have been identified and taken.

Clinical Audit & Effectiveness

- Receive reports on the progress and lessons learnt from clinical audit and effectiveness relating to US service delivery which will include updates on national standards implementation e.g. Royal College Guidance, Medicines and Healthcare products Regulatory Agency (MHRA), National Science Foundations (NSF)s, National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD) evidence-based practices.

- Undertake annual digital audits for each US service, to inform development of an Annual Audit Plan for the UHB, ensuring arrangements are in place to monitor and review related outcomes.

- To receive summaries of US clinical audits from Clinical Boards and / or individual US service providers. This will include audits

carried out by individual services for external regulatory authorities.

Clinical Risk Management

- Monitor the arrangements in place to assess, control and reduce clinical risk associated with use of US within the Clinical Boards.

Audit Requirements

- Demonstrate co operation with Auditors in reviewing US systems and processes, including timely response.

- Monitor, review and evaluate the timescales for implementation of Audit recommendations, and ensure that they are in line with the Audit Committee requirements.

Personal Development, Review, Training and Education

- Receive progress reports from US service departments.

- Where appropriate direct Clinical Board / Directorate / Locality priorities.

Authority

The Group is authorised to investigate or have investigated any activity within its terms of reference.

In doing so, the Group shall have the right to inspect any books, records or documents of the UHB relevant to the Group's remit in keeping with data protection and other relevant legal regulations. Patient/client and staff confidentiality will be respected at all times as appropriate. The Group may seek any relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Group); and

- Other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

Access

The Chair of the Group shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Groups

The Group may establish sub groups and task and finish groups to carry out specific aspects of business and feed their activity into the Group.

MEMBERSHIP

Members

The group will comprise of:

- Chair: Assistant Director Therapies and Health Science
- Vice Chair: Clinical Specialist – to be appointed at first meeting.
- Senior Nurse representation as nominated by the Executive Nurse Director
- Senior Medical representation as nominated by the Executive Medical Director
- Lead Sonographer representation as nominated by the Clinical Director of RMPCE
- Lead US Radiologist representation as nominated by the Clinical Director of RMPCE
- Non-Ionising Safety Lead, Principal Clinical Scientist (Medical Physics).
- Physiotherapy representation as nominated by the head of Physiotherapy.
- Clinical Engineering representation – to be nominated by the Head of Clinical Engineering.
- C&V UHB Directorates* (involved in US) to provide representation. Where they have been appointed, the representative should be one of the following:
    - Clinical Lead User
    - Speciality Lead User

- Educational Supervisor / Training Supervisor

*Which must include representation from the following directorates and any others where diagnostic US is used:

- Obstetrics and gynaecology
- Radiology
- Sonography
- Cardiology
- Emergency Department

Where members are unable to attend then alternates should be identified to ensure constant representation and attendance.

Attendees

Clinical Directors or their representatives may be requested to attend from time to time as required by the Group Chair.

By Invitation

The Group Chair may extend invitations to attend Group meetings as required to the following:

- Directorate clinical leads
- Infection, Prevention and Control
- Those with specialist knowledge as required.

ULTRASOUND GOVERNANCE GROUP MEETINGS

Quorum

At least 5 members of the Group must be present to ensure the quorum of the Group, one of whom should be the Group Chair or Vice Chair.

Frequency of Meetings

Meetings shall be held quarterly with a minimum of 4 meetings per year with the Chair will make every effort to be present at all meetings, and otherwise as the Chair of the Group deems necessary, consistent with the UHB's annual plan of Board Business.

Withdrawal of individuals in attendance

The Group may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.

Probity

All interest must be declared so that the Group can inform and facilitate better decision and making and good governance in the purchase of US equipment.

RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

The Group, through its Chair and members, shall work closely with the other sub groups as appropriate, including joint (sub) committees, the Medical Equipment Group and the Decontamination Group to provide advice and assurance to the Quality, Safety and Experience Committee through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

The Group shall embed the UHB's corporate standards, priorities and requirements through the conduct of its business.

REPORTING AND ASSURANCE ARRANGEMENTS

The Group Chair shall:

- Bring to the attention of the Executive Director of Therapies and Health Science directly or via the Medical Equipment Group any significant matters under consideration by the Group;
- Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may

compromise patient care and affect the operation and/or reputation of the UHB,

- Escalate particular issues to the Quality Safety and Patient Experience sub committees where deemed appropriate.

- Access senior advice on procurement, finance, decontamination and IP&C where necessary and as required.

- Review the Terms of Reference annually to ensure collective responsibilities can be assured/ discharged.

- Routinely provide minutes of the USCGG to the MEG.

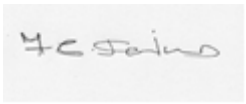
APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

Not applicable.

REVIEW

These terms of reference and operating arrangements shall be reviewed annually, or as required, by the Group.

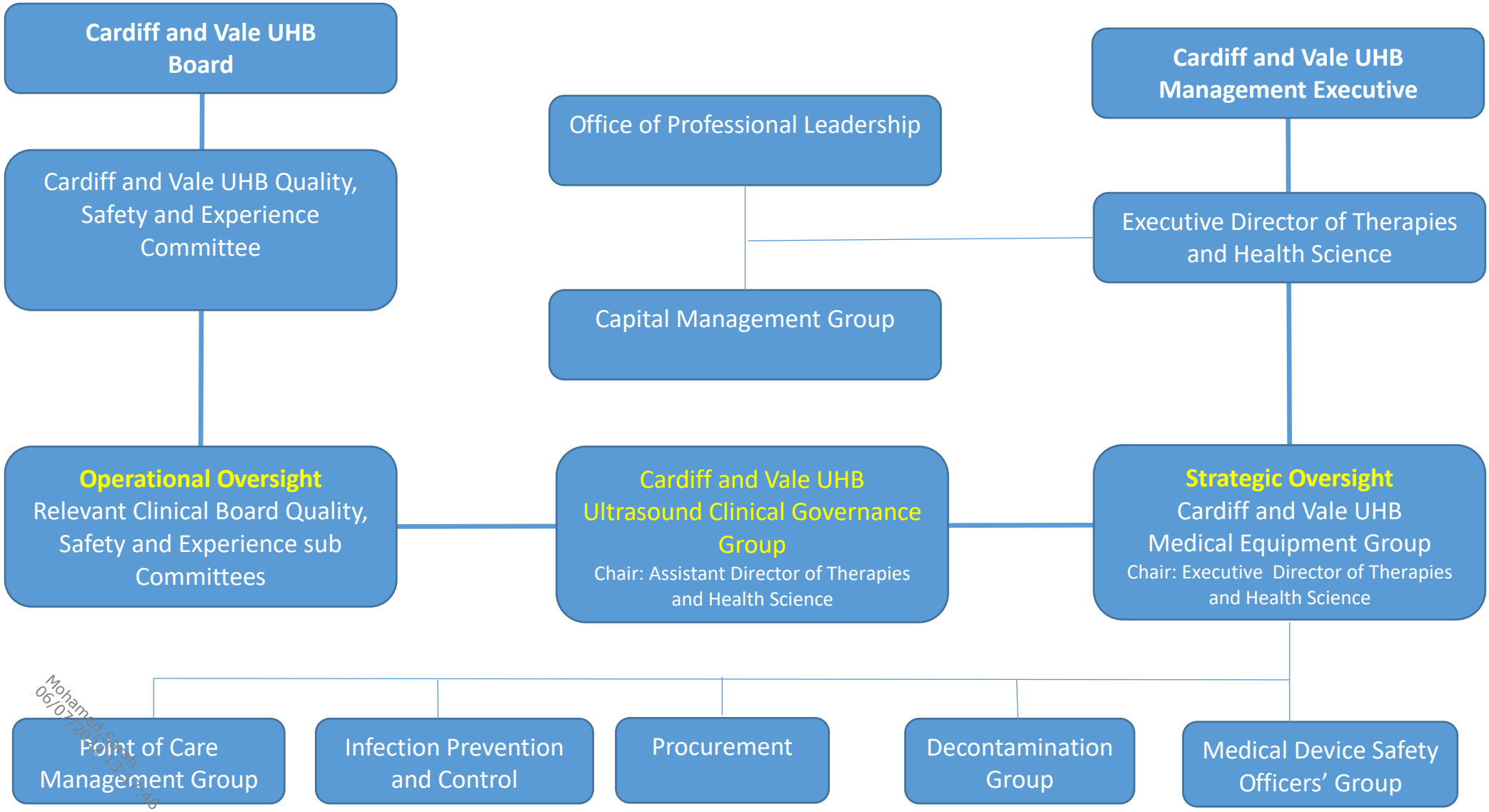
Agreed:



Singed:
Name: Fiona Jenkins
Position: Executive Director of Therapies and Health Science
Date: 25/01/2021

Proposed date for review: **Dec 2022**

1 Appendix 1: Governance and Reporting Framework



Ultrasound Governance

(Clinical Diagnostics and Therapeutics Clinical Board)

Final Internal Audit Report

August 2021

Cardiff and Vale University Health Board

NWSSP Audit and Assurance

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

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Auditors:	Stuart Bodman, Principal Auditor Wendy Wright, Deputy Head of Internal Audit
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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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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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 ultrasound governance, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

Overview

This report provides limited assurance for Ultrasound Governance arrangements, which stems from issues relating to the design and implementation of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2).

Governance arrangements were found to be lacking and require review to effectively direct and oversee the implementation of the requirements prescribed by the revised policy and procedure.

Two high priority recommendations are proposed, which fall under the scope of objectives one and two.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	-

Assurance summary[1]

Assurance objectives		Assurance
1	Design and implementation of ultrasound governance arrangements	Limited
2	Roles and responsibilities	Limited
3	Servicing, maintenance, repair and quality assurance	Substantial
4	Procurement of diagnostic and therapeutic ultrasound equipment	Substantial
5	Ultrasound training	Reasonable

Matters Arising

		Control Design or Operation	Recommendation Priority
1	Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2)	Operation	High
2	Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science	Operation	Medium
3	Design and feedback of the Medical Ultrasound Risk Management Procedure	Design	Medium
4	Ultrasound governance arrangements require review	Operation	High
5	Roles and responsibilities outlined by procedure require formalisation	Operation	Medium

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

1. Introduction

The review of Ultrasound Governance was deferred in 2020/21 and carried forward to the 2021/22 Internal Audit Plan. The Clinical Diagnostics and Therapeutics Clinical Board proposed the review for inclusion in the plan.

The Health Board's Medical Ultrasound Risk Management Policy (UHB 322 v.2) was updated in 2020 and approved by the Quality, Safety and Experience Committee. The policy notes, "Cardiff and Vale UHB is committed to providing uniform, high quality diagnostic and therapeutic ultrasound services which consistently meet as a minimum all national evidence-based standards".

The lead executives for the review are Steve Curry, Chief Operating Officer and Dr Fiona Jenkins, Executive Director of Therapies and Health Science.

Audit Risks

The potential risks considered in this review are 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;
- Inadequate monitoring of performance and scrutiny of outcomes.

The following policy commitment will be outside of the scope of this audit, *"Provide a robust framework for the documentation of ultrasound referrals, examinations and procedures, and the secure storage of images, to ensure data is recorded accurately and consistently, and stored safely across the UHB".* (To be considered as a discrete audit for future audit plans).

2. Detailed Audit Findings

Objective 1: The design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.

Medical Ultrasound Risk Management Policy & Procedure (UHB 322 v2)

- The Quality, Safety and Experience Committee approved the revised Policy and Procedure on 20 July 2020. The accountable executive is the Executive Director of Therapies and Health Science.
- Both documents are available on the UHB's intranet site.

The following matters arising were noted:

- Audit testing identified that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure, which was published in February 2021. *(Matters Arising 1 – High Priority)*
- Further consideration is required of how Clinical Boards are to provide assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policy and procedure. *(Matters Arising 2 – Medium Priority)*

- Feedback during the audit highlighted the comprehensive nature of the procedure but an abridged version would be welcomed. Also, the naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance. *(Matters Arising 3 – Medium Priority)*

Medical Ultrasound Governance Arrangements

- There is an Ultrasound Clinical Governance Group (UCGG) in place.
- The acting Chair of the UCGG has had opportunity to raise concerns through the Medical Equipment Group and Quality Safety and Experience sub-committee in 2019.

The following matters arising were noted:

- The Ultrasound Clinical Governance Group Terms of Reference is out of date (2015) and has not been reviewed in tandem with the revised Medical Ultrasound Risk Management Policy and Procedure.
- Whilst the outdated terms of reference suggests a formal means of escalation beyond the group, we were unable to evidence routine or embedded reporting arrangements.
- The current chairing arrangements of the UCGG meetings falls short of the terms of reference, with reduced authority in the UHB, which has impacted the ability of the group to guide and direct matters of ultrasound governance.
- Poor attendance of the UCGG has been an issue, which was highlighted by the sampled audit areas and the acting chair of the UCGG.

  (Matters Arising 4 – High Priority)

Conclusion: To support the implementation of the updated Medical Ultrasound Risk Management Policy and Procedure the governance arrangements require review to provide sound oversight and direction. (Limited Assurance)

Objective 2: Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services.

- The revised policy and procedure requires three key ultrasound governance roles to be allocated within Clinical Boards; Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor.
- Whilst these roles may have been nominally allocated, we were unable to formally evidence the allocation of these roles within Obstetrics & Gynaecology, Cardiology Directorates, and the Medical Physics Doppler Ultrasound Service. *(Matters Arising 5 – Medium Priority)*

Conclusion: The three key roles in the management of diagnostic and therapeutic ultrasound services require formal adoption by Clinical Boards. (Limited Assurance)

Objective 3: Servicing, maintenance, repair and quality assurance of diagnostic and therapeutic ultrasound equipment, in addition to decommissioning.

- For the sampled audit areas, all ultrasound equipment in use within the Obstetrics & Gynaecology, Cardiology Directorates, and Medical Physics Doppler Ultrasound Service are covered by formal UHB-wide contractual managed service agreements.
- Regular meetings are held between managed service agreement providers and key ultrasound user representatives within the UHB. Reports are provided that cover asset support given, a report of current equipment in place, issues/faults/repairs reported, and action and training provided to users in the period.
- All three areas held records of regular servicing and maintenance of their ultrasound equipment and that of call-outs for issues/faults/repairs.
- Daily quality assurance safety checks are performed by the clinical and medical users on ultrasound equipment within the Directorates as a matter of course before the equipment is put into use.

Conclusion: There are no matters arising in respect of this Objective. (Substantial Assurance)

Objective 4: Procurement of diagnostic and therapeutic ultrasound equipment.

- Purchases of new ultrasound equipment made by the Cardiology Directorate were done so in compliance with the requirements of the Medical Equipment Management Procedure prior to the publication of the revised Medical Ultrasound Risk Management Procedure.
- There are no items of ultrasound equipment on loan, trial or hire within any of the three areas at the time of the audit as confirmed by the respective Directorate Managers and the Lead Clinical Scientist of the Non-Ionising Radiation Team.

NB: We were advised that there have been no purchases of ultrasound equipment in any of the tested areas since the publication of the Ultrasound Risk Management Procedure in February 2021.

Conclusion: There are no matters arising in respect of this Objective. (Substantial Assurance)

Objective 5: Training and competence for the use of diagnostic and therapeutic ultrasound.

In accordance with Section 4 of the Medical Ultrasound Risk Management Procedure, all clinical and medical staff working with ultrasound equipment within the Obstetrics & Gynaecology, Cardiology Directorates, and the Medical Physics Doppler Ultrasound Service held evidence of:

- Up to date records of statutory registration status in respect of their professional bodies/institutions.
- Up to date records of all ultrasound users' relevant qualifications and the awarding institution.

Beyond the above training requirements of the Procedure which were satisfied, section 4.1, Ultrasound Equipment Training, is nuanced to the training requirements of specific equipment, and section 4.2, Ultrasound Safety Training, to general requirements of safe management of medical ultrasound equipment. Our testing did not extend to requirements 4.1 and 4.2 given

the lack of awareness of the procedure. In accordance with 'Matters Arising 2' of this report, further consideration is required of how Clinical Boards are to provide assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policy and procedure.

The Non-Ionising Radiation Team have acknowledged that for greater oversight of ultrasound safety training an e-learning module is currently in development, with the intention of linking to ESR, which will provide a means of monitoring compliance and fulfilment of section 4.2 of the procedure.

Conclusion: Whilst no recommendations are made under this objective, the fulfilment of recommendation two of this report will provide greater assurance to the Executive Director of Therapies and Health Science on the requirements of 4.1 and 4.2 of the procedure. In addition to the introduction of an e-learning tool to provide greater oversight of general ultrasound safety training across the UHB. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) (Control Operation)	**Impact**
It was evident through audit testing that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2), although both were available on the UHB intranet site. For the sampled areas, none of the directorate management, clinical or medical ultrasound users in Obstetrics & Gynaecology and Cardiology Directorates were aware of the existence of the finalised policy and procedure. The Ultrasound Clinical Governance Group in July 2020 reviewed draft iterations of the policy and procedure, and both directorates had representatives who attended. Once the policy and procedure had been formally ratified by the UHB Quality, Safety and Experience Committee in July 2020, there was no evidence of communication to all UHB Directorate Managers or the membership body of the Ultrasound Clinical Governance Group.	Potential risk of there being no effective clinical ultrasound governance framework in place.
Recommendation 1	**Priority**
The Executive Director of Therapies and Health Science should be provided with assurance that the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) has been adequately communicated within the Health Board.	**High**

Agreed Management Action	**Target Date**	**Responsible Officer**
The Policy and Procedure will be promoted through the Medical Equipment Group, Medical Device Safety Officer's group, Clinical Board operational teams as well as through the Clinical Executive's Office of Professional Leadership.	October 2021	Assistant Director of Therapies and Health Science

Matter Arising 2: Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science (Control Operation)		**Impact**
The Medical Ultrasound Risk Management Procedure provides direction to Clinical Boards regards required assurance to the Executive Director of Therapies and Health Science, which notes, *"The Clinical Board Heads of Operations and Delivery are responsible for:* *Providing assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policies and procedures."* Given the further findings within this report relating to ultrasound governance (finding 4), it is unclear how the required assurance is determined and how it is communicated.		Potential risk of there being no effective clinical ultrasound governance framework in place.
Recommendation 2		**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**
Agreed Management Action	**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.	March 2022	Assistant Director of Therapies and Health Science
Opportunities to develop a digital audit tool will be explored with corporate IM&T teams.	March 2022	Assistant Director of Therapies and Health Science

Mohamed.Sarah 06/07/2022 13:17:46

Matter Arising 3: Design and feedback of the Ultrasound Risk Management Procedure (Control Design)	**Impact**
The audit provided opportunity to disseminate the procedure and obtain feedback from those that engaged with the audit. The following observations were noted: • Whilst the procedure is comprehensive, it is a lengthy document (23 pages of text) which covers an extensive depth of content to read and retain. • An abridged version of the procedure would be welcomed, capturing key themes and requirements, summarised into two or three pages, underpinned by the full procedure for clarification when required. • The naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance.	Potential risk of the design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.
Recommendation 3	**Priority**
Following feedback through the course of the review, consideration should be given to: • Producing an abridged version of the Medical Ultrasound Risk Management Procedure, summarising key themes, to underpin the full procedure; and • The renaming of the procedure to reflect the actual content of Ultrasound Governance and to align with the role of the Ultrasound Clinical Governance Group.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
Provide an abridged version of the procedure, about 2 or 3 pages. Rename the policy and procedures to reflect more closely what they contain. Mohamed.Sarah 06/07/2022 13:17:46	26th August 2021	Paul Williams, Principal Clinical Scientist

Matter Arising 4: Ultrasound governance arrangements require review (Control Operation)	**Impact**
The following observations were noted regarding the ultrasound governance arrangements and were prevalent pre-COVID: • There is an Ultrasound Clinical Governance Group (UCGG) in place, with a formal terms of reference, dated April 2015. • The UCGG terms of reference has not been reviewed in tandem with the revised policy and procedure (published 17 February 2021). • The terms of reference for the UCGG notes the following roles: Chair, Deputy Chief Operating Officer, and Vice Chair, Assistant Director of Therapies and Health Science. The auditor was advised that neither positions have chaired the group since 2018. Acting chairpersons have been assigned but hold reduced authority in the UHB. • The auditor was advised by the sampled areas that attendance at the UCGG has been poor. There were no records of attendance held, and thus quorate arrangements were uncertain. Due to the lack of documentation, we were unable to validate the strength of the UCGG. • The terms of reference for the UCGG refers to 'relationships and accountabilities with the Board and its committees/groups', specifically referencing the Medical Equipment Group (MEG) and the Decontamination Group. Minutes of the MEG and Quality Safety and Experience sub-committee (Clinical Diagnostics and Therapeutics Clinical Board) did evidence the raising of ultrasound clinical governance concerns in 2019 by the acting Chair. • There is no evidence of routine reporting to and from the UCGG. • The auditor was advised that the acting Chair and Vice Chair of the UCGG do attend the Quality, Safety and Experience Committee, with opportunity to raise concerns, as outlined within the UCGG terms of reference, but it was unclear if there are any embedded reporting arrangements of a more formal nature.	Potential risk of no effective clinical ultrasound governance framework.

Recommendation 4		Priority
Ultrasound governance arrangements should be reviewed as follows: • The placing of the Ultrasound Clinical Governance Group (UCGG) within the Health Board's governance structures. • The appointment of appropriate person(s) to Chair the UCGG meetings with sufficient seniority to escalate issues as they arise. • The reporting mechanisms to facilitate the escalation and cascade of ultrasound governance. • Membership of the UCGG should be sourced from all ultrasound using Directorates. • Actions and attendance (including quorum) are recorded for the meetings. On completion of review, the governance arrangements should be revised and formalised through an updated Terms of Reference.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
The UCGG ToR will be formally reviewed to ensure that it has appropriate governance arrangements. The UCGG will formally report through the Medical Equipment Group (MEG) which is chaired by the Executive Director of Therapies and Health Science. The MEG will receive minutes and a written report. The TORs for UCGG and MEG will be amended accordingly.	October 2021	UCGG / Assistant Director of Therapies and Health Science
The membership of the UCGG will be signed off by the Executive Director of Therapies and Health Science. Communication on expected attendance from clinical areas at the UCGG will be disseminated through the operational Clinical Board structures and the Office of Professional Leadership.	November 2021	Assistant Director of Therapies and Health Science

Matter Arising 5: Roles and responsibilities outlined by procedure require formalisation (Control Operation)		**Impact**
So as to appropriately focus, organise and stratify areas of ultrasound governance at Directorate / Departmental level, the UHB Ultrasound Risk Management Procedure has adopted three key roles based upon areas of expertise that allow this to be undertaken effectively; these are, Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor. Since the publication of the revised procedure, we were unable to evidence the formal adoption of the roles outlined within the procedure, for the three sampled areas. It is noted that within the Obstetrics & Gynaecology Directorate, and the Medical Physics Doppler Ultrasound Service that these roles had been identified, but not formalised.		Potential risk of poor training and competence for the use of diagnostic and therapeutic ultrasound.
Recommendation 5		**Priority**
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.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics.	Complete	
The O&G Directorate is setting up a quarterly formal ultrasound governance meeting, the first of which is starting in September. Within this we will be formalising roles and working through each aspect of the policy inc: roles and responsibilities and communication plan around this.	30th September 2021	Mark Denbow, Directorate Ultrasound Governance Lead

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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Report Title:	Declarations of Interest, Gifts and Hospitality Tracking Report			Agenda Item no.	7.6
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.

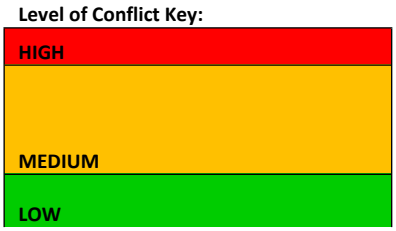
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The following Declarations have been received and included on the register which covers the period 01 Apr 20 to 24 June 2022:

- 1,672 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms have been recorded on the register. This represents a 11.2% increase in submissions following the April 2022 Committee Meeting.

- 77.5% 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:



High Conflict which needs managing

Potential Conflict - Line Manager should be made aware and expectation that declaration is updated should conflict arise

No cause for concern

- 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).

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 me managed so as to avoid conflict arising.

A register of all interests can be found at the following link (which will need to be copied and pasted into a web browser 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'; there has been an above average increase in the quantity of declarations made, as well as increased use of ESR rather than the more administratively heavy use of hardcopy forms and email returns.

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

Recommendation:

The Committee are requested to:

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

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

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

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

Prevention		Long term		Integration		Collaboration	x	Involvement	x

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

Risk: Yes

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 declrations is updated should conflict arise
No cause for concern

Level of Conflict	First Name	Surname	Position held in UHB	Directorate / Speciality	Band	Clinical Board / Corporate Dept	Date Form Returned		Interests to Declare (Yes/No)	Third Party Organisation / Spouse/Partner (Yes/No)	Unit Address:	Unit Tel No:	Confirmed read & understood Standards of Behaviour Statements Policy	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	Start - End Date	Financial / Other Benefits	b) Ownership or partnership of private 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 that could be perceived as having an influence on a 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, charitable or other organisation which could create a potential opportunity for conflicting interests	Start - End Date	Financial / Other Benefits	g) Employment/self-employment by any other employer, business or consultancy which may be in conflict with NHS duties. This includes the undertaking of private practice	Start - End Date	Financial / Other Benefits	h) Undertake to notify the UHB of any changes which may occur within four weeks from the date of the change, in writing to the Corporate Risk and Governance Office. Please return completed forms to risk.declarations@wales.nhs.uk	i) I confirm that the information accurately reflects my interests and those of my family and understand that relevant information will be included in the Register which is available for public inspection	Signed	Date	Document Saved in Corporate Governance Mail Our Office Use Only	EscalationOther details:
Low	Elijah	Akinnu	Consultant Transplant and General Surgeon	Nephrology and Transplant	Consultant	Specialist Services	09.01.20	Yes		Yes	UHW	8047	Yes																															
														Medigold Ltd, 6-8 Senior Care Ltd Spuson Medigo Ltd, 6-8 Senior Care Ltd				Medi-gel 2015/2312, 6-8 Sc Care Ltd Medi-gel, 2015/2312, 6-8 Sc Ltd 22/1/2016			6-8 Senior Care Ltd 6-8 Senior Care Ltd																							
Low	Paola	Adams	Principal Pharmacist	Pharmacy	Bi	CD&T	18.01.20	Yes		No	UHW	83490	Not Ticked		N/A		N/A		N/A		Attended two meetings at a specialist Pharmacist in a 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		Panle;ipated in a podcast for Cardiff University	13.11.20 - 13.11.20	Payment received		Yes		Yes	Paola Adams	18.01.20	Yes	Secondary Work Form sent 05.12.20
Low	Charlotte	Addy	Consultant	Cystic Fibrosis Unit	Consultant	Medicine	11.03.22	Yes		No	UHW		Yes	N/A		N/A		N/A		N/A		N/A		Support for educational lectures/studies from GlaxoChem	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		£185	11.03.22	£185	
Low	Sanjeev	Agarwal	Consultant Orthopaedic Surgeon	Orthopaedics	Consultant	Surgery	07.01.21	Yes		No	UHL		Not Ticked	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	07.01.21	Yes	Sponsorship form sent 11.02.21
Low	Vaishri	Ahuja	Consultant	Trauma and Orthopaedics	Consultant	Surgery	22.09.21	Yes		No	UHW		Yes	No		N/A		N/A		N/A		No	Jul-21 - Ongoing	None	Fellowship posts funded by Depuy Synthes, Trauma and Globus Medical LTD.	No		N/A		N/A		No		N/A		N/A		N/A		N/A	22.09.21	Yes	Vaishri Ahuja	22.09.21	£185	
Low	Emma	Aldridge	Clinical Psychologist / Clinical Lead of the Integrated Autism Service	Psychology and Psychological Therapies / Autism	Bi	Mental Health	12.11.20	Yes		No	Ken House	2023834240	Yes	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. This includes medico-legal assessments and court reports. I do not assess anyone for autism in CAV UHB in a private capacity	2012 - current	Financial		Yes		Yes	Esma Eldridge	12.11.20	Yes	Secondary Work Form sent 30.11.20 Updated secondary work form received 25.01.21
Low	Kathryn	Allen	Community Pharmacy Advisor	Pharmacy	Bi	PCIC	15.11.20	Yes	No	No	Woodland House	36156	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	Policy and planning manager Company Chemists' Ltd/Boots Ltd	2016 - to date	Yes salaried 7.5 hours per week		Yes		Yes	Kathryn Allen	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Louise	Allen	Pharmacist	Primary Care Prescribing Advisors	Bi	PCIC	17.11.21	Yes	No	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		Louise Allen	17.11.21	£185	
Low	Callum Charles	Allen-Ridge	Senior Manager	Innovation and Improvements Team	Bi	Corporate	17.05.22	Yes	No	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	2020-Ongoing	Financial		Yes		Yes	£185	17.05.22	£185	
Low	Shehraz	Al Hayouti	Podiatrist	Podiatry	S	Specialist Services	10.11.21	Yes	No	No	UHL		Yes	No		N/A		No		No		No		No		No		No		No		No		No		No		Shehraz Al Hayouti	10.11.21	Yes	
Low	Saaeed	Anand	Consultant	Haemophilia	Consultant	Specialist Services	10.03.22	Yes	No	No	UHL		Yes	N/A		N/A		N/A		N/A		Astra Zeneca supervised research in UHW - performing tests out of hospital hours. If patients approach.	2022	Discussion with Senior Management 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		£185	10.03.22	£185	
Low	Richard	Anderson	Consultant Cardiologist	Cardiothoracic	Consultant	Specialist Services	25.05.21	Yes	No	UHW		42788	Yes	Shareholder of Richard Anthony Anderson Ltd	1.06.15 - ongoing		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Richard Anderson	25.01.21	Yes	
Low	Angela	Ardenkjaer	Consultant Transplant Surgeon	Nephrology and Transplant	Consultant	Specialist Services	25.01.21	Yes	No	No	UHW		Yes	N/A		N/A		Small number of shares in Pfizer	1.10.19 - ongoing	£500 (shares in part of portfolio	Consultant	01/10/2012 - 31.10.2015	Funding for an MD research project	01/10/2012 - 31.10.2015	Cardiff Fractures, Novartis	Ortho-geriatrics and MD research	01/10/2012 - 31.10.2015	Funding for an MD research project	01/10/2012 - 31.10.2015	Cardiff Fractures, Novartis	Ortho-geriatrics and MD research	01/10/2012 - 31.10.2015	Kidney Wales Trustee	2012-2017 - ongoing	Board of Trustees and its HR	N/A		N/A		N/A		N/A		N/A		N/A		Angela Ardenkjaer	25.01.21	Yes	
Low	Basil	Ashkenu	Consultant	Anaesthetics	Consultant	Surgery	24.03.22	Yes	No	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		Private Practice at Spire Hospital Cardiff		Fees per session		Yes		Yes	£185	24.03.22	£185	
Low	Philip	Atkin	Consultant in Oral Medicine	Dental	Consultant	Surgery	20.03.22	Yes	No	No	UHW	82464	Yes																																				
														C. Wynnhill Ltd (orthodontics & (aesthetic medicine) I. Nafsinn Medical Aesthetics Ltd (aesthetic medicine) S. Spooner				2014 - current 2020 - current																														
Low	Kim	Atkinson	Strategic Lead Occupational Therapist	Therapies & Occupational Therapy		CD&T	12/03/2020	Yes	No	No	UHL		Not 20990	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Kim Atkinson	12/03/2020	Yes	
Low	Lee	Atkins	Lead Quality and Safety	CD&T	Bi	CD&T	28.03.22	No	No	No	Woodland House		Yes	Director of dormant maintained 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		£185	28.03.22	£185	
Low	Sarah	Bailey	Senior Specialist Speech & Language Therapist	Neuropsychiatry Service	Ti	Mental Health	17.11.20	Yes	No	No	Ely Valley Road	20453	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		Sarah-Louise Bailey	17.11.20	Yes	Secondary Work Form sent 20.11.20
Low	Philip	Ball	Mental Health Nurse	CAMT	Bi	Mental Health	17.02.21	Yes	No	No			Yes	No		N/A		No		No		I have accepted an offer to join an All Wales Scrum for mental health nurses sponsored by Janssen. The Forum is a group of nurses from all health boards in Wales. It is useful for myself and other senior nurses to network and share our practice. There is one gastronomic introduction for the 26th April 2021. But all other work is virtual.	Feb 21 - Ongoing	Yes	Yes		N/A	Nil	No		N/A	Nil	No		N/A	Nil	No		N/A	Nil	No		N/A		N/A		N/A		N/A		Philip Ball	17.02.21	
Low	Timothy	Banner	Pharmacist	Pharmacy Unit,	Bi	CD&T	09.03.20	Yes	Yes	Yes	UHL		Yes	No		N/A		No		No		No		No		No		No		No		No		No		No		Timothy Banner	09.03.20	£185	
Low	Miranda	Barber	Consultant Clinical Psychologist	MHSOP	Bi	Mental Health	13.01.21	Yes	No	No	UHL		Yes	I am the Director of a UK company which has not traded for 18 months		N/A		2021 - current	None		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Miranda Barber	13.01.21	Yes	
Low	Robert	Bevan	Principal Clinical Engineer / Design & Manufacture Team Leader / Health and Safety Advisor	Artificial Limb and Appliance Service		Specialist Services	21.04.22	Yes	No	No	Cathedral	01443 841799	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		Robert Bevan	21.04.22	Yes	
Low	Gary	Baxter	Independent Member of the Board	Executive / Corporate	Executive	Executive	10.03.21	Yes		No	Woodland House		Yes	N/A		N/A		N/A		N/A		Member, Governance Board ACCLEARATE (Life Sciences Hub)	2019 - ongoing		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Cardiff University	2007 – ongoing	Salary		Yes		Yes	Gary Baxter	15.03.21	Yes	
Low	Andrew	Beamish	ST3 General Surgery	General Surgery	ST3	Surgery	10.11.20	Yes	No	No	UHW		Yes	Director and Trustee of Limited Company 'HUT Events'	2014 - ongoing	Nil (Voluntary)	N/A		N/A		N/A		Director and Trustee ofAssociate of Surgeons in Training - Currently applying for its' Limited company 'HUT Events' to become a charitable company.	2014 - ongoing	Nil (voluntary)	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Andrew Beamish	19.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Melissa	Beard	High Intensity Psychological Practitioner	Psychology & Psychological Therapies		Mental Health	15.01.21	Yes	No	No	Cardiff Royal Infirmary	0163 21542	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		Melissa Beard	8.04.21	Yes	
Low	Robert (Bryan)	Beattie	Consultant Obs & Gynae	Fetal Medicine	Consultant	Children and Women	08.01.21	Yes	No	No	UHW		Yes	Founding Director of Inverinsol Secrets Ltd trading as Inverinsol Healthcare	10+ years - current	Financial	N/A		N/A		N/A		N/A		N/A		N/A		N/A		Founding Chairman of Inverinsol Learning Registered Charity				N/A		N/A		N/A		Robert Beattie	08.01.21	Yes	Secondary Work sent 20.02.21
Low	Cerrie	Bennett	Director of Public Health	Corporate Executives	E	Corporate Executives	01.03.22	Yes	No	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		Cerrie Bennett	01.03.22	£185	10.03.22
Low	Claire	Beynon	Deputy Director of Public Health	Corporate Executives	E	Corporate Executives	09.05.22	Yes	No	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	2016-Ongoing	Payment for teaching duties		Yes		Yes	Claire Beynon	09.05.22	Yes	
Low	Powlesion	Bhal	Consultant Gynaecologist	Cynaecology	Consultant	Children and Women	09.01.21	Yes	No	No	UHW		Yes	NHA 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		Powlesion Bhal	09.01.21	Yes	
Low	Viswapanamale	Biju	Consultant	Elderly Care Medicine	Consultant	Medicine	12.11.20	Yes	No	No	UHW		Not Ticked	Medical training centres - private work from participants of MRCP, attending on - leave		£ 3.5k 17 - ongoing				N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Viswapanamale Biju	12.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Robert	Bleehen	Medical Consultant	Consultant Radiologist	Consultant	CD&T	17.11.20	Yes	Yes	Yes	UHL		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		Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)				Yes		Yes	Robert Bleehen	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Charlotte	Blodworth	Advanced Nurse Practitioner	Haematology	Bi	Specialist Services	28.03.22	Yes	Yes	UHW			Yes	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		N/A		£185	28.03.22	£185	
Low	Mike	Bourne	Consultant Radiologist	Radiology	Consultant	CD&T	3.03.21	Yes	No	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		Mike Bourne	3.03.21	Yes	Secondary form sent 12.02.21
Low	Ann	Bowen	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	16.12.20	Yes	No	No	UHL		Awaiti	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Chairman of MLOGANYA Wales, an immediate family member of Sarah Bowen				N/A		N/A		N/A		Ann Bowen	16.12.20	Yes	Secondary form sent 30.03.21
Low	Matthew	Boyd-Anderson	Physiotherapy Technical Instructor	Therapies		CD&T	19.01.2020	Yes	No	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		Matthew Boyd-Anderson	19/01/2020	Yes (Paper and Scanned)	
Low	Paul	Brazenghe	Senior Projects & Deputy Directorate Manager	Ophthalmology	Bi	Surgery	9.12.20	Yes	No	No	UHW		Yes	Active Director at Tre-Gob Court Management Ltd, Residents House Reference Number 3883560			N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Paul Brazenghe	9.12.20	Yes	
Low	Karen	Bruinsma	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	04.01.21	Yes	No	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		Karen Bruinsma	04.01.21	Yes	
Low	Andrea	Bryan	Independent Member of the Board	Executive / Corporate		Executive / Corporate	29.01.21	No	No	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		Andrea Bryan	29.01.21	Yes	
Low	Robert	Bryden	Consultant Physician	Specialist Medicine	Consultant	Medicine	25.11.20	Yes	No	No	UHW	74128	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		Robert Bryden	25.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Jeremy	Bryer	Consultant Urologist	Urology	Consultant	Surgery	29.01.21	Yes	No	No	UHW	85135	Yes	Director of Urology Solutions Cardiff Ltd Spouse - Director of Urology Solutions Cardiff Ltd		01.12.18 - current 01.12.18 - current		Dividends ad hoc 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		Jeremy Bryer	29.01.21	Yes	
Low	Andy	Davies	Clinical Psychologist	Neuropsychiatry Service	Bi	Mental Health	04.03.22			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		Andy Davies	07.03.22	£185	
Low	Gareth	Davies	Clinical Scientist	Biotype	Bi	CD&T	10.03.22	Yes	No	No	UHW		Yes	Company Director of Pentaine Property - dormant for 4 years	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		Gareth Davies	10.03.22	£185	
Low	Huw	Davies	Consultant Paediatric Gastroenterologist	Child Health		Children & Women	20/03/2020	Yes	Yes	Yes	UHW	029 2074 6784	Not Ticked	N/A		N/A		N/A		N/A		Wife has done consultancy work for which she has been paid within he last 7 years with Janssen, Takeda and Jazz		Yes		N/A		N/A		Chair of MCA NGI (2019), Retired CHM of the EGPGANN Endoscopy Working Group and member of LAG (2012-2018). Have been a NICE expert witness for technology appraisals. Chair of the Midcare programme twice each year. Health Advisory Council of Coeliac UK since spring 2020 and Chair of the Research Group at Coeliac Disease since spring of 2020.	2019	N/A	Value money for and contribute to events (as a speaker) held by CICHA and Crohn's and Colitis UK, am part of IBD Wales.	N/A	N/A	N/A		N/A		N/A		N/A		N/A		N/A		Huw Davies	29/03/2020	Yes	
Low	Robyn	Davies	Head of Innovation	Improvement and Implementation	Bi	Corporate	09.01.20	Yes	No	No	Woodland House	7813636358	Not Ticked	Chairman - Cultureate Ltd	1.09.17	None	Chairman - Cultureate Ltd (existing UHB customer)	1.09.17	None	N/A		N/A		N/A		N/A		N/A		N/A		Visiting Professor - University of South Wales; Hon Innovation Fellow - Cardiff University	1.07.20 - 1.07.23 16.11.20 - 1.01.25	None	N/A		N/A		N/A		N/A		Robyn Davies	17.11.20	Yes	
Low	Fred	Davis	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes	No	No	St David's Hospital	2920536353	Yes	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Scientific Advisor to The Lullaby Trust				Private clinic at Cynllwyd Consulting Rooms; Medical Examiner in relation to child safeguarding cases (Caerphilly Council)				Yes		Yes	Fred Davis	12.11.20	Yes	
Low	Megan	Davis	Psychologist & Psychological Therapist.	Mental Health			08.03.22	Yes	No	No	Llwis Clwtf, CRI	02920 336036	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		Megan Davis	08.03.22	Yes	
Low	Clive	Della	Psychiatrist/ Consultant in Metabolic Medicine	Haematology/ Immunology / Metabolic Medicine	Consultant	Specialist Services	25.11.20	Yes	No	No	UHL	36844	Yes	N/A		N/A		N/A		N/A		Honoria received for expert advice and speaker fees from: Amgen, Sanofi, Actelion, Alnylyl, Kyowa Kirin, Novartis	2011 - ongoing	Financial	N/A		N/A		N/A		N/A		N/A		N/A		N/A		Trustee, HEART UK	2018	None	N/A		N/A		N/A		N/A		Clive Dalla	26.11.20	Yes	Secondary Work Form sent 3.12.20
Low	Lee	Davenne	Public Health Dietitian	Nutrition and Dietetics		Community Dietetics	10.09.20	Yes			UHW	2920507048	Yes	N/A		N/A		N/A		N/A		I have done work advising Queen Mooki around diet for monetary payment. I have also worked with the WDA in cooperation with dairy providing dietetic advice for monetary payment for E-learning.	16th October 2019 and 02/6/20	Low-off payment	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Black		Lee Davenne	10.09.20	Yes	
Low	Catherine	Davies	Director of Health and Social Services / Chief Executive	Health and Social Services	Ii	Health and Social Services	12.11.20	Yes	No	No	Strategic Planning	07493 613475	Yes	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Trustee for Llamau (Homelessness Charity)	Jan 20 - ongoing	Nil	No		N/A		N/A		No		N/A		N/A		Cath Gwinnon	12.11.20	Yes	
Low	Gemma	Davies	Consultant in Dental and Maxillofacial	Dental	Consultant	Surgery	12.10.20	Yes	No	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		Gemma Davies	12.10.20	Yes	Secondary Work Form sent 21.11.20
Low	Mark	Dayton-Smith	Consultant Cardiologist	Cardiovascular and Medicine	Consultant	Specialist Services	29.01.21	Yes	No	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		Mark Dayton-Smith	29.01.21	Yes	Sponsorship form sent 10.02.21
Low	Aimee	Dickens	Consultant Medicine	Specialised Medicine	Consultant	Medicine	3.02.21	Yes	Yes	Yes	UHL		Yes																																				
														Of: service has previously received educational grant	2015		Shave holder in Time for Medicine company Wife is GP partner at Brynderwen and Minster Surgery	Ongoing Ongoing																														
Low	Martin	Edwards	Consultant Paediatrician	Paediatrics	Consultant	Children & Women	01.04.21	Yes	No	No	UHW	74361	Yes	No		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Joint Academic Clinical Lead				I work 2.5 sessions for HEIW as a deputy director for secondary care.				Yes		Yes	Martin Edwards	31.04.21	Yes	Secondary Employment Form sent 19.10.21
Low	Natalie	Elliott	Special Advanced Practitioner	Mental Health	Bi	Mental Health	13.01.20	Yes	Yes	Yes	Academic Centre Llwis	7811020508	Yes	No		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Spouse: Executive Director of People & Places at Taff Housing	2017-ongoing	Salaried Salary	No		N/A		N/A		N/A		Natalie Elliott	13.01.20	Yes	
Low	Nigel	Emsumbaf	Consultant Haematologist	Haematology	Consultant	Specialist Services	09.01.21	Yes	No	No	UHW		Not Ticked	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		Roche, Abbvie, AstraZeneca		Fees for organising talks and to attend	N/A		N/A		N/A		N/A		N/A		Nigel Emsumbaf	09.01.21	Yes	Sponsorship form sent 21.01.21

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	Susan	Elsmore	Independent Member of the Board	Executive / Corporate	Executive	Executive	24.02.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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	Susan Elsmore	24.02.21	Yes	
Low	George	Erall	Consultant Neurosurgeon	Neuroscience	Consultant	Specialist Services	12.03.22	Yes	No	UHW	46851	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 - ongoing	Fees	Yes	Yes	George Erall	13.11.20	Yes	Secondary Work Form sent 25.11.20
Low	Libby	Erin	Consultant Clinical Psychologist	Child Psychology	8c	Children & Women	13.11.20	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 work privately seeing families where children are struggling with their mental health	2018 - ongoing	N/A	Yes	Yes	Libby Erin	13.11.20	Yes	Secondary Work Form sent 24.11.20
Low	Ioulia	Evangelou	Consultant Cellular Pathology	Cellular Pathology	Consultant	CD&T	29.01.21	Yes	No	UHW	41894	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	2018 - January 2021	Salary	Yes	Yes	Evangelou Ioulia	29.01.21	Yes	Secondary form sent 12.02.21
Low	Caroline	Evans	Consultant Healthcare Scientist	Biochemistry	8d	CD&T	21.04.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsored Research: Applied for funding from Abbott for a QI project for diabetes.	2022 - Ongoing	No personal financial gain	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	ESR	21.04.22	ESR	
Low	Caroline	Evans	Consultant Anaesthetist	Periopertive Care	Consultant	Children and Women	11.03.22	Yes	No	UHW/UHL	43106	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I receive ad hoc honoraria for giving talks on my own published research - these are fully declared on the drug company website	Ongoing	Honoraria	1. Recruitment chair for the RCoA. 2. eL TFT advisor to the RCoA	2022	Unpaid	N/A	N/A	N/A	1. I do occasional private work at Spire Health - none this year but practicing priviledges 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	Caroline Evans	26.01.21	Yes	Secondary and sponsorship form sent 11.02.21
Low	Jon	Featherstone	Consultant	Urology	Consultant	Surgery	03.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice at the Spire Hospital	NK	Fees per session	Yes	Yes	ESR	03.03.22	ESR	
Low	Karen	Fido	Radiographer	Radiology	8a	CD&T	10.03.22	Yes	No	UHW	2920744557	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	Jul 08 - Ongoing	Fees per session	Yes	Yes	Karen Fido	10.03.22	Yes	
Low	Patrick	Fielding	Consultant Radiologist	Radiology	Consultant	CD&T	17.11.20	Yes	No	UHW	46959	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 smyposium	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	Patrick Fielding	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Elaine	Flannery	Counsellor	MHSOP Psychology	5	Mental Health	20.10.21	Yes	No	CRI		Yes	No	N/A	No	No	N/A	Nil	No	N/A	No	No	N/A	No	No	N/A	No	No	N/A	No	2 hours per week as a self employed counsellor.	2021-Ongoing	Yes	Yes	Yes	Elaine Flannery	20.10.21		
Low	Joseph	Flora	Genetic Counsellor	All Wales Medical Genomics Services		AWMGS	7.04.21	Yes	No	Institute of Medical Genetics, UHW	2184 2577	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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	Flora Joseph	7.04.21	Yes	
Low	Nicola	Foreman	Director of Corporate Governance	Corporate / Executive	VSM	Corporate / Executive	02/03/2021	Yes	No	Woodland House	41506	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	Company secretary for Safe Ventures Ltd			N/A	N/A	N/A	Yes	Yes	Nicola Foreman	2.03.21	Yes	
Low	Mark	Forster	Consultant Orthopaedic Surgeon	Trauma & Orthopaedics	Consultant	Surgery	8.02.21	Yes	Yes	UHW		Yes	Cardiff Knee Surgery Ltd (private practice0	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	Yes	Yes	Mark Forster	8.02.21	Yes	Secondary form sent 12.02.21
Low	Aaron	Fowler	Head of Risk and Regulation	Corporate Governance	8b	Corporate Governance	20.09.21	Yes	Yes	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	My wife is employed by NWSSP Legal and Risk, who the health board contact for legal advice.	2019-ongoing	N/A	Yes	Yes	Aaron Fowler	20.09.21	ESR	
Low	Joanna	Fox	Consultant	Anaesthetics	Consultant	Surgery	01.04.22	Yes	Yes	UHW		Yes	Onw own 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	Yes	Yes	ESR	01.04.22	ESR	
Medium	Scott	Gable	Cellular Pathology Service Manager / lead Biomedical Scientist	Cellular Pathology and Mortuary Service, Laboratory Medicine	8b	CD&T	12.11.20	Yes	No	UHW		Yes	Director - Labxcell Ltd	Jul-19	Retainer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Scott Gable	12.11.20	Yes	Secondary Form sent 26.01.21
Low	Malcolm	Gajjraj	Consultant	PICU	Consultant	Children and Women	10.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1. Director of quality management HEIW. 2. GMC Enhanced monitoring associate	2022	Ad hoc payments	Yes	Yes	ESR	10.03.22	ESR	
Low	James	Galea	Consultant Neurosurgeon	Neurosciences	Consultant	Specialist Services	01.03.21	Yes	No	UHW	43762	Yes	Neurosurgery Services Ltd (Not seeking to do business with UHB)	30.11.17 - ongoing	Nil	N/A	N/A	N/A	Clinical Research involving but not funded by pharmaceutical companies 9SOBI 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	Yes	Yes	James Galea	1.03.21	Yes	
Low	Claire	Ganderton	Senior Pharmacist	AWTTC	8b	CD&T	13.11.20	Yes	Yes	UHL	2921 826900	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	Yes	Yes	Claire Ganderton	13.11.20	Yes	Secondary Work Form sent 24.11.20
Low	Simona	Gatto	Consultant in Haematology	Haematology	Consultant	Specialist Services	04.04.22	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	Roche Advisory Board			Yes	Yes	ESR	04.04.22	ESR	
Low	Sarah	Goldsmith	Consultant	Anaesthetics	Consultant	Surgery	03.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I was the project manager for Obs Cymru, 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 meetings. At my request, all payments for this are paid to MSF by the company	2017-2019	Nil	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	ESR	03.03.22	ESR	
Low	Andrew	Goringe	Consultant in Haematology	Haematology Laboratory	Consultant	CD&T	13.11.20	Yes	No	UHW	42033	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 help supervise the haematology laboratory at the Spire hospital in Cardiff including reporting occasional blood films and chairing their Blood Transfusion Committee	June 18 - ongoing		Yes	Yes	Andrew Goringe	13.11.20	Yes	Secondary Work Form sent 25.11.20
Low	Vanessa	Goulding	Podiatrist	Podiatrty	8a	CD&T	04.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honarary lecturer for Cardiff University. External lecturer for Uiversity of South East Norway - commitment for 1 x lecture per annum.		Costs only	Yes	Yes	ESR	04.03.22	ESR	
Low	Sumit	Goyal	Consultant Surgeon	Surgery	Consultant	Surgery	23.12.20	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	Member of Breast Centre Charity	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sumit Goyal	23.12.20	Yes	Secondary form sent 6.1.20
High	Jonathon	Gray	Interim Director of Transformation and Informatics	Executive	9	Executive	8.06.22	Yes	Yes	Woodland House	2921836020	Yes	Previous role as CEO of SWAHSN - a company Limited by guarantee Wife owns private company delivering mindfulness / training resilience training Brother-in-law Director of Ernst Young	0/11/17 - 0/11/19	N/A	I formed a Ltd Company in Dec 21 called 'Graymattrs' jointly with my wife. This is currently the route I am paid for the work by Q5 and Becton Dickinson. I anticipate using the company for any other advisory/consulting should they occur. I work 2 months a year in Singapore?Australia/New Zealand/USA contracted to deliver innovation work. I stop my contract with C&V UHB when I do this work.	2020 - ongoing	Financial	Note links to Singapore Life Sciences Hub. I am a global ambassador for Hillary Institute - non profit leadership group in New Zealand. Visiting Fellow Green Templeton College, Oxford Spouse works for (Mindfulness and Resilience) for Cardiff Met and Education Centre	2016 - present	N/A	N/A	N/A	N/A	1. Trustee of Fathom Trust. 2. Member of Maggies Clinical Board. 3. Fellow at Better Value Healthcare. 4. Visiting Chairs - Wellington (NZ), Exeter, Singapore. 5. Adjunct Professor at the Health Services Research Centre, Faculty of Health at Victoria University of Wellington. 6. Honorary Clinical Professor, University of Exeter Medical School.	01/06/19 - 31/05/2022 01/08/18 - 31/07/21	N/A	Global Ambassador for Hillary Leadership Institute (New Zealand) Health Foundation / IHI Fellow Member Insitute of Directors. Fellow of Better Value Healthcare - Led by Professor Sir Muir Gray (Not a relative) Deputy Lead	2004 2015 2012 2020	Present Present	Employed by Singapore as previous - arranged through C&VUHB but clear arrangement - I stop C&VUHB pay during 2 months Spouse: Maggies Centre and private work as previously mentioned Global Healthcare Advisor for Q5 Associates			Blank	N/A	Jonathon Gray	04/02/2020	Yes (Paper and Scanned)	
Low	Craig	Greenstock	Counterfraud Manager	Finance	8b	Finance	04.06.21	Yes	Yes	Woodland House	02921 836265	Yes	No	N/A	Nil	No	N/A	Nil	Member of Family works for another NHS Body	N/A	Nil	No	N/A	Nil	No	N/A	Nil	I am a Magistrate (Justice of the Peace) and sit on the Mid Wales Adult Criminal, Family and Crown Court Benches.	2020-Ongoing	Nil	No	N/A	N/A	Yes	Yes	Craig Greenstock	04.06.21	ESR	
Low	Sian	Griffin	Consultant Nephrology & Transplantation	Nephrology and Transplant	Consultant	Specialist Services	15.03.22	Yes	No	UHW	48451	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Advisory Board attendance - Roche, Novartis, Retrophin, Astra, Zeneca	17.08.20 - 16.11.20	Honoraria	N/A	N/A	N/A	General Secretary British Transplantation Society	01.03.18 - 01.03.21	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sian Griffin	26.01.21	Yes	Secondary form sent 10.02.21
Low	Helen	Griffiths	Occupational Therapist	Community Resource Team	7	PCIC	14.10.20	Yes	No	Whitchurch Hospital	32501	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Work as occupational therapist for Stroke case management on ad hoc basis	Sept 2016 - ongoing	zero hour contract	Yes	Yes	Helen Griffiths	14.10.20	Yes	Secondary form sent 20.01.21
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.11.20	Yes	Yes	UHW	43533 / 42354	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Caridology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd My wife is a Director and Shareholder in Groves Cardiology Services Ltd	June 96 - current	Income and Dividends	Yes	Yes	Peter Groves	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.11.20	Yes	Yes	UHW	43533 / 42354	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Caridology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd My wife is a Director and Shareholder in Groves Cardiology Services Ltd	June 96 - current	Income and Dividends	Yes	Yes	Peter Groves	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Tristan	Groves	Lead Cardiology and Anticoagulation Pharmacist	Adult Cardiology	8a	Specialist Services	18.11.20	Yes	No	UHW	20746826	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Receiving Honoraria for providing educational sessions from Pharmaceutical companies related to anticoagulation. Honoraria received from BMS/Pfizer	2016 - current	Honoraria and meeting travel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tristan Groves	18.11.20	Yes	Sponsorship Form sent 1.12.20
Low	Laura	Gwyther	CART Clinical Nurse Specialist	Haematology		Specialist Services	13/10/2020	Yes	No	UHW	Ext 48494	Yes	N/A	N/A	N	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have been asked along side all the other CART nurses across the UK to participate in a paid advisory board discussion hosted by Celgene. I would like to partake in the discussion to get more understanding of the new product and hear about other nurses experiences of CART so far. It is being held on 19th October 2020 from 1pm until 5pm. This is a one off participation as far as my knowledge serves.	19/10/2020	£140	Yes	Yes	Laura Gwyther	13/10/2020	Yes	
Low	Richard	Hain	Consultant and Clinical Lead, Paediatric Palliative Care	Child Health (Community)	Consultant	Children & Women	19.11.20	Yes		UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CVUHB Office space within Ty Hafan Children's Hospice	2018		Office space, coffee			Yes	Yes	Richard Hain	19.11.20	Yes	
Low	Sarah	Hale	Consultant Opthalmologist	Ophthalmmology	Consultant	Surgery	8.04.20	Yes	No	UHW	02920 748249	Yes	N/A	N/A	N/A	Nominated member of Cardiff Eye Surgeons LLP. Company that carries out ophthlamic work	2006 - current	Paid for any work carried out	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sarah Hale	8.04.20	Yes	Secondary Work Form sent 24.11.20
Low	Khalid	Hamandi	Consultant Neurologist	Epilepsy Unit	Consultant	Specialist Services	26.01.21	Yes		UHW	46662	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secretary, International League Against Epilepsy Britich Chapter. Chair Epilepsy Action Cymru National Advisory Council.	2019 - present	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Khalid Hamandi	26.01.21	Yes	
Low	Kathrin	Hammer	Consultant Radiologist	Radiology	Consultant	CD&T	28.09.20	Yes	No	UHW		Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	Nil	No	N/A	nil	No	N/A	N/A	No	N/A	No	Fee for service at European scanning centre Cardiff and Spire Hospital Cardiff for radiology work	One session	One off payment	Yes	Yes	Kathrin Hammer	28.09.20	ESR	
Low	Kathrin	Hammer	Consultant Radiologist	Radiology	Consultant	CD&T	16.01.22	Yes	No	UHW	NK	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Clinical Private Practice	28.09.20 - Ongoing	Fees	Yes	Yes	ESR	19.01.22	ESR	
Low	David	Hanna	Consultant Paediatrician	Emergency Medicine	Consultant	Medicine	11.01.21	Yes	Yes	UHW	48008	Yes	N/A	N/A	N/A	My wife, Dr Alison Whyte is a partner in Clark Avenue Surgery, a GP Practice in Cwmbran, within the Aneurin Bevan UHB area. This practice does not currently do business or is it seeking to do business with Cardiff and Vale UHB.	2019		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Hanna	11.01.21	Yes	
Low	Abigail	Harris	Executive Director of Strategic Planning	Strategic Planning	Director	Corporate	27.01.21	Yes	Yes	Woodland House		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	My husband is an Independent Board member of the Wales Council for Voluntary Action. My uncle is a Trustee of the Teenage Cancer Trust.	Ongoing	No	I am an Independnet Board member of Social Care Wales.	Ongoing	No	Husband works for Competition and Markets Authority which on occasions rules in matters of fair competition in the NHS and healthcare.	Ongoing	Husband's salary.	Yes	Yes		27.01.21	Yes	
Low	Sara	Harrison	Consultant Radiologist	Radilogy	Consultant	CD&T	07.04.22	Yes	Yes	UHW	43052	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 patient scans at Cardiff Spire Hospital during non contracted time.	2022 - Ongoing	Fees	Yes	Yes	Sara Harrison	07.04.22	Yes	
Low	Mary	Hart	Consultant Radiologist	Radiology, Medical Physics, Clinical Engineering		CD&T	12.11.20	Yes	No	UHW	2920743538	Yes	Director Hart-Jones Consultancy LTD	Apr-19	Salary	N/A	N/A	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	Self employment: Hart-Jones Consultancy LTD	Apr-19	Salary						
Low	Jamie	Hayes	Pharmacist	AWTTC	8d	CD&T	13.11.20	Yes	Yes	UHL	26869	Yes	Director of JMH Collaborations	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Director of JMH Collaborations Ltd	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Honorary Senior Lecturer appointments with Cardiff University School of Medicine and School of Pharmacy and Pharmaceutical Sciences	2006 - ongoing	Honoraria	N/A	N/A	N/A	Elected Board member of the Royal Pharmaceutical Society and member of the Royal Pharmaceutical Society Assembly. Wife is Medical Director at Marie Curie, Cardiff and Vale Hospice, Penarth	June 2016 - ongoing	Honoraria, expenses	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jamie Hayes	13.11.20	Yes	
Low	Caroline	Hayhurst	Consultant	Neurosurgery	Consultant	Specialist Services	15.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Programme Leader for University of Buckingham MSc Neuroisurgery.	2022-Ongoing	Ad hoc payments from Learna Ltd	Yes	Yes	ESR	15.03.22	ESR	
Low	Rhys	Hewett	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	44687	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsored by Fresnus Kabi to attend BAPEN conference Nov 2019.		Paid for conference, hotel and flights.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Rhys Hewett	12.11.20	Yes	
Low	Julie	Highfield	Consultant Clinical Psychologist /Associate Director	Critical Care		Specialist Services	12/10/2020	Yes	Yes	UHW	45114	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National Director of Wellbeing Intensive Care Society	15/06/20 - Ongoing	secondment from NHS 0.4WTE at 8c	N/A	N/A	N/A	Occasional private practice	2005-Ongoing	adhoc salary	Yes	Yes	Julie Highfield	12/10/2020	Yes	
Low	Christopher	Hingston	Consultant Critical Care	Critical Care	Consultant	Specialist Services	13.11.20	Yes	Yes	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spouse: Director and Trustee of Latch Childrens Charity	2014 - current	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Chris Hingston	13.11.20	Yes	
Low	Emma	Hingston	Consultant & Honorary Senior Lecturer Paediatric Dentistry	Paediatric Dentistry	Consultant	Surgery	5.02.21	Yes	No	UHW	42458	Yes	Director of LATCH cancer charity	2014 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee for LATCH - Children's Cancer Charity	2013 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Emma Hingston	5.02.21	Yes	
Low	Thomas	Hockey	Consultant Histopathologist	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	Yes	UHW	41986	Yes	Director Director / Secretary	Dividend Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I perform post mortem examinations for HM Coroner and do some private histology reporting.	Jan 21-Ongoing	payment per case.	Yes	Yes	Thomas Hockey	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Jessica	Hodges	Physiotherapist	Frailty	5		13/10/2020	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Work as a Physiotherapist for Cardiff City Ladies Football Club	9/10/20 - ongoing	paid	Yes	Yes	Jessica Hodges	13/10/2020	Yes	
Low	Paul	Hodgson	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	16.11.20	Yes	No	UHL	2071 5677	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice (company name PDH Ortho Ltd)	Feb 2013 - ongoing	payment per case	Yes	Yes	Paul Hodgson	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Rebecca	Hopes	Training Manager	Genomics Strategy	8A	All Wales Medical Genomics Service	03.03.2022	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	Yes - Volunteer at Cardiff Dogs Home	01/03/2022	n/a	n/a	n/a	n/a	Yes	Yes	ESR	03.03.2022	Yes - ESR	
Low	Mathew	Hoskins	Locum Consultant Psychiatrist	Adult Psychiatry	Consultant	Mental Health	16.11.20	Yes	No	Barry Hospital	1446 454300	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am the Chief Investigator for a phase 2 clinical trial sponsored by the Multidisciplinary Association for Psychedelic Studies (MAPS, USA), which will take place in partnership with Cardiff Uni and Cardiff and Vale UHB in 2021. I have recevied training funded by MAPS.			I have done part time agency locum consultant work for Powys Health board. Finished in July 2020. No more planned as I'm no longer part time.		Yes	Yes	Yes	Mathew Hoskins	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Gary	Howell	Macmillan AHP Cancer Lead	Therapies	8a	CD&T	13.11.20	Yes	No	UHW	44294	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private dietetic practice	2008 - ongoing	Salary	Yes	Yes	Gary Howell	13.11.20	Yes	Secondary Work Form sent 03.12.20
Low	David	Howells	Consultant	MHSOP	Consultant	Mental Health	11.01.21	Yes	No	South East Cardiff team	2920536880	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Health Inspectorate Wales - SOAD work Schedule 2 Mental Health Act / Mental Capacity Act work Trustee for Charity 'RESEC' Private Mental Health Clinical Work at Cyncoed Consulting Rooms, Cardiff	Jan 21 - Ongoing	Yes	Yes	Yes	David Howells	11.01.21	ESR	Secondary Employment Form sent 18.10.21
Low	Richard	Hughes	Consultant Anaesthetist	Peri-Operative Care	Consultant	Surgery	12.11.20	Yes	No	UHW	44139	Yes	Director of R H Health Ltd (to manage private medical anaesthetic activities undertaken outside my NHS contract)	08/01/2013	Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Hughes	12.11.20	Yes	
Low	Nia	Humphry	Consultant	General Surgery	Consultant	Surgery	04.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University 0.1 WTE		Salary	Yes	Yes	ESR	04.03.22	ESR	
Low	Jenny	Hunt	Psychology Manager	Child Psychology	8d	Children and Women	21.03.22	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	ESR	21.03.22	ESR	
Low	Sarah	Hunt	Consultant Anaesthetist	Anaesthetics and Critical Care	Consultant	Specialist Services	15.11.20	Yes	No	UHW		Yes	Vale Anesthetics Ltd	2014 - ongoing	I do not draw a salary or dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd I undertake private practice in Spire Hospital. They do not employ me. See Ltd co	2014 - ongoing	I do not draw a salary or dividends	Yes	Yes	Jayne Sara Hunt	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Nicola-Xan	Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory		Medicine	15/10/2020	Yes	No	UHL	2920716847	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for European 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	Nicola-Xan Hutchinson	15/10/2020	Yes	
Low	Louise	Ingleton	Avanced Paediatric Clinical Nurse Specialist	Community Child Health Deurodevelopmental	8a	Children and Women	13.01.21	Yes	No	St David's Hospital		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of UK Nurse Advisory Board-ADHD sponsored by Takeda Pharmaceuticals	March 20 - ongoing	honoria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Louise Ingleton	13.01.21	Yes	Secondary form sent 13.01.21
Low	Wendy	Ingram	Consultant Haematologist	Haematology	Consultant	Specialist Services	12.03.22	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	ESR	12.03.22	ESR	
Low	Bethan	Ingram Holden	Senior Nurse	Haematology	8a	Specialist Services	09.03.22	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	ESR	09.03.22	ESR	
Low	Sharon	Irving	Senior Nurse ENT	ENT	8a	Surgery	07.02.21	Yes	No	UHW	02920 742783	Yes	No	N/A	N/A	No	N/A	N/A	A position with HIW as a nurse peer reviewer	2019-Present	No	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Sharon Irving	07.02.21	Yes	
Low	Carly	Jackson	Clinical Psychologist	Child Health	8a	Children and Women	14.12.20	Yes	No	St David's Hospital	2920536733	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Psychologist with Sport Wales (employed by Sport Wales) and Clinical Psychologist for Mindful Mindset (Self-Employed)	Sports Wales (1.09.19) both ongoing	Sports Wales Salary	Yes	Yes	Carly Jackson	14.12.20	Yes	Secondary form sent 5.1.20
Low	Charles	Janczewski	UHB Chair	Executives / Corporate	VSM	Executive	12.11.20	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Swansea University - Chair of Governance Board for Health & Wellbeing Academy	May 2018 - ongoing	Unpaid	N/A	N/A	N/A	Yes	Yes	Charles Jancewski	12.11.20	Yes	
Low	Benjamin (Ben)	Jelley	Consultant Gerentologist	Clinical Gerentology	Consultant	Medicine	12.04.22	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	ESR	12.04.22	ESR	
Low	Fiona	Jenkins	Executive Director of Therapies and Health Science	Executive	Executive	Executive	03.03.22	Yes	No	UHW		Yes	Interim Executive Director Therapies and Health Science, Cwm Taf Morgannow UHB	Nov 20 - tbc	Shared role with C&V UHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Fiona Jenkins	26.11.20	Yes	
Low	Lynda	Jenkins	Nursing Informatics Lead	Corporate Nursing		Corporate Nursing	09/10/2020	Yes	No	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake hospital inspections in other health boards/ private health care in Wales on invitation from health inspectorate Wales. These are infrequent.			N/A	N/A	N	Yes	Yes	Lynda Jenkins	08/10/2020	Yes	
Low	Meriel	Jenney	Medical Director	Executive	Executive	Executive	23.03.22	Yes	No	Woodland House	2921836001	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	Meriel Jenney	23.03.22	Yes	
Low	Michaela	John	Programme Manager	Genomics Strategy	8a	AWMGS	22.03.22	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	ESR	22.03.22	ESR	
Low	Adam	Jones	Consultant Dental Surgeon	Dental	Consultant	Surgery	8.01.21	Yes	No	UHW	44365	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Merck Sharp & Dohme Ltd. funded travel / hotel and course expenses for training on 'PD-L1 testing (22C3) Professional Expert Course Head and Neck - Advanced Training'.	13.01.21 - 14.01.21	Course, travel and hotel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Adam Jones	8.01.21	Yes	Secondary form sent 11.01.21
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	Consultant	Medicine	24.11.20	Yes	No	UHL	25653	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Amy Jones	26.11.20	Yes	
Low	Ceri Hopcyn	Jones	Consultant Haematologist (BMT & CAR T)	Consultant Haematologist	Haematology	Specialist Services	1.02.20	Yes	No	UHW	41976	Yes	I received sponsorship to attend various conferences including European Haematology Asssociation General meeting (EHA) 2019 and American Society of Hematolgy (ASH) 2019 from Abbvie, and EHA 2020, British Society of Haematology Annual General Meeting 2020 and ASH 2020 from Kite Gilead and Novartis	May 2019 - ongoing	Travel and registration costs only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ceri H Jones	1.12.20	Yes	Sponsorship Form sent 3.12.20
Low	Lisa	Jones	Clinical Psychology	Neuropsychology	8+	Sepcialist Services	21.02.21	Yes	No	UHW	43224	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work as a self employed clinical neuropsychologist	2014 - ongoing	salary	Yes	Yes	Lisa Jones	21.02.21	Yes	Secondary form sent 25.02.21
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	7	Mental Health	30.11.20	Yes	Yes		1446 454200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for Re-Live (Registered Charity Number: 1162546) Spouse is a Board Member with the charity 'Wish Upon a Star'.(Registered Charity Number 1168140).	01/07/2015 01/07/2015	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Jones	30.11.20	Yes	
Low	Menna	Jones	Clinical Lead	Mental Health	8c	Mental Health	16.11.20	Yes	No	Global Link	02921 832200	Yes	Director of Vegan International Ltd	24.12.19 - ongoing	none	Self employed as complementary therapist	2018 - ongoing	sessional payments		N/A	N/A	N/A	N/A	N/A	Director of British Eating Disorders Society	10.01.18 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Menna Jones	16.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Sharon	Jones	Consultant Rheumatologist	Specialised Medicine	Consultant	Medicine	25.01.21	Yes	No	UHW	42886	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Educational funding from Lily for EULAR conference (virtual) in June 2021			Have been an advisor to NASS - National Ankylosing Spondylitis Society and received an award in 2018		N/A	N/A	N/A	N/A	Private rheumatology practice at Spire funded (self employment) since 2001	N/A	N/A	Yes	Yes	Sharon Jones	25.01.21	Yes	Secondary and sponsorship form sent 10.02.21
Low	Stephen	Jones	Consultant	T&O	Consultant	Surgery	29.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at the Nuffield Cardiff and Vale Hospital - performed outside NHS timetable	2022 - Ongoing	N/A	Yes	Yes	ESR	29.03.22	ESR	
Low	Nia	Jones	Podiatrist	Therapies	7	CD&T	11.11.21	Yes	No	CRI	029 20335370	Yes	No	N/A	No	No	N/A	N/A	No	N/A	N/A	Receives honoraria for speaking at wound care conferences	May 2019-Ongoing	Honoraria	No	N/A	N/A	No	N/A	N/A	Employed by Toetal Footcare Private Clinic.	May 2019 - Onwards	Fees	Yes	Yes	Nia Jones	11.11.21	Yes & ESR	
Low	Anurag	Joshi	Consultant	Cellular Pathology	Consultant	CD&T	02.09.21	Yes	No	UHW	428876	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	I report on cases referred to AWLP from Spire Hospital Cardiff when these are allocated to me.	Sep 21-Ongoing	Yes	Yes	Yes	Anurag Joshi	02.09.21	ESR	Secondary Work Form sent 18.10.21
Low	Naushad Ali	Junglee	Consultant in Acute Medicine and Nephrology	Acute Medicine	Consultant	Medicine	17.11.20	Yes	No	UHL	46645	Yes	NAJ Clinical Services PLC. A PLC set up by me for the purposes of private medical practice	2018 - current	private practice earnings	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Nephrologist at Spire Hospital Cardiff	2017 - current	Private Practice earnings are paid	Yes	Yes	Naushad Ali Junglee	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Sridhar	Kamath	Consultant Radiologist	Radiology	Consultant	CD&T	29.01.21	Yes	No	UHW	44887	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have private practising privileges at Spire cardiff hospital, Nuffield hospital cardiff and St Josephs hospital Newport.			Yes	Yes	Sridhar Kamath	29.01.21	Yes	Secondary form sent 12.02.21
Low		Kandan	Service Group Manager	T&O	8b	Surgery	17.03.22	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	ESR	17.03.22	ESR	
Low	William Jonathan	Kell	Consultant Haematologist	Haematology	Consultant	Specialist Services	22.12.20	Yes	No	UHW	42654	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional requests from Pharmaceutical companies to give education (non-promotional) talks, or to sit on paid advisory boards	2002 - ongoing	Less than £2k	Treasure of UK MDS forum	2010 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jonathan Kell	22.12.20	Yes	Secondary form sent 6.1.20
Low	Emma	Kempshall	Consultant Haematologist	Haematology / BMT	Consultant	Specialist Services	10.02.21	Yes	Yes	UHW	47053	Yes	Director Gloucestershire Knee Surgery Ltd Spouse: Director Gloucestershire Knee Surgery Ltd	August - ongoing August - ongoing	No No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Emma Kempshell	10.02.21	Yes	
Low	Alexander	Kennedy	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Consultant	Surgery	12.11.20	Yes	No		7413908743	Yes	Director South East Wales Hang Gliding and Paragliding Club Ltd	16.03.17 - ongoing	No benefits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alexander Kennedy	12.11.20	Yes	
Low	Mohid	Khan	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	29.01.21	Yes	No	UHW	43443	Yes	Dr Mohid Khan Ltd	16.04.19	None	N/A	N/A	N/A	AAA	9.03.20	Speaker Fee	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mohid Khan	28.01.21	Yes	previous year 2019 - 2020
Low	Robert	Kidd	Consultant Psychologist	Mental Health	Consultant	Mental Health	16.11.20	Yes	Yes	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Partner is a Consultant Psychologist within Child Health at the Health Board.	Current	Salary	N/A	N/A	N/A	N/A	N/A	N/A	Declarant is a member of the All Wales Approval Panel for Approved Clinicians in Wales, which sits within BCUHB and carries out its functions on behalf of the other LHBs. Declarant is also an external examiner at Birmingham University & an honorary lecturer at Cardiff University & an honorary (consultant) assistant professor to the school of 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	Robert Kidd	16.11.20	Yes	Secondary Employment form completed. Manager content with external work.
Low	Caroline	Kirwan	Counsellor	Medical Genetics	8b	AWMGS	24.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Intermittent private genetic counselling workvia Innermost Healthcare	2022	Fees	Yes	Yes	ESR	24.03.22	ESR	
Low	Anna	Kuczynska	Clinical Board Director	PCIC	8+	PCIC	12.11.20	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	GP partner, Highlight Park Medical Practice , Lakin Drive, Barry CF628GP		Yes	Yes	Yes	Anna Kuczynska	12.11.20	Yes	
Low	Howard	Kynaston	Consultant Urologist	Medicine	Consultant	Medicine	2.02.21	Yes	No	UHW	7834196104	ESR	Co Director of Bay Tree Wine Company - retiring from NHS 28.02.21 Spouse also co Director	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Howard Kynaston	2.02.21	Yes	Retiring from NHS 28.02.21

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	Mary	Lawrence	Associate Specialist in Psychiatry	Mental Health	Consultant	Mental Health	20.11.20	Yes	No	Hamadryad CMHT	2046 3488	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private work in the form of reports for solicitors, DVLA, CPS, CICB, Child Services, Benefits Appeals, Immigration Applications, Occupational Health, Police etc. plus Mental Health Act Assessments. These are conducted in my own time (if undertaken during my normal working hours time slipping utilised with equivalent amount of NHS work undertaken in my own time)	Ongoing		Yes	Yes	Mary Lawrence	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Mari	Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy	8a	CD&T	20.11.20	Yes	No	UHL	2071 5261	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University MSc in clinical pharmacy. Provide 2 hour teaching session every 12 or 24 months. Annual leave taken, therefore undertaken during my own time.	March 11 - present	Hourly rate for delivering presentation	Yes	Yes	Mari Lea-Davies	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Fong	Leong	Consultant	Cardiothoracic	Consultant	Medicine	25.03.22	Yes	No	UHW	02921 844090	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	Private work at Spire Hosp Cardiff	Ongoing	Fees	Yes	Yes	Fong Leong	25.03.22	Yes	
Low	Robert	Letchford	Consultant Physiotherapist	Physiotherapy	8	CD&T	07.03.22	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		Yes	Yes	Robert Letchford	07.03.22	Yes	
Low	Aled	Lewis	Consultant	Nephrology and Transplant	Consultant	Specialist Services	23.06.21	Yes	Yes	UHW	746645	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	My wife is a joint owner/director in a private physiotherapy company specialising in exercise/rehabilitation for Parkinson's disease. I have no direct interests in the company.	Jun 21-Ongoing	none	Yes	Yes	Aled Lewis	23.06.21	ESR	
Low	Christopher	Lewis	Interim Executive Director of Finance	Finance	VSM	Executive	13.11.20	Yes	Yes	Woodland House	41507	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	President of Wales Branch of the Healthcare Financial Management Association(HFMA). HFMA is a registered charity.	Oct 09 - Preesent	None anticipated	My wife is Samantha Lewis, Assistant/Deputy Director of Finance, Swansea Bay University Health Board	2011 - Present		N/A	N/A	N/A	Yes	Yes	Christopher Lewis	13.11.20	Yes	
Low	Kenneth	Lim	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children & Women	10.03.22	Yes	No	UHW	41249	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of South Wales Gynae Cancer Fund - registered charity	2009 - ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Kenneth Lim	13.11.20	Yes	
Low	Peter	Lindsay	Locum Consultant	Obs & Gynae	Consultant	Children & Women	13.11.20	Yes	No	UHL	21841268	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Treasurer - South Wales Gynaecological Cancer Fund	1997 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Lindsay	13.11.20	Yes	
Low	Kate	Littler	Principal Clinical Psychologist	Haematology		CD&T	11.03.2020	Yes	No	UHW	45558	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	01/07/2020 - Ongoing	Salary	Yes	Yes	Kate Littler	03.08.2020	Yes	
Low	Andrea	Liu	Consultant Neuroradiologist	Radiology	Consultant	CD&T	28.01.21	Yes	No	UHW	44325	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4Ways Healthcare and Spire Cardiff	2012 and April 2010		Yes	Yes	Andrea Liu	28.01.21	Yes	
Low	Andy	Lodwick	Lead Clinician Psychological Therapy Hub	Psychology		Mental Health	19/10/2020	Yes	Yes	UHL	2183 22249	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Andy Lodwick	2014 - ongoing	Self employed as a sole trader as Dr Neil Kitchiner. Personal website cbt cardiff attracts individuals seeking Private out-pt psychological therapy.	Yes	Yes	Andy Lodwick	19/10/2020	Yes	
Low	Ne-on	Loh	Consultant Paediatrician	Child Health	Consultant	Children and Women	26.01.21	Yes	No	UHW	44291	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	Bne-ron Loh	26.02.21	Yes	Secondary form sent 11.02.21
Low	Rachel	Long		Directorate Manager	8b	Specialist Services	03.05.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Magistrate on Cardiff Bench	N/K	Expenses only	Yes	Yes	ESR	03.05.22	ESR	
Low	Julie	Loxton	Clinical Lead Nurse	Vale Locality Office / Daytime Servi	7	PCIC	24.11.20	Yes	No	Barry Hospital	7989223435	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	I offer locum shifts to general practice as self employed. This does not conflict with my C&V role	March 22 - Ongoing	Salary	Yes	Yes	Julie Loxton	13.11.20	Yes	
Low	Alice	Loyal	Clinical Psychologist	Psych EMI Community	8C	Mental Health	30.11.21	Yes	No	N/K		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	I am company secretary for my husband's design engineering company. I hold a 7% share in the company. This does not conflict with my duties in C&V UHB.	Nov 21-Ongoing	Dividends	Yes	Yes	Alice Loyal	30.11.21	ESR	
Low	Jill	Lubienski	Family Therapist	SHED	8a	Mental Health	14/10/2020	Yes	No	Global Link	2921 832200	Yes	N/A	N/A	N//A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have a private psychotherapy practice based at my home in Cardiff. I do not see clients privately where they could be seen in the SHED team. I am also a self employed Associate for Partnership Projects UK (www.partnershipprojectsuk.co.uk) providing NVR parenting therapy, and training to practitioners and therapists but again this work does not cross over with my SHED employment.	13/10/20 - ongoing	Yes I have some income from my self employed work.	Yes	Yes	Jill Lubienski	14/10/2020	Yes	
Low	Helen	Ludlow	Macmillan Senior Nurse Band 8a	Medicine	8a	Medicine		Yes	No	UHW		Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	I have spoken at 3 non-promotional webcasts for Janssen, a pharmaceutical company that provides one of our Biologic drugs. 1 meeting was how IBD Nurses coped during COVID, and tips to keeps services running smoothly and then 2 (both the same presentation) on a case study of an IBD pt and also again keeping IBD services running during COVID	3 sessions	total amount received as honorarium: £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	Helen Ludlow	10.10.20	ESR	
Low	Jane	Maddison	Paediatric Physiotherapy	Acute Child Health	8a	Children and Women	13.11.20	Yes	No	Woodland House	365578	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of Chartered Society of Physiotherapy Welsh Board	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jane Maddison	13.11.20	Yes	
Low	Roger	Maggs	Laboratory Manager	Dental	8c	Surgery	16.11.20	Yes	No	UHW	42411	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	N/A	Managing Director of a company for private work Wife - Director of same company	01/04/2015 - current 01/04/2015	salary	Yes	Yes	Roger Maggs	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Claire	Main	Nurse Manager	Clinical Board	8d	Specialist Services	23.03.22	Yes	No	UHW	ext 45069	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Executive member of Association of Nephrology Nurses UK. I receive no renumeration for this.	29.05.2018 - ongoing	No	N/A	N/A	N/A	Yes	Yes	ESR	22.03.22	ESR	
Low	Aleksander	Marin	Consultant Radiologist	Radiology	Consultant	CD&T	14.11.20	Yes	No	UHL	25563	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Medica Teleradiology Speciality Advisor in Thoracic Radiology, Spire Hospital Cardiff Reporting Radiologist	20.06.16	Monthly p0ayable fees for service	Yes	Yes	Aleksander Marin	14.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Carys	Marshall	Principal Clinical Psychologist	Clinical Health & Neuropsychology	8a	Mental Health	25.01.21	Yes	No	Global Link	20832243	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment - private practice	Mar-21	Ad hoc	Yes	Yes	Carys Marshall	2.03.21	Yes	Secondary work form sent 2.03.21
Low	Joanne	May	Locum Consultant Paediatric Rheumatologist	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43400	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Medical advisor to treat to target panel for systemic Ju	Nov 2020 - Nov 2021	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	The department is supported by Versus Arthritis family workers. We have a project (currently on hold) with ballet cymru and the Arts Council for Wales to provide patient support.	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Joanne May	13.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Kenneth	May	Consultant Cellular Pathology	Cellular Pathology and Mortuary Service, Laboratory Medicine	Consultant	CD&T	12.11.20	Yes	No	UHW	48040	Yes	STTC Limited	Jul-19		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Histopathology reporting for backlogs Ltd				Yes	Kenneth May	12.11.20	Yes	
Low	Haydn	Mayo	Assistant Clinical Board Director, PCIC	Community Director	8+	PCIC	28.01.21	Yes	No	Woodland House		Yes	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	N/A	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	Haydn Guy Mayo	28.01.21	Yes	Secondary form sent 12.02.21
Low	Neil	McCann	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	27.02.21	Yes		UHW	43105	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship by Medtronic UK to attend a day meeting in Leeds	4.12.19 - 5.12.19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Neil McCann	27.02.21	Yes	
Low	Mike	McCarthy	Consultant	Trauma & Orthopaedics	Consultant	Surgery	04.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad Hoc educational contract with Globus Medical. I teach on 2 x courses per year.			Yes	Yes	ESR	04.03.22	ESR	
Low	Annette	McLean	Dietetic Lead Mental Health	Dietetics	8a	CD&T	12.11.20	Yes		UHL	2071 5281	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc private dietetic work: Orbis education, plus dietetic consultation/training ad hoc on request, eg: cardiff uni/somek/knights-absorb.	2005 - ongoing		Yes	Yes	Annette McLean	12.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Jan	Melichar	Consultant Psychiatrist	Addictions	Consultant	Mental Health	26.01.21	Yes	No	CRI	2920461788	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultancy & training for all UK pharmaceutical companies in this area	1995 - ongoing	Honoraria	Consultancy at third sector organisation (DHI) in Bath and Bristol	2011 - ongoing	Honoraria	Consultancy to LearnitOnline - online health education and training	2016 - ongoing	Honoraria	Self employed in private practice primarily Spire	2011 - ongoing	Fees	Yes	Yes	Jan Melichar	26.01.21	Yes	Secondary & Sponsorship form 10.02.21
Low	Angela	Miser	Associate Specialist, Paediatric Haematology / Oncology	Acute Child Health	Consultant	Children & Women	15.11.20	Yes	Yes	UHW	48805	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Chief Medical Officer, Lixte Biotechnology Holdings, Inc., East Setauket, New York 11733, USA	2020 - Present	Salary	N/A	N/A	N/A	**1.** Chairman of Board, Christian Salvation Service, Taipei, Taiwan (USA Office), **2.** Chairman of Board, Desi Geestman Foundation (supports children with cancer), Los Angeles, USA	20+	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Angela Miser	15.11.20	Yes	
Low	Biju	Mohamed	Consultant	Gerentology	Consultant	Medicine	24.03.22	Yes	No	UHW	2920743646	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	Biju Mohamed	24.03.22		
Low	Adul	Moideen	Consultant Spinal Surgeon	Trauma and Orthopaedics	Consultant	Surgery	30.03.22	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	ESR	31.03.22	ESR	Secondary work form sent 12.03.21
Low	Siobhan	Moore	Clinical Psychologists	Neurosciences	8+	Specialist Services	3.02.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	One off training session for a drug company (Biogen where I was paid during this financial year	Apr-20	Yes	N/A	N/A	N/A	Yes	Yes	Siobhan Moore	3.02.21	Yes	Secondary form sent 12.02.21
Low	Matthew	Morgan	Consultant in ICU	Critical Care	Consultant	Specialist Services	12.11.20	Yes	Yes	UHW	7760220095		Matt PG Morgan Ltd, Director - Author/Writing Business for a book publishing about ICU Spouse - Matt PG Morgan Ltd, Director - Author/Writing Business	01/11/2017 - present 01/11/2017 - present	Dividends Dividends and salary	N/A	N/A	N/A										I have donated £5000 to the 2 Wish Upon a Star charity and £200 to the C&V Health Charity.	2020		Writer for BMJ and BMJ Learning	2005 - present	Salary	Yes	Yes	Matt Morgan	12.11.20	Yes	
Low	Paul	Morgan	Consultant Critical Care	Critical Care	Consultant	Specialist Services	26.01.21	Yes	No	UHW	43064	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	Lead volunteer, the UK Sepsis Trust	2013		Lecturer for Doctors Academy	Apr-19		Yes	Yes	Paul Morgan	26.01.21	Yes	Secondary form sent 11.02.21
Low	Rhiannon Meleri	Morgan	Consultant in Cellular Pathology	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	No	UHW	41988	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board Member of Manon Jones Foundation - not yet established as a charity	01.01.20	None	Coronial post mortem work for South Wales Central Coroner's Office	2004	£96 per individual PM	Yes	Yes	Meleri Morgan	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Consultant	Surgery	13.11.20	Yes	Yes	UHW	42083	Yes	Dan Morris Ltd Spouse: Director	2003 - present	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sambury Trust, Vale 4 Africa Keeler Trust (Trustee)	Ongoing	Nil	N/A	N/A	N/A	Work at Spire & Nuffield Paid via DM Ltd			Yes	Yes	Daniel Morris	13.11.20	Yes	
Low	Ian	Morris	Consultant	Neonatal	Consultant	Children and Women	09.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2 sessions per week as programme director for neonatal MSc Cardiff University	Ongoing	Salary	Yes	Yes	ESR	09.03.22	ESR	
Low	Jeffrey	Morris	Head of Electronic Assitive Technology Service for Wales	ALAS	8a	Specialist Services	12.11.20	Yes	No	Rookwood Hospital	02920 313852	Not Ticked	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Organising Committee and Scientific Committee member of the European Seating Symposium (ESS), based in Ireland.	Jun-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jeffrey Morris	12.11.20	Yes	
Low	Sara	Moseley	Independent Member of the Board	Executives / Corporate	Executive	Executive	2.03.21	Yes	No	Woodland House		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director, Mind Cymru	01.11 - 04/.21	Salary	Head of GMC Wales	04/21 - current	Salary	N/A	N/A	N/A	Yes	Yes	Sara Moseley	2.03.21	Yes	
Low	Richard	Motley	Consultant Dermatologist	Dermatology	Consultant	Medicine	03.03.22	Yes	No	UHW	44629	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake Private Practice at the Spire Cardiff Hospital and in The Welsh Institute of Dermatology	1994 - ongoing		Yes	Yes	Richard Motley	25.01.21	Yes	Secondary form sent 25.02.21
Low	Sian	Moynihan	Consultant Paediatrician	Child Health	Consultant	Children and Women	4.02.21	Yes	No	St David's Hospital	2920536789	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am welfare Officer (Safegarding Officer) which is voluntary and unpaid for the Maindy Youth Cycling club- Im on the committee supporting decision making for the club that involves child welfare. It is recognised by British Cycling Authority and Welsh Cycling Authority and done necessary Safeguarding training. I do not believe there is any conflict of interest as this is done in outside work hours.		None	N/A	N/A	N/A	Yes	Yes	Sian Moynihan	4.01.21	Yes	
Low	Peter	Mullaney	Consultant Radiologist	Radiology	Consultant	CD&T	11.12.20	Yes	No	UHW	43956	Yes	Yes	2019		Yes	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Mullaney	11.12.20	Yes	Secondary form sent 5.1.20
Low	Pippa	Mundy	Consultant Clinical Psychologist	Child Health	Consultant	Children & Women	16.11.20	Yes		Global Link	07976 702638	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Orbis Education & Care	2014	Payment for clinical services	Independent practice as psychologist	2014	Payment for clinical services	Yes	Yes	Pippa Mundy	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Alexandra	Murray	Consultant Medical Genetics	Genetics	Consultant	CD&T	26.11.20	Yes	No	UHW	44654	ESR	N/A	N/A	N/A	N/A	N/A	N/A	Paid a fee per patient to counsel them about private genetic test results purchased via Inntermost Healthcare	6.02.2017 - ongoing	Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am paid a month fee to provide a consultancy service to the National Pathology Manager about genetic tests	1.11.2017 - ongoing	monthly fee	Yes	Yes	Alexandra Murray	26.11.20	Yes	Secondary form sent 1.03.21
Low	Ravindra	Nannapaneni	Consultant	Neurosurgery	Consultant	Specialist Services	07.07.21	Yes	No	UHW	029 2074 8487	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Cardiff and St Joseph's Hospital, Newport	Jul 21 - Ongoing	Yes	Yes	Yes	Ravindra Nannapaneni	07.07.21	ESR	Secondary Employment Form sent 18.10.21
Low	Jones	Nia	Podiatrist	Podiatry	7	CD&T	26.10.21	Yes	No	UHL		Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Private Podiatry Work	Oct 2021-Ongoing	Fees	Yes	Yes	Nia Jones	26.10.21	ESR	
Low	Peter	O'Callaghan	Medical Consultant	Cardiothoracic	Consultant	Specialist Services	13.11.20	Yes	No	UHW		Not Ticked	Dr Peter O'Callaghan Ltd	2012 - ongoing	Private practice income	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter O'Callaghan	13.11.20	Yes	Secondary Work Form sent 24.11.20
Low	George	Oliver	Physiotherapist	Physiotherapy	8b	CD&T	22.03.22	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	ESR	22.03.22	ESR	
Low	Balarao	Oruganti	Consultant in Psychiatry	Psychiatry	Consultant	Mental Health	18.11.20	Yes	No	UHL	47747	Not Ticked	Director of limited company but cannot see any conflict as not doing or seeking any business with UHB Spouse - Director of a limited company but cannot see any conflict as not seeking or doing any business with UHB			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Works for HIW and Judicial Appointment Committee for MHRT on ad hoc basis			Yes	Yes	Balarao Oruganti	18.11.20	Yes	Secondary form sent 21.12.20
Low	Craig	Parry	Consultant Radiologist	Radiology	Consultant	CD&T	26.01.21	Yes	No	UHW	43966	Yes	Craig Parry Diagnositics Ltd Co	Jul-17		Craig Parry Diagnositics Ltd Co	Jul-17	Salary	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice - Spire Hospital Cardiff		Salary	Yes	Yes	Craig Parry	26.01.21	Yes	Secondary form sent 11.02.21
Low	James	Peaker	Clinical Scientist	Cellular Pathology	8c	CD&T	09.03.22	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	ESR	09.03.22	ESR	
Low	Frauke	Pelz	Associate Specialist in Clinical Genetics	All Wales Medical Genomics Service	Associate Specialist	All Wales Medical Genomics Service	20.11.20	Yes	Yes	UHW	48921	Not Ticked	Director of limited company	Since May 2016 - ongoing	Dividends	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I hold a very small private psychotherapy practice, limited to very few monthly hours, well outside my job planned hours in NHS post			Yes	Yes	Frauke Pelz	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Thomas	Pembroke	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	45608		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University Employee			Yes	Yes	Thomas Pembroke	12.11.20	Yes	
Low	Richard	Penketh	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children and Women	26.01.21	Yes	Yes	UHW	44390	Not Ticked	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	N/A	N/A	N/A	N/A	N/A	N/A	Trustee Welsh Institue for Women's Health Trustee Welsh Institue for Women's Health			N/A	N/A	N/A	Private practice at Spire all the income goes into RPSF Ltd			Yes	Yes	Richard Penketh	26.01.21	Yes	Secondary form sent 11.02.21
Low	Ceri	Phillips	Independent Member of the Board	Board	Not Applicable	Board	23.09.21	Yes	No	Woodland House	4366771	Yes	No	N/A	No	No	N/A	No	No	N/A	N/A	No	N/A	N/A	No	N/A	No	Emeritus Professor at Swansea University and Honarary Professor at Cardiff University.	Sep 21-Ongoing	N/A	No	N/A	N/A	Yes	Yes	Ceri Phillips	23.09.21	ESR	
Low	Gwenda	Phillips	Clinical Psychologist	Psychology Therapies	8d	Mental Health	25.01.21	Yes	No	UHL	24850	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director in Carers Trust South East Wales	2018 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Gwenda Phillips	25.01.21	Yes	
Medium	Trevor	Pickersgill	Consultant Neurologist	Neurosciences	Consultant	Specialist Services	23.10.20	Yes	No	UHW	7971243314	ESR	N/A	N/A	N/A	N/A	N/A	N/A	I am a Chief Officer and Director of the BMA; and associated am a Director of BMA Charities and BMA Foundation for Research.			Over the last several years I have received travel bursaries/fees, conference registration sponsored by various pharmaceutical companies and occasional honoraria as follows: PHARMA REMUNERATION COI 2018: Novartis Chair symposium MS Trust - £1500 2017: Sanofi-Aventis ECTRIMS Paris travel/accom - £478.37 ECTRIMS registration - £536.36 Med Day Ad Board - £1000 Hilton Euston 2016: Roche Consultancy Cnicht climb project- £2,960; expenses £144 2015 - Teva Ad Board 2013 Biogen Ad Board Cardiff ECTRIMS 2018 Berlin no 2017 Paris yes Sanofi-Aventis 2016 London no 2015 Barcelona no 2014 Boston yes Novartis/Biogen 2013 Copenhagen no 2012 Lyon yes-Novartis 2011 Amsterdam yes - Novartis 2010 Gothenburg - no 2009 Dusseldorf yes - Biogen 2008 Montreal Yes-Merck Serono 2007 Prague Yes Merck Serono 2006 Madrid Yes Serono 2005 Thessaloniki Yes Serono 2004 Milan Yes Serono AAN 2008 Chicago - Biogen	Nothing of note for 2019-20		I am a Chief Officer and Director of the BMA; and associated am a Director of BMA Charities and BMA Foundation for Research.			N/A	N/A	N/A	I perform Private medical Practice based in Cardiff			Yes	Yes	Trevor Pickersgill	26.10.20	Yes	Secondary Work form sent 1.03.21
Low	Katie	Pink	Respiratory Consultant	Medicine	Consultant	Medicine	13.11.20	Yes	No	UHL	25088	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma management (Astra Zeneca)		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Katie Pink	13.11.20	Yes	Sponsorship Form sent 25.11.20
Low	Katie	Pink	Respiratory Consultant	Medicine	Consultant	Medicine	13.11.20	Yes	No	UHL	25088	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma management (Astra Zeneca)		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Katie Pink	13.11.20	Yes	Sponsorship Form sent 25.11.20
Low	Laura	Price	Assistant Psychologist	Neuroscience		Specialist Services	13/10/2020	Yes		Rookwood Hospital	02920 313713	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private healthcare work within ithe community	9/09/20 - ongoing	paid hourly	Yes	Yes	Laura Price	13/10/2020	Yes	
Low	Ann Marie	Procter	Consultant in Medical Genetics & Clinical Board Director	AWMGS	Consultant	Mental Health	17.11.20	Yes	No	UHL	24995	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Kaleidoscope Addictions Charity	2018	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ann Procter	17.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Michael	Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engine	6	CD&T	12/10/2020	Yes	No	Medicentre	02921 848676	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member of the catholic Medical Association Club	15/04/2018 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michal Pruski	12/10/2020	Yes	
Low	Rebekah	Pryce	Consultant Endocrinologist	Paediatric Endocrinology	Consultant	Children & Women	22.06.21	Yes	No	UHW	426965	Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Public Health Wales Clinical Lead for Congenital Hypothyroidism. Paid 6 sessions per year.	Jun 21-Ongoing	Yes	Yes	Yes	Rebekah Pryce	22.06.21	ESR	Secondary Work Form sent 18.10.21
Low	Clare	Quinn	Consultant Clinical Psychologist	Psychology and Psychological The	8d	Mental Health	18.02.22	Yes	No	UHL		Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	Feb 22 - Ongoing	Fees	Yes	Yes	ESR	18.02.22	ESR	
Low	Jessica	Quirke	Consultant Clinical Neuropsychologist	Neuroscience	8c	Specialist Services	16.11.20	Yes	No	Rookwood Hospital	02920 313748	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	2008	Salary	Yes	Yes	Jessica Quirke	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Ella	Rafferty	Consultant Clinical Psychologist	Welsh Gender Service	Consultant	Medicine	16.03.22	Yes	No	St David's Hospital		Yes	Director of Raffery Psychology Ltd (Dormant Company)	Oct 13 - Ongoing	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed private practice	2011 - ongoing		Yes	Yes	Ella Rafferty	1.02.21	Yes	Secondary form sent 12.02.21
Low	Rajeswari	Ramaraj	Consultant	Gastroenterology	Consultant	Medicine	12.03.22	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	ESR	12.03.22	ESR	
Low	John	Rees	Consultant Radiologist	Radiology	Consultant	CD&T	03.03.22	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	ESR	03.03.22	ESR	
Low	Suzanne	Rees	Lead Nurse CD&T	CD&T	8b	CD&T	11.03.22	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	ESR	11.03.22	ESR	
Low	Aled	Roberts	Clinical Board Director	Medical Consultant	Consultant	Medicine	15.03.22	Yes	Yes	UHW	42344	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	Aled Roberts	19.11.20	Yes	
Low	Gareth	Roberts	Consultant	T&O	Consultant	Surgery	18.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	2022-Ongoing	Fees	Yes	Yes	ESR	18.03.22	ESR	
Low	Stuart Ashley	Roberts	Consultant Radiologist	Radiology	Consultant	CD&T	15.11.20	Yes	No	UHW	45207	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Whilst not a Trustee of the Intubation Box Charitable Trust, I was involved developing this protective device for COVID-19 staff protection. Charity Ref ZD07662	21.04.20 - ongoing	Nil	Private Practice at Spire	1997 - Present	Fee per case payment	Yes	Yes	Stuart Ashley Roberts	15.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Zoe	Roberts	Consultant	EU Medical Rota	Consultant	Medicine	10.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reviewer HIW	2022	Expenses	Yes	Yes	ESR	10.03.22	Yes	
Low	Debbie	Roberts	Health Visitor	Flying Start	7	Children & Women	15/10/2020	Yes	No	Eastmoors Road	029 2035 1375		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Volunteer with Breastfeeding Network and Volunteer on the National Breastfeeding helpline	2004 - ongoing	Reduced study costs	N/A	N/A	/A	Yes	Yes	Debbie Roberts	15/10/2020	Yes	
Low	Angus	Robertson	Consultant in Trauma and Orthopaedics	Trauma and Orthopaedics	Consultant	Surgery	14.03.22	Yes	No	UHW	7809839881	ESR	N/A	N/A	N/A	Managing Partner Cardiff Sports Orthopaedics 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	Angus Robertson	25.01.21	Yes	Secondary work form sent 1.03.21
Low	Natalie	Robertson	Principal Physiotherapist in Mental Health	Physiotherapy		CD&T	13/10/2020	Yes	Yes	UHL	02921 824652	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Husband is Director of Operations for CD&T - Matthew Temby	01/12/2014 - Ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	Yes	Yes	Natalie Robertson	13/10/2020	Yes	
Low	Darren	Robinson	Registered Nurse	Addictions	7	Mental Health	8.01.21	Yes	No	UHW	2920744901	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trusteeship with Recovery Cymru	Jan-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Darren Robinson	8.01.21	Yes	
Low	Graham	Roblin	Consultant	Surgery	Consultant	Surgery	03.03.22	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	ESR	03.03.22	ESR	
Low	Matthew	Rodd	Senior Clinical Perfusion Scientist	Perfusion	8a	Specialist Services	03.03.22	Yes	No	UHW		ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Second Employment with Assured Perfusion Services	2022 - Ongoing	Salary	Yes	Yes	ESR	03.03.22	ESR	
Low	Sheelagh	Rogers	Dental Consultant	Orthodontics	Consultant	Surgery	17.03.22	Yes	No	UHW	42448	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Specialist Practitioner; Cathedral Orthodontics; Cathedral Road; Cardiff	Oct 20 - Ongoing	Fees	Yes	Yes	Sheelagh Rogers	24.11.20	Yes	Secondary Work Form sent 3.12.20
Low	Clare	Rowntree	Consulant Haematologist	Haematology	Consultant	Specialist Services	28.01.21	Yes	No	UHW	42033	Not Ticked	N/A		N/A	N/A	N/A	N/A	Members of previous advisory Boards for Novartis and Amgen in past 3 years		Yes	N/A	N/A	N/A	Advisory role to Leukaemia Care		No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Clare Rowntree	28.01.21	Yes	Secondary form sent 11.02.21
Low	Rachel	Rushforth	Senior Nurse Education, Quality, Safety and Patient Experience	Mental Health	Not Known	Mental Health	03.03.22	Yes	No	Hafan Y Coed	02921 824617	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Associate Lecturer at the Open University	Jan 19 - Ongoing	Salary	Yes	Yes	Rachel Rushforth	03.03.22	Yes	
Low	Joanna	Rutkowska-Wheel	Specialist Occupational Therapist	neurology		CD&T	09.12.21	Yes	No	UHW	2920746809	Yes	No	N/A	N/A	No	N/A	N/A	I received an honoraria for presenting on a MS ACADEMY: Fatigue in MS webinar sponsorde by Novartis.	22.11.21	22.11.21	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	Yes	Yes	Joann Rutkowska-Wheeldon	09.12.21	Yes	
Low	Ramsey	Sabit	Consultant Physician in General and Respiratory Medicine	Medicine	Consultant	Medicine	11.03.22	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 Gilead/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	Ramsey Sabit	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Seetal	Sall	POCT Lead	Laboratory Medcine	8a	CD&T	1.02.21	Yes	No	Ty Glas, Llanishen	45411	Yes	Yes	Jan 20 - Dec 20	None	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	S Sall	1.02.21	Yes	
Low	Caroline	Scherf	Consultant	Sexual Health	Consultant	PCIC	03.05.22	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	ESR	25.05.22	ESR	
Low	Annette	Schlaudrdaff	Consultant SRH	DoSH	Consultant	PCIC	3.02.21	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	Annette Schuaudraff	3.02.21	Yes	Sponsorship form sent 12.02.21
Low	Stefan	Schwarz	Consultant Radiologist	CD&T	Consultant	CD&T	16.11.20	Yes	No	UHW	43042	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Practising privileges at SPIRE Hospital Cardiff, I also hold a honorary position at the University of Nottingham as a 'Clinical Associate Professor' since May 2016 for which I receive honoraria.	Current	Honoraria	Yes	Yes	Stefan Schwarz	16.11.20	Yes	
Low	Jane	Scourfield	Speciality Doctor	CAMHS	Specialist	Mental Health	04.03.22	No	Yes			Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director APPERTA Foundation Charity	2019 - ongoing	No	No	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jane Scourfield	03.03.22	Yes	
Low	Prabhu	Sekaran	Consultant Paediatrician Surgeon	Child Health	Consultant	Children and Women	25.01.21	Yes	Yes	UHW		Not Ticked	Director - Novel Surgery	2019 - current	nil	N/A	N/A	N/A	Spouse shares in GlaxoSmithKine			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Prabhu Sekaran	25.01.21	Yes	Secondary Form sent 10.02.21
Low	Sagar	Shah	Specialist in Acute and Special care dentistry	Max Fax Surgery	Specialist	Surgery	10.03.22	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	ESR	10.03.22	ESR	
Low	Nimish	Shah	GP MHSOP	MHSOP	GP	Mental Health	25.01.21	Yes	No	UHL		Yes	Director Dr Nimish Shah Ltd	2016 - ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Nimish Shah	25.01.21	Yes	Secondary Form sent 10.02.21
Low	Swaroop	Shanbhag	Consultant Spinal Rehabilitation	Neurosciences	Consultant	Sepcialist Services	30.01.21	Yes	No	UHW	33800	Not Ticked	Abergavenny Hand Surgery Ltd - Director Partner - 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	Swaroop Shanbhag	30.01.21	Yes	
Low	Aarti	Sharma	Consultant	Obs & Gynae	Consultant	Children and Women	28.01.21	Yes	No	UHW	43758	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spire Hospital	Feb-18	Payment for seeing patients	Yes	Yes	Aarti Sharma	28.01.21	Yes	Secondary form sent 12.02.21
Low	Jacqueline	Sharp	Physio Manager		8c	CD&T	07.03.22	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	ESR	07.03.22	ESR	
Low	Andrew	Sharp	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	11.04.22	Yes	No	UHW	2921847089	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	Andrew Sharp	14.12.20	Yes	Secondary form sent 5.1.20
Low	Timothy	Sheppard	Locum Consultant O&G	Obs & Gynae	Consultant	Children & Women	16.11.20	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Discussion and offer of employment in BPAS (not yet accepted, pending job planning)	2020	Sessional	203 Field Hospital, Army Reserve	1998 - Ongoing	Sessional / Daily Rate	Yes	Yes	Timothy Sheppard	14.11.20	Yes	Secondary Work Form sent 26.11.20

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	Hamsaraj	Shetty	Consultant Physician	Medicine Stroke	Consultant	Medicine	17.03.22	Yes	No	UHW	43837	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have received honoraria for GP lectures sponsored by Bayer on 7th October, 2020 and 28th January 2021) & from Portola/Alexion Pharmaceuticals for being a member of Delphi panel	6.10.20 - Ongoi	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Hamsaraj Shetty	25.01.21	Yes	Secondary Form sent 9.02.21
Low	Somashekara	Shivashankar	Consultant Psychiatrist	Adult Mental Health	Consultant	Mental Health	26.11.20	Yes	No	CRI	20335555	Yes	Director of a Limited company but have no actual or perceived conflict with the Health Board Spouse is also a Director of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019		Part ownership of a limited company but have no actual or perceived conflict with the Health Board Spouse is also a part owner of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Yes	Yes	Somashekara Shivashankar	26.11.20	Yes	
Low	Anju	Sinha	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children and Women	26.01.21	Yes	No	UHW	43238	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Cardiff Hospital	Ongoing	consultant fees charged	Yes	Yes	Anju Sinha	26.01.21	Yes	Secondary form sent 11.02.21
Low	Philip	Smith	Consultant Neurologist	Neuroscience	Consultant	Specialist Services	13.11.20	Yes	No	UHW	0292074 2834	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Co-Editor of BMJ journal, Practical Neurology (2011–present)	2011 - present	Honorarium	1. Chair of NICE Guidelines Panel on Heart Valve Disease 2. Member of NICE Guidelines Panel on Epilepsy	2019 - 2021	Nil	Member of GMC Tests of Competence Panel	2018 - present	ad hoc payment for specific tasks	Yes	Yes	Philip Smith	13.11.20	Yes	Secondary Work Form sent 25.11.20
Low	Alex	Speakman	PN Pharmacist	Pharmacy		CD&T	09/10/2020	Yes	No	UHW	02920 748109	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Offer of sponsorship to ESPEN nutrition conference from B.Braun, travel and conference fees, this was declined.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alex Speakman	09/10/2020	Yes	
Low	Sarah	Spencer	Deputy Head of Midwifery	Obs & Gynae	8b	Children & Women	4.12.20	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	Huntleigh Healthcare	2-14 - ongoing	£1,000	Yes	Yes	Sarah Spencer	4.12.20	Yes	Secondary form sent 2.12.20
Low	Pushplata	Srivastava	Speciality Doctor	Dermatology	Specialist	Medicine	21.03.22	Yes	Yes	UHW	2921845024	Yes	Cutis Consulting Ltd	Mar 19 - Ongoing	Dividends	Cutis Consulting Ltd	Mar 19 - Ongoing	Dividends	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Clinical Lecturer Cardiff University 1 day per week	Apr 18 - Ongoing	Salary	Yes	Yes	Pushplata Srivastava	21.03.22	Yes	
Low	Mark	Stacey	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	16.11.20	Yes	No	UHL	2920716860	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board member of the Association of Anaesthetics	Oct 20 - Oct 24	Nil	No	N/A	N/A	I run a course called Medtrim - I occasionally run private courses	2017 - current	Yes	Yes	Yes	Mark Stacey	16.11.20	Yes	Secondary Work form sent 26.11.20
Low	Michael	Stechman	Consultant Surgeon	General Surgery	Consultant	Surgery	13.11.20	Yes	Yes	UHW		Yes	Director of KVMS Medical, Private Medical Practice Company Director of KVMS Medical, Private Medical Practice Company	June 2019 - present June 2019 - present	Dividends Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of the British Association of Endocrine and Thyroid Surgeons	October 2018 - Present	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michael Stechman	23.11.20	Yes	
Low	Michael	Stephens	Consultant Nephrologist	National Organ Retreival Service	Consultant	Specialist Services	04.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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	ESR	04.03.22	ESR	
Low	Emyr	Stephens	Prescribing Advisor	Pharmacy	8a	PCIC	25.01.21	Yes	No	Woodland House	36176	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I attended a Health Service Journal (HSJ) award dinner in London in Feb '20, as a project that I (and other C&V colleagues) was involved with was shortlisted for an award. This was in the category of 'Partnership working with the Industry', and so the company (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	Emyr Stephens	25.01.21	Yes	Secondary and Sponsorship forms sent 25.02.21
Low	Lawrence	Sunder Raj	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	25.01.21	Yes	Yes	UHW	44879	Yes	Yes Spouse Yes	6.01.19 - 18.02.20 18.02.20	Directors salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Cardiff Bay Hospital	N/A	N/A	Yes	Yes	Lawrence Sunder Raj	25.01.21	Yes	Secondary Form sent 10.02.21
Low	Gillian	Swift	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	04.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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	ESR	04.03.22	ESR	
Low	Indu	Thakur	Consultant Paediatric Oncologist	Child Health	Consultant	Children and Women	2.11.20	Yes	No	UHW	7533167483	ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I was given a sponsorship place on a Haematology update conference by Novartis amounting to registration and stay costs of £268.20		Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Indu Thakur	2.11.20	Yes	Sponsorship form sent 1.03.21
Low	Abraham David	Theron	Consultant Anaesthetist, CD Perioperative Care	Anaesthetics	Consultant	Surgery	13.11.20	Yes	No	UHW	43256	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	As Chair of the Royal College of Anaesthetist Welsh Advisory Board I am a co-opted member of college council. I am also Vice Chair of the Academy of Medical Royal Colleges of Wales.	N/A	N/A	Executive Member of the Welsh Medical Committee. Part od the clinical reference group of the National Clinical Framework.	N/A	N/A	I have co-edited the Oxford Handbook of Obstetric Anaesthetsia for Oxford University Press. Royalties for this book is to be donated to SAFE Africa.	N/A	N/A	Yes	Yes	Abrie Theron	13.11.20	Yes	
Low	Lena	Thia	Consultant in Paediatric Respiratory Medicine	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43530	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honorarium for speaking to nurses on asthma sponsored by AstraZeneca. Honorarium for speaking at two webinars sponsored by Vertex	13.02.20 - 1.10.20	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Lena Thia	13.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Benny	Thomas	Consultant Neurophysiologist	Neuroscience	Consultant	CD&T	27.01.21	Yes	No		46690	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private Practice	2002 - Present	Reimbursement of fees	Yes	Yes		25.01.21	Yes	Secondary Employment Form and Policy sent 28.01.21
Low	Christopher	Thomas	Consultant Physician	Clinical Gerontology	Consultant	Medicine	25.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Previous sponsorship to attend international conferences and honoraria for teaching from pharmaceutical agencies (BIAL, GSK, Abbvie, Britannia) on various occasions between 2009 and 2019. I also sat on expert advisory panel for GSK for one day in approx 2012.	2009 - 2019	Honori & Sponsorship	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Christopher Thomas	25.01.21	Yes	
Low	David Hywel	Thomas	Consultant Histopathologist	Histopathology	Consultant	CD&T	01.12.20	Yes	No	UHW	45316	Yes	Co-director of company to provide autopsy service for HM Coroner My wife is a co-director of the company	March 20 - ongoing March 20 - ongoing	payment from HM Coroner per autopsy salary from company	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Thomas	1.12.20	Yes	Secondary Work Form sent 3.12.20
Low	Gareth	Thomas	Consultant in Gastroenterology	Gastroenterology	Consultant	Medicine		Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Underake 1 session private work per week in uncontracted time	2001 - current		Yes	Yes	Gareth Thomas		Yes	Secondary Work Form sent 25.11.20
Low	Mary Annette	Thomas	Director Weqas	Weqas	8d	CD&T	17.12.20	Yes	No	Llanishen	48332	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Becton Dickinson - European Advisory Board member for Point of Care. Provided Advice and attended meetings. Invited Speaker at Siemens Healthineers meeting in Bangkok in 2019 and Brussels Oct 2018. Invited speaker at Nova Biomedical User Group meetings in Manchester and London November 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	Mary Thomas	17.12.20	Yes	Secondary form sent 6.1.20
Low	Matthew	Thomas	Consultant Restorative Dentistry	Dental	Consultant	Surgery	26.11.20	Yes	No	UHW	42519	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	West Coast Dental Care - Self employed private practice	ongoing		Yes	Yes	Matthew Thomas	26.11.20`	Yes	Secondary Work form sent 4.12.20
Low	Nerys	Thomas	Radiographer	Radiology	8b	CD&T	03.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PHW Ultrasound Adviser. 10 sessions per annum paid to radiology dept. No personal financial gain		none	Yes	Yes	ESR	03.03.22	ESR	
Low	Rhian	Thomas	Independent Member of the Board	Executive / Corporate		Executive / Corporate	28.01.21	Yes	No	Woodland House		Yes	N/A	N/A	N/A	Owner of consultancy business	01.03.19 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Glas Cymru Cyf (Welsh Water) Co-opted Board Director of Cardiff & Vale Credit Union	01.10.19 - present 15.05.20 - present	Voluntary Voluntary	Senior Lecturer - University of South Wales	04.05.20 - ongoing		Yes	Yes	Rhian Thomas	28.01.21	Yes	
Low	Rhian	Thomas-Turner	Clinical Research Facility Manager	Paeds Clinical Research	8a	Children and Women	11.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Office holder at MHRA - Paediatric Medicines Expert Committee	Ongoing	Expenses	Yes	Yes	ESR	11.03.22	ESR	
Low	Andrew	Thompson	Psychologist	Whit Psychology Training	9	Mental Health	13.03.22	Yes	No			Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Trustee for the charity Changing Faces, also member of research board for The Vitiligo Society. Occasional spokesperson for The British Psychological Society, The British Skin Foundation, The British Association of Dermatologists. All are unpaid occasional activities	Oct 20 - Ongoing	Nil	No	N/A	Nil	Occassional clinical psychology private practice (registered with HMRC as a sole trader) - medico-legal reports, invited talks/workshops, occassional psychological therapy	Oct 20 - Ongoing	Yes	Yes	Yes	Andrew Thompson	02.10.20	ESR	
Medium	Clare	Tibbatts	Consultant	Gastroenterology	Consultant	Medicine	03.03.22	Yes	No	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	I have several grants from pharma to fund IBD improvement projects (Takeda, Abbvie, Johnson&Johnson).	Ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Registered with several locum agencies. Including Remedy that currently provide weekend insourcing at UHW.								
Medium	Jared	Torkington	Consultant	General Surgery	Consultant	Surgery	12.11.20	Yes	Yes	UHW	44158	Yes	Director - Moondance Cancer Initiative Wife is a director of Cardiff Medical Events Ltd- a company that organises meeetings and conferences	2020 - 2019 -	N/A	N/A	N/A	N/A	Shareholding in Alessi Surgical Instruments - spinout from Cardiff University. Also act as a chair of medical advisory board.	2015 -	N/A	Consultancy to a trial management team from Medtronic Ltd for scientific study	2020	Consultancy	Medical Advisory Board Bowel Cancer UK Charity	2017 -	N/A	N/A	N/A	N/A	Private Practice at Spire	current	Salary	Yes	Yes	Jared Torkington	12.11.20	Yes	Secondary Form sent 26.01.21
Low	Ryan	Trickett	Consultant	T&O	Consultant	Surgery	24.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice - Vale Hand Surgery Ltd	2022-Ongoing	Fee	Yes	Yes	ESR	24.03.22	ESR	
Low	Ryan	Trickett	Consultant Head Surgeon	T&O	Consultant	Surgery	12.11.20	Yes	Yes	UHL	25234		Director: Vale Hand Surgery (Private Practice) & Dragon Locums Spouse - Director: Vale Hand Surgery & Cardiff NHS GP Partner		salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member BSSH, BOA, BMA Spouse: Member BMA, RCGP	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ryan Trickett	12.11.20	Yes	
Low	David	Tuthill	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes		UHW	46725	Yes	Director Cardiff Paediatrics Partner: Director Cardiff Paediatrics	ongoing ongoing	Dividends	N/A	N/A	N/A	I am chair of the Paediatric formulary committee of the BNF. I have advised the company AI Immune on Palforzia.	2021	Fee paid	Organiser of the South Wales Paediatric Allergy Forum (in Cardiff) - aannually over the last 10 years. This meeting has been sponsored by a variety of pharmaceutical companies	2012 - Ongoing	N/A	I am a boiard member of Medicines for Children	2008-Onwards	Nil	Cub Scout Leader	2008-Onwards	N/A	N/A	N/A	N/A	Yes	Yes	David Tuthill	05.03.22	Yes	
Low	Jonathon	Underwood	Consultant Physician	Infectious Diseases	Consultant	Medicine	17.05.22	Yes	No	UHW	2921842184	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Previously received payment for serving on advisory board, providing educational material (without editorial oversight) for Gilead Sciences, ViiV Healthcare and Celltrion.	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	Yes	Yes	Jonathon Underwood	17.05.22	Yes	
Low	John	Union	Independent Member of the Board	Executives / Corporate	Executive	Executive	23.02.21	Yes	No	Woodland House		Yes	NED, Swansea Building Society Ignious Ltd (Subsidiary of Cadwyn Housing) Cardiff Business Club Ltd	1.11.17 - ongoing 1.1.20 - ongoing 1.1.20 - ongoing	Salary No salary No salary	John Union Ltd	1.4.16 - ongoing	No Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board Member/Vice Chair Cadwyn Housing Ltd Board member, Cambria Cudfuddiannol Ltd (Will step down shortly)	1.1.20 - ongoing 1.1.10 - ongoing	No salary No Salary	N/A	N/A	N/A	Yes	Yes	John Union	23.02.21	Yes	
Low	Stephen	Usher	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Consultant	Surgery	16.03.22	Yes	No	UHW	2920743107	Yes	No	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private Practice at Spire Hospitals	Mar 22 - Ongoing	Fees	Yes	Yes	Stephen Usher	16.03.22	Yes	
Low	Judith	Van der Voort	Consulant Paediatrician	Paeds Nephrology	Consultant	Children and Women	09.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Support and consultancy to Chiesi (Pharm Company) who are preparing a submission to the Welsh medication group for inclusion of the medication to NHS Wales.	2022	£1700 in total	Yes	Yes	ESR	09.03.22	ESR	
Low	Vinod	Varghese	Consultant Clinical Geneticist	AWMGS	Consultant	AWMGS	7.12.20	Yes	Yes	UHW	43976	Yes	One of the directors of a ltd complany - Apps4Medics Ltd. Not linked to NHS or Cardiff & Vale UHB	11.01.2011 - ongoing Spouse - 11.01.21	Both have shares	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Vinod Varghese	7.12.20	Yes	
Low	Andrew	Vidgen	Consultant Psychologist	Mental Health	8c	Mental Health	15.04.20	Yes	No	Whitchurch Hospital	2921832610	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	private medico-legal work. Approximately 1.5 sessions / month outside normal working hours. Undertaken in Gwent area	Apr-17		Yes	Yes	Andrew Vidgen	12.11.20	Yes	
Low	Andrew	Vidgen	Consultant Clinical Psychologist	Applied Psychology	8d	Mental Health	04.03.22	Yes	No			Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private medico-legal work. Approx 1.5 sessions mper month. Undertaken in Gwent area.	2022 - Ongoing	Fees	Yes	Yes	Andrew Vidgen	08.03.22	ESR	
Low	Karen	Visser	Professional UHB Lead for Speech & Language	Community Child Health	8c	Children and Women	17.11.20	Yes	No	Riverside Health Centre	029 2183 6585	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Community Music Wales	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Karen Visser	17.11.20	Yes	Secondary form sent 5.1.20
Low	Ulrich	Von Oppell	Consultant Cardiac Surgeon	Cardiac Services	Consultant	Specialist Services	16.11.20	Yes	No	UHW	45078	Yes	Director - U & C Von Uppell Ltd	Mar-10	Private Practice	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ulrich Von Oppell	16.11.20	Yes	
Low	Amar	Wahid	Consultant Paeds Gastroenterology	Paediatric Gastroenterology	Consultant	Children and Women	26.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Secretary for Private Practice	November - ongoing November - ongoing	Salary Salary	Yes	Yes	Anwar Wahid	26.01.21	Yes	Secondary form sent 11.02.21
Low	Fiona	Walker	Head of Prescribing	Cardiff North and West Locality	8c	PCIC	12.11.20	Yes	No	Woodland House	7812554527	ESR	N/A	N/A	N/A	N/A	N/A	N/A	I am a NICE Medicines and Prescribing Associate. This is a role that does not attract a salary or any payment. I am standing down from this role at the end of 2020.		Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	Yes	Fiona Walker	12.11.20	Yes	
Low	Ruth	Walker	Executive Nurse Director	Executive	VSM	Executive	15.04.22	Yes	No	Woodland House	36006	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member of the Nursing and Midwifery Council	2016 - ongoing	salary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ruth Walker	13.11.20	Yes	Secondary Work Form sent 25.11.20
Medium	Stuart	Walker	Executive Medical Director	Executive	VSM	Executive	30.09.20	Yes	Yes	UHW	2921836001	Yes	Sister - Gilead employee, Father ILC CEO (both healthcare companies we may have relationships with)	N/A	risk of direct influence				see above re. sister/father - Gilead and ILC are pharma companies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	N/A	N/A	N	Yes	Yes	Stuart Walker	30.09.20	Yes	
Low	Mark	Wardle	Consultant Neurologist	Neurology	Consultant	Specialist Services	09.11.21	Yes	No	UHW	44016	Yes	ELDRIX	21.05.14 - ongoing	Company Director-Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Wardle	09.11.21	Yes	
Low	Jonathon	Watts	Senior Manager	Strategic Planning	8c	Executive	10.03.22	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	Committee member of Whitchurch Hockey Club which has an interest in purchasing the land that C&VUHB 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	ESR	10.03.22	ESR	
Low	Peter	Welsh	Senior Hospital General Manager Llandough/Barry	Executives / Corporate	VSM	Executive	10.03.22	Yes	Yes	UHL	20715698	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	Magistrate - Cardiff Bench	1989 - ongoing	N/A	N/A	N/A	N/A	Wife - Optician for Roberts Opticians Whitchurch Road, Cardiff Son has own web design business	1985 - ongoing 2014 - ongoing		Yes	Yes	Peter Welsh	17.11.20	Yes	
Low	Richard	White	Consultant Radiologist	Radiology	Consultant	CD&T	05.05.22	Yes	No	UHW		Yes	Director of White Imaging Services Ltd	2022-Ongoing	Dividends	As per (a)	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	Consultant Radiologist with 4 Ways Healthcare Ltd	2020-Ongoing	Fees	Yes	Yes	ESR	12.05.22	ESR	
Low	Simon	White	Consultant Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	12.11.20	Yes	No	UHW	48044	Yes	Director, Simon P White Ltd	2008 - Present	Nil	N/A	N/A	N/A	Educational contract with Zimmer Biomet	2018 - present	Paid to lecture in annual leave	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Simon Paul White	12.11.20	Yes	
Low	Kathrin	Whitehouse	Consultant Neurosurgeon	Neurosurgery	Consultant	Specialist Services	01.10.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member for British Neurological Surgeons	N/A	N/A	N/A	N/A	N/A	Neurosurgical Tutor for online MSc with Learna LTD	Jan 22-Ongoing	Fees	Yes	Yes	ESR	01.10.21	ESR	
Low	Rebecca	Whiticar	C onsultant Physician	EU Medical Rota	Consultant	Medicine	17.03.22	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work 1 PA per week as Medical Examiner for NWSSP, Medico-legal consultant (Medical Protection), Expert Witness Emergency Medicine.	2022 - Ongoing	Fees	Yes	Yes	ESR	17.03.22	ESR	
Low	Joy	Whitlock	Head of Quality and Safety Improvement	Patient Safety and Quality Improver	8b	Corporate Nursing	23.11.20	Yes	No	Woodland House	36311	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sole trader of Joy Whitlock Coaching and Business Development www.joywhitlock.co.uk . Since I work part time for the UHB there will not be conflict with NHS duties. I'm declaring this, however, in the name of transparency.	2016 - ongoing	Hourly fee as work arises. Mostly pro bono	Yes	Yes	Joy Whitlock	23.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Richard	Whitson	Consultant Vascular Surgeon	General Surgery		Surgery	14/10/2020	Yes	No	UHW	Ext 43356	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Haven Homecare	2010 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Whiston	14/10/2020	Yes	
Low	Lauren	Whittington	Clinical Psychologist	CAMHS	8+	Children and Women	3.12.20	Yes	No	St David's Hospital	36730	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I currently work 1 session a week for Oxford Health NHS Foundation Trust as a clinical psychologist	27.11.20 - current	Salary as sessional worker	Yes	Yes	Laura Whittington	3.12.20	Yes	Secondary Employmet Form and Policy sent 3.02.21
Low	Melanie	Wilkey	Deputy Director of Commissioning	Commissioning	8d	Corporate Executives	07.03.22	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	Part time lecturer University of South Wales	2021 - Ongoing	Hourly rate	Yes	Yes	ESR	07.03.22	ESR	
Low	Simon	Wilkins	Associate Editor Pharmacist	Therapeutics & Toxicology	8b	CD&T	1.02.21	Yes	No	UHL	26868	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secondment (0.4FTE) to, and employment (0.2FTE) by, Cardiff University School of Medicine as a Senior Lecturer and Programme Director of two MSc programmes.	2006	Salary	Yes	Yes	Simon Wilkins	1.02.21	Yes	Secondary form sent 12.02.21
Low	Ian	Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital		Children & Women	08/10/2020	Yes	No	St David's Hospital	2920536789	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Tutoring with the Open University - Nursing	01/10/2020	Salary	Yes	Yes	Ian Williams	01/10/2020	Yes	
Low	Matthew Gareth (Matt)	Williams	Nurse Manager	OOH Primary Care	8a	PCIC	27.04.22	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	Occasional pitch side medical cover for Cardiff City Football Club - employed by Lubas Medical	2020 - Ongoing	Fees	Yes	Yes	ESR	27.04.22	ESR	
Low	Paul	Williams	Principal Clinical Scientist	Therapies and Health Science	8b	CD&T	3.02.21	Yes	No	UHW	42010	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	25.10.20 - 31.10.20	One off payment	Yes	Yes	Paul Williams	3.02.21	Yes	Secondary form sent 12.02.21
Low	Claire	Wilson	Consultant Clinical Psychologist	Neuropsychology	8c	Specialist Services	13.09.21	Yes	No	UHW	029 2074 3224	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am a partner at Positive Neuro Rehab. I work as a	Sep 21 - Ongoing	Yes	Yes	Yes	Claire Willson	13.09.21	ESR	Secondary Employment Form sent 18.10.21
Low	Justyna	Witczak	Consultant Physician	Medicine	Consultant	Medicine	12.11.20	Yes	No	UHW	42341	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes. I received travel grants and honoraria for talks	Nov 19 -	Travel grants/honoraria for	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Justyna Witczak	12.11.20	Yes	
Low	Joon	Wong	Specialty Doctor in Paediatric Cardiology	Child Health	8+	Children & Women	13.11.20	Yes	No	Childrens Hospital for wales	02920 744743	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Employed by Independent General Practice Cardiff on ad hoc basis (no more than 6 to 8 times per year) to do Children Heart Screening Day on behalf of the Welsh charity organisaion Welsh Hearts	Oct 2017 - ongoing (but haven't done a session since October 2019	Fees	Yes	Yes	Joon Wong	13.11.20	Yes	
Low	Andrew	Wood	Consultant	Radiology	Consultant	CD&T	11.03.22	Yes	Yes	UHW	3955	Yes	N/A	N/A	N/A	Wife has a private garden design business (Eileen Garden Landscapes): currently working on the 'Orchard' project at Llandough	2008	Ongoing	N/A	N/A	N/A	Occassional Lecturing Honoraria	Last date 2016	Fees	Treasurer - Heart Research Fund Wales	2000 - Ongoing	N/A	N/A	N/A	N/A	Private Medico-Legal Cases	Current	Fees	Yes	Yes	D Andrew M Wood	12.11.20	Yes	
Low	Karen	Wright	Clinical Endoscopist	Gastroenterology		Medicine	16.03.22	Yes	No	UHL	2921926688	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Agency work in off duty time for an insourcing company	2020 - Ongoing	payments	Yes	Yes	Karen Wright	16.03.22	Yes	
Low	Meinolfus	Wulf	Consultant Anaethesia	Perioperative Care / Anaesthetics	Consultant	Surgery	1.02.21	Yes	No	UHL	26660	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Research Cooperation (History of Technology): Draeger Company, Luebeck, Germany & Wood Library Museum, Schaumburg, ILL., USA	2001/2015 - ongoing	No	Occasional sponsorship of conference and travel expenses	2001 - ongoing	nil recent	N/A	N/A	N/A	Welsh Medical Committee (Member)	2018 - 2021	No	N/A	N/A	N/A	Yes	Yes	Meinofus Tratling	1.02.21	Yes	
Medium	Zaheer	Yousef	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	10.03.22	Yes	No	UHW	42972	Yes	ZY Consultant Ltd - Director	31.07.19 - ongoing	Shareholder: ad hoc dividend payments (nil to date)	N/A	N/A	N/A	Minority shareholder in Spire Healthcare	Ongoing	Twice yearly dividends	Competitive grants awarded and received by Medtronic, Novo, Novartis to support local service development and travel expenses	2019-Ongoing	Nil personal (Grants held in UHB accounts)	Chairman: Heart Research Wales and Medical Director Pace4Life	2015 - ongoing	No financial gain	N/A	N/A	N/A	1) Private practice: clinics and interventional procedures within NHS scope of practice at Spire and Cardiff Bay Hospitals. 2) cardiac assessments for elite athletes. 3) Lecture fees, advisory board activities and ad hoc consultancies for device & pharma industries	2005 - ongoing	Yes	Yes	Yes	Zaheer Yousef	18.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Abbas	Zaidi	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.03.22	Yes	No	UHW	42972	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 - Spire Hosp	2022 - ongoing	Fees	Yes	Yes	ESR	15.03.22	ESR	
Low	Syeda	Zatman	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	25.01.21	Yes	No	UHW	43106	Yes	Brockweir Clinic Ltd	Apr-19	Nil	Brockweir Clinic Ltd	Apr-19	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tahsin Zatman	25.01.21	Yes	

Report Title:	Internal Audit Recommendation Tracker Report				Agenda Item no.	7.7
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	05.07.2022
			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 and 2021/22.

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 84 individual recommendations to 91 during the period April 2022 to July 2022. The change can 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 have been removed from the Tracker to be monitored offline. At the time of reporting all 16 advisory recommendations remain recorded as partially complete);
- A further 37 entries have been added to the tracker since April 2022.

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

1. Surgery Clinical Board Medical Finance Governance Follow-up Final (1 entry, recorded as complete)
2. Deprivation of Liberty Safeguards Final (4 entries recorded as complete)
3. Charitable Funds Final (3 entries)
4. PCIC Business Continuity Final (4 entries)
5. Wellbeing at Maelfa (4 entries recorded as complete)
6. Verification of Dialysis Sessions (3 completed entries
7. Raising Staff Concerns Final Report (5 entries – 3 of which are recorded as complete)
8. IT Service Management Final Report (8 entries – 2 of which are recorded as complete)
9. Delivery of Mental Health Services – Advisory Final Report (5 entries)

It should be noted that the historic Audit recommendations at entries 1 to 5 above were added retrospectively as confirmed and agreed at the April Committee meeting.

The following Audits (and associated recommendations) shared at the May meeting of the Committee meeting will be added to the Tracker at the September Committee meeting:

- COVID 19 Vaccination Programme (Phase 3) Final Report
- Health & Safety Final Report
- Wellbeing Hub at Maelfa Final Report
- Development of Genomics Partnership Wales Final Report
- Network and Information Systems (NIS) Directive Final Report
- Welsh Risk Pool Claims Final Report
- Nurse Rostering Children's Hospital for Wales, Children and Women's CB Final Report
- Nurse Bank Final Report

Advisory Reports

As confirmed above, the Advisory IM&T Control and Risk Assessment Audit has been removed from the Tracker shared with the Committee to be tracked offline.

The Advisory Delivery of Mental Health Services Report has been added to the Tracker for noting on at this Committee meeting. The 5 advisory recommendations from this report will also be removed from the Tracker prior to the September Committee meeting, with implementation of recommendations tracked offline.

Moving forward all Advisory reports and recommendations will initially reported to and noted by the Committee and subsequently tracked offline. Following the removal of Advisory recommendations from the Tracker regular progress updates will be shared to establish whether best practice suggestions have been implemented.

Of the 91 recommendations listed within the Tracker, 25 are recorded as completed, 56 are listed as partially complete and 10 are listed as having no action taken or reported since the April 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 (April 2022). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

It should be noted that the narrative at Column J (Management Response/Executive Update) of the attached tracker are the updates provided for this meeting. Where no update has been shared for an individual entry this is confirmed within narrative 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	7	12	7	3	27

Attached at Appendix 2 are summary tables which provide an update on the April 2022 position as of the 23/06/2022.

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 April 2022.

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

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

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

Prevention		Long term		Integration		Collaboration	x	Involvement	

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

Risk: Yes/No
N/A
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A

Mohamed Shah 06/07/2022 13:17:46

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 February 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	01/07/2020	Medical Staff Study Leave - Reasonable	R1/6	Medium	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: - roles and responsibilities – of Directorates, Managers, Consultants; - funding and budget guidance. - monitoring and compliance arrangements including KPIs; and - reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	Executive Director of People and Culture	Executive Director of Workforce and OD & Medical Director	PC	Draft Procedure is still with the BMA. The BMA unfortunately did not meet the required deadline of the 7th Jan 2022, although they have assured us that the document will tabled at LNC in March 2022. Therfore will not be presented to the Strategy and Delivery Committee in March 2022 as previously indicated. Meeting between BMA and Medical Director's team re-scheduled for June 2022.
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.
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. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R2/5	Medium	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R3/5	Medium	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet. 2. Correct and improve accessibility of documents. Review publishing process to ensure documents are circulated through correct location in internet and/or intranet sites. 3. A combined EHIA should be completed for all policies or where a Health Impact Assessment is not required this should be clearly stated. 4. The Corporate Governance Department should ensure the integrity of the 'Register', by reviewing accuracy of all key information.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022. The updated draft Management of Policies, Procedures and Other Written Control Documents Policy is scheduled to go to Board for approval in July 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R4/5	Low	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R5/5	Low	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	N/A	Pre-employment Checks	R10/10	Low	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.	Executive Director of People and Culture	Executive Director of People and Culture	C	Work current taking place, led by the Workforce Resourcing team to review and update all of our Trac adverts and associated documentation

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2020-21	31/12/2020	Management of Serious Incidents	R3/6	Medium	Management should ensure that all outstanding actions are completed.	Executive Nurse Director	Assistant Director Patient Safety and Quality	C	Nationally reportable incident previously known as Serious Incidents are managed using the closure forms which should be completed by the Clinical Boards and submitted to the Asst. Director of Patient Experience to sign off. The NRI (Nationally reported Incident) policy has been implemented. Clinical Boards are regularly advised of the closure forms required through a robust monitoring process. The closure forms are quality checked through the Head of Patient Safety and/or Assistant Director prior to submission to the Delivery Unit. From 14th June 2021 the reporting of and management of Serious Incidents changed. They are now called NRIs (Nationally Reportable Incidents) and some categories which had previously been reported asd an SI are no longer considered an NRI (example is adolescent in an adult setting and unexpected death in the community of a Mental Health patient). NHS Organisations now have longer to fact find before reporting (now 7 days from date of incident/knowledge of incident). NHS Organisations are now able to determine the level of and timeframe for investigation (which was previously the remit of the DU). Dependant on the findings of the investigation, one of 3 closure forms will be submitted dependant on whether there were any causative or contributory factors identified through the investigation process. The Head of Patient Safety and the Patient Safety Facilitators meet regularly with the Clinical Board Directors of Nursing to review progress and actions against the open and overdue NRIs to improve closure timeframes. we have in place a robust tracking system for NRI's and we have reformatted the NRI meetings to address clear terms of reference. immediate learning and mitigation and promote early contact with families and those affected.
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.
2020-21	31/03/2021	Consultant Job Planning 2nd Follow-up	R4/4	Medium	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	Executive Medical Director	Kirsten Mansfield, Senior Medical Systems Advisor	C	The Allocate e-job planning system has been purchased and continues to be rolled out across the UHB. **Update Oct 2021** - As of 1st October 2021 54% of the Consultant and SAS grades have a job plan on the system. We are currently also working at aligning them to an annualised Job Plan cycle where all job plans will start from 1st April 2022 and will be reviewed yearly from then on. **Update Dec 21** - We now have 74% of job plans held in the system. Engagement is excellent and Job plan meetings are taking place accross the board despite winter pressures and Covid. The plans are moving through the sign off process and we hope to reach our target of 85% compliance by April 1st. This allows for long term sickness and maternity leave. Engagement has been our biggest challenge with many feeling that the timing of implementation was ideal Regardless of this we have seen a significant increase in engement and are moving closer to our target. **Update Mar 22** - 81% of job plans held in the Allocate, almost reaching our target of 85% by April. Concentration is now on getting them fully signed off and a plan for departments moving forward to ensure all consultants have a vaild job plan as of 1st April each year. **Update Jun 22** - 83.5% of job plans now in Allocate. Still working towards all plans being signed off and renewed/updated each year. Final push from MD to follow shortly.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R1/5	Medium	Management should continue as planned to finalise the review of the Data Quality Policy (UHB 298) (to reflect the General Data Protection Regulation framework), and the Data Quality Procedure (UHB 288). Once finalised, formal approval of the documents should be sought from the Board.	Interim Chief Operating Officer	Director of Digital and Health Intelligence September 2021	PC	The Data Quality policy is complete but not yet reviewed. It will be completed and taken through the relevant committee for approval by end of Qtr4 21/22.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R5/5	Low	Management should consider implementing an issues log to capture discrepancies in the data and help identify any negative trends.	Interim Chief Operating Officer	Cancer Services Lead Manager, 30 September 2021	C	•There are daily huddles between the service improvement manager, cancer tracking supervisor and trackers. This allows for 2-way feedback – issues noted from both management and tracking sides. This has been in place since Dec 21. •Monthly validation on the data for completeness, this also picks up discrepancies and common issues identified are then fed back into the daily huddles. •Weekly meetings using the PTL snapshot data with the services is also used to flag potential issues in the data. •A 'housekeeping' document is updated based on feedback and findings from various sources such as month end validation, tracking meetings, etc. In addition SOPs for individual tumour sites are being pulled together. •Business Analyst attends the weekly Cancer Services Management meeting as an IT contact for Cancer Tracking Module (CTM).

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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.
2020-21	15/12/2021	Rostering in Community Children's Nursing Service	R4/7	Low	The CCNS Memorandum of Understanding: Home Based Continuing Care Packages should be updated, approved by senior management at both departmental and Clinical Board level for dissemination to parents / guardians as soon as is practicable so as to formalise mutual arrangements between the UHB and parent(s)/carers of children under the department's care.	Interim Chief Operating Officer	Paula Davies, Lead Nurse Alison Davies, Senior Nurse 15th December 2021	PC	MOU is with the legal team and awaiting clarification on a recent clinical issue. Once returned it will be sent out to families with a covering letter and opportunity to discuss with the management team via a telephone or virtual meeting. The memorandum is a comprehensive parental agreement that sets out the role and expectations of the UHB and parents working together in partnership.
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.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	UHB will work with South Glamorgan CHC to review and update internal practical guide to engagement and associated processes. However, first step is to review the Local Framework for Engagement and Consultation on Changes to Health Services agreed between UHB and CHC in 2018, as this underpins the advice provided in the practical guide. Local Framework reviewed and updated internally by December 2021, including provision of advice from Corporate Goverance. Sharing for discussion with CHC delayed pending outcome of mediation on a disuputed service change, in which Local Framework is material. Once agreed, internal practical guide and associated suite of resources which have also been reviewed and updated, will be issued internally.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R2/5	Medium	In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	Director of Planning	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle	PC	Importance of timely completion of CHC Service Change Proforma for discussion with CHC when service change proposals are being developed will be reinforced with Clinical Boards; consideration given to building it into IMTP templates. Service Change Proforma has been reviewed and updated, pending discussion and agreement with the CHC. It forms a part of the Local Framework that has been reviewed as above and will be reissued to Clinical Boards once agreed between the UHB and CHC. Note decision to delay discussion with CHC pending outcome of mediation described in section 52

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2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R5/5	Low	In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, has been reviewed and updated to include stakeholder mapping advice based on current best practice. Once the actions in section 52 on Local Framework have been completed, the Practical Guide and suporting resources will be re-issued to Clinical Boards and put on the UHB intranet.
2021-22	22/06/2021	Cancellation of Outpatient Clinics Follow-up Mental Health CB	R1/5	Low	Clarification of the approving forum and next review date should be added to the written procedure for the Cancellation of Outpatient Clinics.	Interim Chief Operating Officer	Clinical Board Director	PC	Document to be formatted to usual UHB standard, with version control, date, authorising body.
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 goone to all Clinical Board to sensure roles are in place 2. Delay in implementation as USCGG membership and ToRs had first to be agreed. 3. None 4. Report to Exec QSE June 2022
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
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
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

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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
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.
2021-22	30.04.2022	Clinical Audit	R6/9	Medium	In conjunction with recommendation 2, the Clinical Audit Policy and underpinning procedure should detail the process for Clinical Boards to produce local Clinical Audit Plans. All Clinical Audit Plans should be made available to the Clinical Audit Team so that they are sighted on all local clinical audits that are being undertaken.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy, strategy and purchase of AMaT will transform the way in which tier 2 local audits are registered and monitored and will allow centralisation of clinical audit plans and reports, improving accessibility and ownership to clinicians for their audits and improvement plans and for Clinical board to have ability to track progress. The Clinical Audit Policy and Strategy will detail roles and responsibilities with a clearly defined process for staff to follow and refer to. Training will be provided and aligned with the policy and strategy for clinical audit. Completion of this action is dependent on the timing and level of investment in response to the business case. **5/1/21** Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness. It is difficult to progress this work without investment in the team and IT manangment system to establish the approach that will be taken. Long term sickness and clinical audit team having to prioritise National Mandatory audits has also had an impact
2021-22	30.04.2022	Clinical Audit	R7/9	Medium	In conjunction with recommendation 2, the mandate to complete a 'Clinical Audit Project Proposal Form' for all tier 2 and 3 audits, which are to be forwarded to the Clinical Audit Team, should be directed by Clinical Audit Policy and Procedures.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy and strategy will include mandated guidance for the proposal, authorisation and registration of Tier 2 and 3 clinical audits aligned with the Health Board information Governance arrangements This action is dependent of the timing and level of investment in response to the business case. 5/1/21 Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness. It is 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.

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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.
2021-22	30.10.2021	Clinical Audit	R9/9	Low	Whilst the remit of the Clinical Effectiveness Committee is developing and embedding, consideration should be given to the good practice sighted in another Health Board, and the potential remit of the Committee to consider pertinent risks that they have the ability to challenge and support.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	Outlier status is a standard item on the Clinical Effectiveness Committee meeting agenda, outliers would remain on the agenda and actions updated until issues resolved. Clinical Leads and/or clinical boards are invited to attend CEC to discuss risks when identified, including any improvement plans and obstacles in place Implementation of a risk register has been added to the agenda for October Clinical meeting for consideration. 5/1/21 To be discussed in January CEC due to CEC meetings capacity
2021-22	31.03.2022	Five Steps to Safer Surgery	R1/7	High	Mechanisms need to be established that enable the Health Board to record Step One (Briefing) and Step Five (Debriefing) of Five Steps to Safer Surgery. Whilst considering options, attention should be given to the ability to report on quantitative data from Theatreman to identify areas of concern with steps two through to four.	Executive Medical Director	IT Service Manager and Interim Lead Nurse	PC	The Perioperative Care Directorate has worked in collaboration with Trisoft (The Manufacturer of TheatreMan, our Theatre Operating system within Cardiff & Vale UHB) to develop a mechanism for recording all 5 stages of the '5 Steps to Safer Surgery' electronically. This development will allow for quantitative data collection. All stages of the '5 Steps to Safer Surgery' will be compulsory. Prior to full implementation, the Theatre Informatics Team will need to undertake a period of testing to confirm that the correct pathways are active. The Perioperative Care Directorate will also need to ensure staff are aware of the change in process and provide any necessary training. Update :12/1/22 Trisoft have placed the questionnaires into other test environment and are awaiting our instruction to place into live. A help guide has been written but reports have not yet been explored due to the development not being attached to the current live system.
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

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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
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.

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2021-22	31.03.2022	Core Financial Systems	R2/2	Low	A review of controls should be undertaken to ensure all leavers of the Health Board have their user access to the Oracle system removed in a timely manner, particularly those outside of central finance.	Director of Finance	Director of Finance	PC	Agree to review controls and implement more robust process to ensure all leavers have access removed in timely manner
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R1/4	High	Peri-operative Care should continue as planned to complete and seek approval of a Health Board Theatre Utilisation Procedure, in addition to a Policy. In doing so, the following should be incorporated: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; - Clarity of roles and responsibilities, including but not limited to the distinction between Peri operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). Additionally, historical information which is no longer valid should be fully removed from the Intranet to avoid confusion and incorrect action occurring.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	The Peri-Operative Care Directorate 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. 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. 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; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). These policies/procedures will be available on the Health Board's intranet pages. The Policy and procedure will be found under the policies section within the Peri Operative Care Directorate web site. All old policies relating to theatre scheduling, utilisation and systems and processes in relation to these will be removed from Cardiff and Vale UHB intranet pages.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R2/4	Medium	In conjunction with recommendation 1, which will provide clarity of roles and responsibilities mandated by procedure, all specialties should be reminded of their responsibility to close down their theatre sessions (at the end of each session), so that the information recorded is complete and accurate to enhance utilisation intelligence.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	The policy on Operating Theatre Scheduling, Cancellation and Utilisation 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.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R3/4	Medium	The current systems and processes for managing theatre utilisation should be enhanced, to ensure that utilisation is maximised, cognisant of the risks faced by the Health Board. The policy and procedure developed as part of Recommendation 1 should reflect the enhanced systems and processes to help ensure they are consistently applied.	Interim Chief Operating Officer	Lead Nurse Peri-operative care Deputy General Manager Peri Operative Care General Manager Peri-Operative Care Head of Operations Surgery Clinical Board	C	Completed - The 'Operating Theatre Scheduling, Cancellation and Utilisation' Procedure/Policy fully details what systems should be used to ensure theatre utilisation is maximised. Four Eyes Insight Ltd continue to meet with all SCB specialities on a regular basis demonstrating and advising what systems should be used for them to maximise time in theatre. Posters have been developed and videos produced around the 'Golden Patient' and 6:4:2 process that have been sent to all users, displayed in theatres will soon be uploaded to the Perioperative Care Intranet Pages. A weekly 6:4:2 process SCRUM meeting takes place prior to the weekly Scheduling meetings with good representation and attendance from all SCB specialities and the scheduling meetings have been enhanced to scuitinise planned elective care two weeks in advance. A review of 'what happened the week before' also takes place. FourEyes Inslight are also working on a full suite of procedure documents, cards and workbooks that will be handed over when the project ends. These will be fully incorporated within the Perioperative Care processes once reviewed and agreed by the governance forum.

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2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R4/4	Medium	The current systems and processes for managing theatre utilisation should be enhanced, to ensure that utilisation is maximised, cognisant of the risks faced by the Health Board. The policy and procedure developed as part of Recommendation 1 should reflect the enhanced systems and processes to help ensure they are consistently applied.	Interim Chief Operating Officer	General Manager Peri-operative Care	C	Opportunities to maximise theatre resources will be achieved through the following actions: • Increase the workforce within the Peri-Operative Care directorate to ensure that there is sufficient amount of staff to work in the theatres. **07/06/2022** - this is ongoing, staffing contraints are the main concern • Work with Specialist Services Clinical Board to ensure that the PACU service provision is increased **07/06/2022** - PACU can be flexed up if demand increases significantly but staffing contraints are the main concern • Work with Theatre IT to ensure that theatre overview reports are sent to appropriate teams. **07/06/2022** - Completed • Theatre overview is discussed with Theatre Managers and General Manger and Lead Nurse for Peri-Operative Care at their regular 2:1 meetings • Theatre overviews is discussed at Theatre scheduling meetings with each individual directorates • If utilisation falls below the agreed performance rate this is escalated to the appropriate Clinical Board. • Engagement with partner (FourEyes Ltd) to adopt best practise following GIRFT recommendations continues • Directorates will not be given extra sessions if their utilisation is below the agreed performance rate continuously and is due to reasons within their control. • Theatre performance reports are sent to Pre-assessment General Manager so that any issues of poor performance due to pre-assessment issues can be addressed. • The associate Clinical Director for Peri-Operative Care works closely with the deputy General Manager for Peri-Operative care to ensure theatre lists are fully booked and utilised. The Deputy General Manager discusses this at the theatre scheduling meetings with the Directorates. • Theatre performance and utilisation and the action points above have been written into the policy on Operating Theatre Scheduling, Cancellation and Utilisation
2021-22	31.03.2022	Retention of Staff	R3/5	Medium	The available resources to deliver the Nurse Retention Action Plan and associated workstreams requires review, to determine if current capacity will facilitate effective delivery of the plan and improve nurse retention, if it is a Health Board priority.	Executive Director of People and Culture	Director of Nursing Strategic Nursing Workforce & Assistant Director of Workforce Resourcing	PC	The Nurse Retention Steering Group has now started to meet and a comprehensive nurse retention framework with a number of themes and actions has been developed, however progress has been slowed down due to the operational pressures Actions: • Steering Group meets monthly, these meetings need to have minutes and actions captured. • Workstream Leads will update the Retention Action Plan with key objectives, timescales, progress, etc. • Progress with the plan will be reported into the monthly meetings with the Executive Director of People & Culture in accordance with the theme 'Attract, Recruitment & Retain'.
2021-22	31.03.2022	Retention of Staff	R5/5	Medium	Consideration should be given to mandating the Leavers' checklists through Health Board approved procedures, to minimise the risks to the Health Board.	Executive Director of People and Culture	Assistant Director of Workforce Resourcing	C	Incorporate the leavers checklist into a 'Leavers Toolkit' accessible for managers and staff. The Toolkit will also include the exit questionnaire process, details on completing a termination form, etc.
2021-22	30.04.2022	Welsh Language Standards	R1/6	Medium	The Equality Strategy and Welsh Language Standards Group should reconsider the approach to the cascade of actions to Clinical Boards and Corporate Departments, to ensure implementation and compliance with the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Office & Assistant Director of OD	NA	Clinical Boards and Corporate Departments will be supported to develop individual action plans. These areas will then maintain responsibility to develop, own and report upon progress at the ESWLSG meetings. Action plan templates are currently being drafted
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	NA	Undertake a demand, capacity and resource review. Report initial findings to ESWLSG to shape recommendations / actions.
2021-22	28.02.2022	Welsh Language Standards	R4/6	Medium	The Equality Strategy and Welsh Language Standards Group should consider if they have appropriate capacity to provide effective oversight of the implementation of the Welsh Language Standards, and how they may wish to be further supported to ensure implementation of the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Officer Equality Manager ESWSLG Chair	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	15.03.2022	Welsh Language Standards	R5/6	Medium	To ensure complete implementation of Welsh Language Standard 79, the Welsh Language Policy (UHB 462) should be published and available to staff. A review of the Policy would benefit from: - Further signposting to supporting procedures and written control documents; and - The supporting documents should also be clearly dated, also noting the date of next review and the link to the Welsh Language Policy.	Executive Director of People and Culture	Welsh Language Officer Equality Manager Assistant Director of OD	C	Policy approved by Board

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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	A dashboard to reflect recommendations is currently in the early stages of development and will be hosted via Sharepoint. It will be presented to ESWLSG for comment / agreement.
2019-20	31.03.2019	Surgery CB Medical Finance Governance Follow-up Final	R1/6	High	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	Interim Chief Operating Officer	Directorate General Surgery & Clinical Director	C	Theatre sessions reviewed on a weekly basis by the specialty manager for General Surgery. Improve annual leave data base has been developed for General Surgery which includes reason for absence. Robust annual leave database, all consultants using intrepid to request leave. Joint job planning meeting is scheduled for the end of August, at which discussions will be held in relation to backfilling. The Directorate have seen improvements in terms of backfilling. All job plans uploaded to Allocate, 60% Colorectal Consultants Job planned, all colorectal consultants to work to an annualised timetable utilising 50 weeks of the year. Directorate team monitoring activity and theatre utilisation.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R1/4	High	Staff should attempt to ensure that all Urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	Executive Nurse Director	TBC	C	**update 10/06/2022. WG Phase 1 funding bid successful recruiting to 2 x BIA and the target is all assessments will be completed within 7 days in prpeparation for implementation of LPS.** All attempts are made to ensure the DoLs assessments are carried out within the specified timeframes, however this remains a challenge with the current resource. Only 1.5 wte (out of 6 wte) staff are funded by health with the remaining staff funded by LA. This means that resource is shared between LA assessments also. This position will be reviewed in 2020 with introduction of LPS.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R2/4	Medium	The Health Board should ensure that staff are provided with appropriate DoLS training and where areas have low compliance these areas should be targeted.	Executive Nurse Director	TBC	C	**Update 10/6/2022.LPS training in preparation for LPS will commence when WG release training framework and resources. MCA training is in place across UHB and will be supported by recruitmnet of 2 xBIA** DoLs training has remained challenging, as it is directly related to the ability of clinical areas to release staff. The inability to release staff for Mandatory and Statutory training remains high on the UHB risk register. Formal monthly training continues to be supported by staff, although attendance poor. Bespoke training (one hour) drop in sessions are now being provided. Training is also incorporated into the general Safeguarding Training to continue to raise awareness of DoLs, however these results are captured in the safeguarding training numbers and not a formal record of DoLs training.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R3/4	Low	Staff should attempt to ensure that all Standard and Further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	Executive Nurse Director	TBC	C	**Update 10/6/2022 WG Phase 1 funding bid successful recruiting to 2 xBIA the target is all assessments will be completed within the 21 stipulated time frames in prpeparation for implmentation of LPS.**All assessments that are deemed as a priority have to be undertaken before the Standard and further assessments as outlined in line with WG priority tool.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R4/4	Low	The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice.	Executive Nurse Director	TBC	C	**update 10/06/2022 The Code of practice consultation was released May 2022, delay due to Covid 19, the UHB has an implmentation plan for phase 1. Which is in line with WG LPS implementation plan** The Whilst LPS will come into force in October 2020, we are unable to formulate a plan without the implementation of the code. Scoping meeting planned for 12th December 2019 to develop framework and code and produce work plan across wales for 2020.
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	NA	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	NA	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.

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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	NA	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.
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.
2019-20	Nov-19	Wellbeing at Maelfa	R1/4	Low	The PEP should be updated accordingly and resonate with other supporting documentation (i.e. terms of reference) (O).	Director of Planning	Director of Capital, Estates & Facilities	C	Accepted. The PEP will be updated accordingly.
2019-20	Nov-19	Wellbeing at Maelfa	R2/4	Low	As the project gains momentum, Project Board and Project Team members should be reminded of the importance of attendance to ensure all discussions / decisions taken are suitably informed.	Director of Planning	Director of Capital, Estates & Facilities	C	Good attendance at project teams and the terms of reference has recently been reviewed, updated and endorsed by the project team
2019-20	Nov-19	Wellbeing at Maelfa	R3/4	Low	Work stream leads should produce resource/ activity plans for the attention of the Project Team/ Board (O)	Director of Planning	Director of Capital, Estates & Facilities	C	Progress is reported at each project team
2019-20	Oct-19	Wellbeing at Maelfa	R4/4	Medium	Arrangements should be made to ensure the correct section of the contract is signed by both parties (O)	Director of Planning	Director of Capital, Estates & Facilities	C	All contracts are in place
2021-22	1.05.2022	Verification of Dialysis Sessions	R1/3	Low	Management should review the desk instruction, 'How to Reconcile Dialysis Session Invoices against electronic data received in VitalData' with a view to expanding many of the steps detailed, for clarity on what action to take, where to access and save key documentation.	Interim Chief Operating Officer	Renal Systems Analysts	C	The Renal Systems Analysts have carefully considered the Matters Arising 1 and will incorporate, expand, and add clarification to the information in "How to Reconcile Dialysis Session Invoices against electronic data received in VitalData " document based on the Audit observations. The document will be reviewed 'live' when performing reconciliation exercises for Feb and Mar session data, in Mar and Apr respectively. Update 15/06/2022: More detail included with screenshots, it is now clear what action to take and guidance on what to access and where. See Version 1.4

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2021-22	1.04.2022	Verification of Dialysis Sessions	R2/3	Medium	Management should ensure that all documentation / evidence that supports the monthly verification process for the provision of dialysis sessions is accessible to all members of the team, either through greater use of the department's shared drive or use of a team email account. With reference to Recommendation 1, management should also consider this recommendation when updating the instruction to support the verification exercise.	Interim Chief Operating Officer	Renal Systems Analysts	C	When considering the matter of lack of visibility or accessibility of information, which informs the verification process, there are 3 core areas of the process that we will review. They are: (1) Excel outputs - generating the raw data, creating a table for analyses to reconcile day-to-day comparison plus the re-runs of the output, (currently observed as held on Analysts' H:/ drive) (2) Word docs - the monthly activity queries to the six SE Wales Dialysis Units (currently created and E-mailed from Analysts' E-mail account) (3) Master workbook - the evolving Performance Monitor table (currently available on the Dept shared drive) [Note: all of the above is accessible and readily available from the source Renal Information System (VitalData) and can be extracted by running pre-defined code] With regard to (1), the raw data and any outputs will be visible on the Master workbook in addition to the Performance Monitor table – both available to view on the Dept shared drive. Update 15/06/2022: Processes reviewed. All of the above documents are accessible to the team as required; i.e. the Raw and Word (error) docs are together in a new shared drive folder structure [ref (1) and (2)] and the Master workbook (3), is a on a separate shared area for access by Finance and N&T staff, but in a controlled way
2021-22	1.04.2022	Verification of Dialysis Sessions	R3/3	Low	Management should consider enhancing the details recorded on confirmation orders raised within Oracle to pay invoices for dialysis sessions provided. Consideration should be given to adding the following information: • Invoice Number; • The relevant month sessions were provided; and • Number of sessions delivered.	Interim Chief Operating Officer	Renal Systems Analysts	c	Please note there is one Braun / Fresenius invoice per unit, per row in Oracle in relation to the number of sessions that have been delivered. Procurement have provided templates for each dialysis unit, e.g. "Invoice payment for renal dialysis unit services at Cardiff South". Once the row is selected, then the Invoice Number is evident. We can add to this narrative and continue to include the month and now introduce the number of sessions delivered, which is exactly what we would instruct payment for. Update 15/06/2022: All changes and additions to Oracle orders implemented; i.e. if an Oracle user selects the ISP and Unit they will see the Invoice Number, Month and No. of sessions
2021-22	Immediately	Raising Staff Concerns (Whistleblowing)	R1/5	Low	For future reference, sub-committees should receive a copy of the procedure they are being asked to formally adopt.	Director of Corporate Governance	Head of Corporate Governance	C	Agreed - This was an isolated occurrence as procedures and policies are usually attached to papers where they are referred to. This will be monitored continuously moving forward.
2021-22	31.03.2022	Raising Staff Concerns (Whistleblowing)	R2/5	Medium	The Risk and Regulation Team should consider making the 'Standard Operating Procedure for Managing Concerns from Staff' visible to all staff via the Health Board website (as previous), with hyperlinks to the 'All-Wales Procedure for NHS Staff to Raise Concerns'.	Director of Corporate Governance	Head of Risk and Regulation	C	Complete - The SOP is now available online at the following link: https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/general-health-and-wellbeing-resources/freedom-to-speak-up/responding-to-a-concern/files/managing-concerns-sop-english/
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	PC	Agreed – The Freedom to Speak up Campaign was relaunched via internal and external communications channels the week commencing 07/02/2022. Regular biannual updates will continue to be issued in conjunction with the Health Boards communications team. The next update will be circulated during the summer of 2022 following which it is proposed that this recommendation be reported as complete.
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.
2021-22	31.05.2022	Raising Staff Concerns (Whistleblowing)	R5/5	Medium	In accordance with the All-Wales Procedure for NHS Staff to Raise Concerns, the executive lead for the Procedure, in conjunction with the Director of Corporate Governance should determine the appropriate reporting arrangements to the Board or sub-committee.	Director of Corporate Governance	Executive Director of People and Culture and Director of Corporate Governance	C	Agreed - This will be reported into the Strategy and Delivery Committee on a Bi Annual Basis as part of the Workforce report

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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)	R4/8	High	4.1a A formal process to ensure call activity is maintained should be established, and completed calls should be closed appropriately.	Director of Digital & Health Intelligence	Head of Digital Operations	C	4.1a June 2022 Update: A new single digital portal for staff to create, view and close incidents and service desks has been created. Accurate ISM and call metrics are beginning to be available. Calls and requests for staff automatically close after four requests have been ignored. Cases which have not been progressed within a timely fashion are reported automatically and flagged. Staff have clear visibility of their case progression via the portal.
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.
2021-22	30.09.2022	IT Service Management (ITIL)	R8/8	Medium	8.1a Service management should consider defining a standard mechanism and process for operational knowledge management.	Director of Digital & Health Intelligence	Head of Digital Operations	C	8.1a - June 2022 Update: FAQ and Knowledge articles are starting to be populated within the new ISM system.

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2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R1/5	Not rated	Looking ahead, the Mental Health Clinical Board should attempt to maintain the data collection tool as a 'live' document, as a means of holding a concise and accurate overview of services, which can inform future planning of services.	Interim Chief Operating Officer		PC	Share the Tool with Directorate Teams and any intra-Clinical Board teams to ensure full coverage. Add risk rating to consolidate tool and ensure there is consistency and easy access to raise any service risks to Clinical Board level if they meet the threshold. Yearly review and use of tool in Performance Reviews to ensure risks are being addressed. Ensure the templates are available on the S Drive for collation, addition and historical reference.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R2/5	Not rated	Management should utilise the information collated through this review to inform an update of the Health Board's Mental Health webpages, to better inform members of the public of the services offered to support mental health.	Interim Chief Operating Officer		PC	Pathway Mapping work in relation to 111 'Press 2' is currently being undertaken. This should be in concert with Comms team and the National 111 groups to ensure simple, accessible routes to urgent care are unified.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R3/5	Not rated	Management should consider the means of responding to, and addressing the issues highlighted through the data collection exercise. This may involve consideration of: • Quick wins which can be addressed at speed; • To seek support from the Health Board's IM&T Service and Digital Health and Care Wales; • The physical location of teams if IT issues cannot be resolved; • The impact on staff wellbeing when IT equipment is prohibiting efficient and effective working, at a time of heightened demand; • Alternative ways of working resulting from the impact of the pandemic; • The barriers prohibiting solutions and how these might be addressed; and • If the issues cannot be addressed within the Clinical Board, how these might be escalated within the Health Board.	Interim Chief Operating Officer		PC	Review of S Drive Risk Registers and ensuring that all Directorate Risk Registers are available for review. Any risk that cannot be adequately mitigated to be escalated to Clinical Board. Support required from Corporate Governance to rate, escalate and provide external view on mitigation.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R4/5	Not rated	The Mental Health Clinical Board would benefit from reviewing their risk management arrangements, particularly the Clinical Board and Directorate risk registers, and the mechanisms of escalation associated with the risks. The Clinical Board may wish to seek support from the Risk and Regulation Team to undertake the review.	Interim Chief Operating Officer		PC	Escalation of key priority areas to Management Executive through work with Director of Service Planning and Director of Digital Transformation
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R5/5	Not rated	The risk and challenges identified in this review should be further explored for solutions, to consider how to further address the gaps in controls or assurance and whether these may look inwardly within the Health Board or externally to partners for support.	Interim Chief Operating Officer		PC	Internally, support from Corporate Governance will be requested. Corporate Governance Team are already providing some support around the Corporate Risk Register.

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2020-21	30/06/2021	IM&T Control and Risk Assessment	R1/18	Not Rated	An IG Forum should be established for the IG leads from each clinical board to meet to discuss issues and to coordinate IG matters across the Health Board at an operational level.	Director of Digital & Health Intelligence	IG Manager by 30 June 2021	PC	We agree with the recommendation; the intention is for IG issues to be picked up at Clinical Board Q&S briefings but this will require additional capacity to ensure that the IG function is able to support the Clinical. This function is supplemented by the monthly IG Sub Group which meets to discuss operational IG issues. Representation from CB as required.
2020-21	31/05/2021	IM&T Control and Risk Assessment	R2/18	Not Rated	The revised governance framework for IM&T / digital should be implemented to ensure that there is a holistic structure for the organisation, with participation from Clinical Boards. Where control over aspects of IM&T has devolved to departments, the assurance flows to the DHIC should be clarified to ensure the committee can maintain oversight over the whole organisation.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence 31 May 2021	PC	Jan 2022 Update: The Digital Service Management Board, to include Clinical Board representation, was re-established to meet on a quarterly basis, from 27 May 2021 onwards. As part of the DSMB function, alignment of those services incorporating informatics and ICT services that sit outside D&HI directorate are mapped and included for oversight at UHB level.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R3/18	Not Rated	A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence 31 July 2021	PC	Jan 2022 Update: A register of compliance for all IM&T related legislation and standard is under development to support the NIS Directive and data security standards, which will be implemented through the Head of Digital Operations.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R4/18	Not Rated	Management should consider providing an annual report that identifies risks that have a low likelihood but have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise. Management Response	Director of Digital & Health Intelligence	Director of D&HI 30 September 2021	PC	The D&HI directorate risk register is shared with the D&HI Committee at each meeting. An annual report to capture the low risk high impact risks will be produced and shared at the committee and with the Management Executive team.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R5/18	Not Rated	The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	Director of Digital & Health Intelligence	Head of IG and Cyber 31 Oct 2021	PC	The risk identification process to support the event and problem management process will be developed for inclusion as part of the management or risk assurance documentation. Jan 2022 Update: IT support staff have successfully completed the ITIL foundation course and are developing the incident and problem management procedure during Q4 21/22.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R7/18	Not Rated	Departmentally managed systems should comply with good practice for the management of digital. The D&HI Directorate should produce good practice guidance documentation for the health board overall as leaders of the digital services provision, with all departments required to comply for areas such as change control.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The D&HI directorate will produce updated good practice guidance documentation, based on ITIL and industry standards, for dissemination across all IM&T functions across the UHB. Jan 2022 Update: using the new IT helped desk tool. Ivanti, Standard Operating Procedures have been developed, linked to ITIL processes, being implemented in Q1 22/23
2020-21	30/09/2021	IM&T Control and Risk Assessment	R8/18	Not Rated	A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The D&HI directorate will undertake a complete baseline assessment against the digital maturity standards (HIMMS) to assist in determining the current position and help inform the digital strategy roadmap. This will be presented at D&HI committee.

2020-21	30/09/2021	IM&T Control and Risk Assessment	R9/18	Not Rated	The roadmap should be fully defined in order to help deliver the Digital Strategy.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The current roadmap has been produced to align with the channel programme boards; a more detailed roadmap to include resources and dependencies will be developed for approval at D&HI committee. Jan 2022 Update: an overhaul of the digital strategy and supporting roadmap is in progress, supporting the emerging UWH2 requirements (SOFH), to be completed by 31/03/22
2020-21	30/09/2021	IM&T Control and Risk Assessment	R10/18	Not Rated	The Strategy should be available on the Health Board website, and flagged, with a communication plan to push awareness with all stakeholders	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	The digital strategy is available as a public document and is accessible via the UHB's website. A communication plan for internal consumption is being developed. Jan 2022 Update: the refreshed digital strategy will be submitted to Board in March 2022.
2020-21	31/08/2021	IM&T Control and Risk Assessment	R11/18	Not Rated	The D&HI Directorate budget should be set to reflect the actual need of the organisation. The capital expenditure budget should be reviewed with the intent to providing a stable funding position to allow for delivery of the digital strategy.	Director of Digital & Health Intelligence	Director of D&HI 31 Aug 2021	PC	A Case for Investment has been produced and shared with the Management Executive team which sets out the capital and revenue requirements for the life of the digital strategy (2020-2025). Discussions on affordability and potential sources of funding are taking place with executive management. Decisions on funding are expected to be made during the second quarter of 2021/22
2020-21	30/09/2021	IM&T Control and Risk Assessment	R12/18	Not Rated	A full assessment of the current skills within the directorate, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	All staff within the D&HI directorate are expected to complete the PADR and objective setting process, which will identify current training and development needs. These will be compared with the known and expected requirements to deliver the digital strategy and will form the annual plan of training and development.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R13/18	Not Rated	A formal cyber security workplan should be developed. This should be based on a formal assessment of the current position of the health board and define the actions needed to improve the position.	Director of Digital & Health Intelligence	Head of IG and Cyber 31 Oct 2021	PC	A full cyber security work-plan, including NIS directive requirements will be completed as soon as the cyber team is in place. Jan 2022 Update: The UHB has completed the Cyber Assessment Framework (CAF) benchmarking exercise as part of the implementation of the NIS Regulation. It will work through the recommendations once received in Q4 21/22. Update June 2022. Recommendations following CAF received. Cyber team in the process of recruitment following successful BCAG application for additional cyber resource.
2020-21	30/06/2021	IM&T Control and Risk Assessment	R14/18	Not Rated	The national cyber security training should be mandated for all staff.	Director of Digital & Health Intelligence	Director of D&HI 30 June 2021	PC	Accepted. The national cyber resilience unit at Welsh Government has been approached for assistance in producing the training plan for staff across the UHB. Jan 2022 Update: a pilot phishing exercise successfully completed in Dec 21 and will be scaled up across the UHB in Q4 21/22.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R15/18	Not Rated	Formal reporting on cyber security should be established, along with a suite of cyber security KPIs in order to show the status of cyber security and the progress of the team in managing issues.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	A formal report on cyber security will form part of the suite of documents to be shared regularly at the D&HI committee. Jan 2022 Update: an update on cyber security work is to be taken to private meeting of DHIC in February 2022. Update June 2022. A cyber security update is a DHIC (private)standing agenda item.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R16/18	Not Rated	Consideration should be given to developing a single register of assets and their configuration status for the Health Board. This should include a process for identifying critical assets and ensuring regular assessment of the need for replacement of these.	Director of Digital & Health Intelligence	Head of Digital Operations, Russell Kent 30 Sept 2021	PC	Jan 2022 Update - The new Service Management solution within CAVUHB Ivanti Helpdesk contains an Asset Management Module. This will be used to collate IT Assets throughout the organisation. - Technical implementation commences Jan 2022. Update June 2022: the new Ivanti tool has gone live and asset management module in use

2020-21	30/09/2021	IM&T Control and Risk Assessment	R18/18	Not Rated	The organisation should develop an overarching BCP / DR process. This should: • consider all the systems and use a business impact analysis to identify the business critical systems to prioritise for recovery; • departments with devolved control should feed into this process to ensure all system have appropriate plans and that the plans do not conflict; • RTO / RPO should be agreed for each system with the key stakeholders; and • The full position should be defined and agreed with executives to ensure that they accept the position and associated risks.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	PC	Agreed. Working with colleagues in corporate planning, a full BCP/DR process will be developed and shared with Management Executive. Jan 2022 Update: additional resource procured to update and refresh existing documentation to delivery comprehensive set of processes for sign for at Management Executive - end Q4 21/22. Update June 2022: working with Emergency Planning team on-going - Director of D&HI attending GOLD command training end June

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

	Update April 2022				Update April 2022				Update April 2022			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months		2	1	1		2	4	4		6	2	2
No date set												
Total	**4**	2	1	1	**10**	2	4	**4**	**10**	6	2	**2**

Total number of recommendations outstanding as of 23rd June 2022 for financial year 2019/20 is 24 (10 of which are complete) compared to 8 outstanding recommendations noted at the April 2022 Audit and Assurance Committee Meeting. This increase can be attributed to the addition of historic entries added to the Internal Audit racker retrospectively.

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

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

Total number of recommendations outstanding as of 23nd June 2022 is 13(*) (3 of which are listed as complete) compared to the position in April 2022 when a total of 31 outstanding recommendations were noted.

* It should be noted that 16 recommendations from the IM&T Control and Risk Assessment advisory review are not included in the above table as the report was not rated. All 16 recorded entries are recorded as partially complete and are overdue by over 6 months, but less than 12 and no longer feature within the Internal Audit Tracker. These entries will continue to be tracked offline.

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

	Update April 2022				Update April 2022				Update April 2022			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached		1	2	1		1	3					
Overdue under 3 months			7				7	2		3		
Overdue by over 3 months under 6 months						7	6				4	
Overdue over 6 months under 12 months							4					
Overdue more than 12 months											1	
Total	**11**	1	9	1	**30**	8	20	2	**8**	3	5	

Total number of recommendations outstanding as of 23nd June 2022 is 54(*) (12 of which are listed as complete) compared to the position in April 2022 when a total of 45 outstanding recommendations were noted.

* It should be noted that 5 recommendations from the Arrangements to Support the Delivery of Mental Health Services advisory review are not included in the above table as the report was not rated. All 5 recorded entries will be removed from the Internal Audit Tracker following the July Audit and Assurance Committee Meeting and will continue to be tracked offline.

Report Title:	Audit Wales Recommendation Tracking Report			Agenda Item no.	7.8
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	05/07/2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Risk and Regulation Officer				

Main Report
Background and current situation:

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

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

Twenty External Audit Recommendations are recorded on the Tracker all of which have been brought forward from April's Audit and Assurance Committee ("the Committee"). No additional entries have been added since the April Committee meeting.

Of the 20 recommendations recorded on the Tracker, 3 are recorded as complete, the remaining 17 are recorded as partially complete.

The status of the recommendations are as follows:

- 3 recommendations are over 12 months overdue.
- 2 recommendations are over 6 months overdue (but less than 12).
- 5 recommendations are over three months overdue (but less than 6), two of which are reported as complete.
- 2 recommendations are less than 3 months overdue; and
- 8 recommendations remain on target to be completed within the agreed implementation date.

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

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken during the years **2019/20, 2020/21** and **2021/22** as at 23rd June 2022.

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

Recommendation:

The Committee are requested to:

(a) Note and receive assurance from the progress which has been made in relation to the completion of Audit Wales recommendations.

(b) To note the continuing development of the Audit Wales Recommendation Tracker.

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

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

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

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

Audit Wales Recommendations 2019/20 – 2021/22 (July 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	1	-	4	2	1	2	-	-	5
Audit of Financial Statement – Report Addendum - Recommendations	-	-	1	-	-	-	-	1	1
Clinical Coding Follow-up from 2014	-	-	1	-	-	-	-	1	2
Follow-up of Operating Theatres	-	-	2		-	2	-	-	2
Implementing the Wellbeing of Future Generations Act	-	-	1	-	-	-	1	-	1
Radiology Services: Update on Progress	1	-	-	1	-	-	-	-	-
Structured Assessment 2021 (Phase 2)	1	-	1	-	1	-	1	-	2
Taking Care of Carers	-	-	6	5	-	1	-	-	6
Total	**3**	**-**	**17**	**8**	**2**	**5**	**2**	**3**	**20**

From the above table it can be seen that since the last report to Committee in April 2022, there have been no recommendations added to the tracking report. The number of recommendations currently stand at 20 of which three actions are complete. There are three outstanding actions which are 1+ years overdue, two are 6+ months overdue, two are less than three months overdue and five are greater than 3 months overdue. Seven actions have not exceeded their agreed implementation date with one showing no date specified.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	Director of Digital and Health Intelligence	James Webb	PC	b)The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments Head of IG working with Medical Record's Directorate Manager to implement regular auditing function.
2019-20	Mar-20	Audit of Financial Statements Report Addendum - Recommendations	R4	4: the Phase 2 and Phase 3 continuing healthcare claims require concluding The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly.	Director of Finance	Deputy Finance Director	PC	Phase 2 – all cases completed Phase 3 – 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.

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	Mar-22	Follow-up of Operating Theatres	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	Chief Operating Officer	Ceri Chinn	PC	Good progress is being made with regular 2:1 Theatre Manager/Lead Nurse and General Manager meetings and also regular 2:1 Clinical Leader, Lead Nurse and General Manager meetings. There is also a Directorate Management meeting on a bi-weekly basis and Clinical Leaders meeting with Theatre Managers occurs on a regular basis. These meetings offer the opportunity to ensure that the Managers and Leaders within the Directorate are being supported and any issues can be discussed through a standardised agenda. Update 07/06/2022 - These meetings occur on a reqular 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. Workforce Manager appointment has been made and we are awaiting a start date. This role will ensure that the staff engagement work that is being carried out will continue and will drive not only workforce redesign but also the professional standards of the directorate. This project approach will be imnplemeted by the end of the year 2021 and progress will be monitored. Update 07/06/2022 - The Workforce Manger commenced employment on 20/12/2022. 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, good progress 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. 3) Work is progressing well to recruit additional Anaesthetic Pactitioners 4) The Workforce Manager is working closely with the Cardiology and Trauma & Orthopaedic Theatre Teams to resolve ongoing cultural and stafing behaviours. 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 07/06/2022 - The booklet has been provided to all Clinical Leaders who are in the process of completing this. This document will be discussed at each Value Based Appraisal on an annual basis and any issues addressed as appropriate.
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.
2021-22	May-22	Audit of Accounts Report Addendum - Recommendations	R1/6	The Health Board should issue its annual related party declarations to associate members	Director of Corporate Governance	Head of Risk and Regulation	C	Complete - This was be undertaken as part of year end arrangements for 2021/22.
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.
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.
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.
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.

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.
2021-22	Mar-25	Taking Care of the Carers	R2/6	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	Executive Director of People and Culture	Executive Director of People and Culture Assistant Director of Organisational Development Assistant Director of Resourcing	PC	The impact of COVID-19 on the health and care system has been immense as has the toll on our staff of simply doing their jobs in such unprecedented conditions. Even with COVID restrictions being lifted, the challenges of increasing service demand, waiting lists and financial strain continue. The People and Culture Plan sets out the actions we will take over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce. This Plan is aligned with the Operational plan; thereby ensuring a whole-system approach. The specific developments under the People and Culture Plan are reported upon monthly and have recently been documented in a flash report, demonstrating progess and outcomes in all areas over the past 6 months.
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 currently being collated in all areas where targeted interventions are being developed, to ensure an effective means of measuring impact and outcomes.
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.
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 - latest updates LNC 23/5/22 Update, discussion and feedback at Clinical Boards Bi-monthly Wellbeing Strategy Group meetings - latest update 01/06/2022 Ongoing evaluation of staff wellbeing offer, including access, impact and value - specific evaluation of OH Services currently being analysed 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 - Strategic Portfolio Steering Group 25/5/22; EQIA 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 from end of June 2022 until end of August 2022, enabling weekly 'check ins' and tempaerature checks.

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) • Five, online 'Ask the CEO / Exec etc' sessions held bi-monthly • Localised engagement aligned to specific strategic projects, e.g. Shaping our future clinical services
2021-2022	Feb-23	Radiology Services: Update on Progress	R2/7	Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff.	Chief Operating Officer	Chief Operating Officer	C	1. The current appraisal rate for non-clinical radiology staff is 88.5% at end of May 2022 2. Brought forward, a focussed plan has been implemented to bring appraisal rates above target 3. We will continue to monitor appraisal rates for all staff groups in radiology through our mothly performance review meetings 4. May 30th 2022, RMPCE performance review
2021-2022	01/01/2022 Jan 2022 Dec 2021 Dec 2021 Jan 2022 Jan 2022 Apr 2022	Structured Assessment 2021 (Phase 2)	R1/2	The Health Board has taken a number of positive steps to enhance public transparency of Board business since our 2020 structured assessment report. However, there is scope for the Health Board to strengthen public transparency further by: a. ensuring all recordings of public Board meetings are uploaded to the Health Board's website in a timely manner after each meeting, and ensuring that links to previous meetings remain active; b. making recordings of public Committee meetings available on its website or publishing unconfirmed minutes of Committee meetings as soon as possible afterwards; c. uploading all Committee papers to the Health Board's website in line with agreed timescales; d. updating the membership details of Committee on the Health Board's website as soon as changes are approved; e. listing the matters to be discussed in private by Committees on the agenda of their public meetings on an ongoing basis; f. signpost the public to Board and Committee papers and recordings of public Board meetings via the Health Board's social media channels on an ongoing basis; and g. ensuring counter-fraud and procurement papers are considered by the Audit and Assurance Committee in public, with only sensitive matters reserved for private meetings.	Director of Corporate Governance	Head of Corporate Governance	C	a. The Corporate Governance Department publish recordings of the Public Board meetings in a timely manner, typically within 2/3 days of the relevant Board meeting. The intention is to make each recording available on the website for a period of 12 months. Thereafter, copies of the recordings would be available upon request. b. As of December 2021 the Corporate Governance Team have been recording public Committee meetings and from the New Year the recordings have been published on the Health Board's website, typically within 2/3 days of the relevant meeting. There have been a couple of "teething" issues and where this has occurred a copy of the unconfirmed minutes from the relevant meeting have been published in place of a recording of the meeting in the interests of transparency. From the New Year we have "livestreamed" the public Committee meetings. c. This has now been completed and SOPs amended to ensure, that going forward, all relevant Committee papers received by the Corporate Governance Team are routinely published in line with agreed timescales (i.e. 7 clear working days before the Committee meeting). d. This has now been completed and SOPs amended to ensure that Membership details are updated, on an ongoing basis, once approved by the Board. e. Noted. This has been implemented with effect from January 2022. f. Noted. Since the New Year we have been signposting the public to our Board and Committee meetings by issuing a monthly "tweet" via the Health Board's social media platforms, in advance of the forthcoming meetings for the month concerned. g. This recommendation has been implemented since April 2022.
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.

Report Title:	Regulatory Compliance Tracking Report			Agenda Item no.	7.9
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:

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 outline, 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 30th May 2022. Since the April 2022 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

- Wales rare diseases action plan 2022 to 2026 (WHC/2022/017)
- The national influenza immunisation programme 2022 to 2023 (WHC/2022/16)
- Changes to the vaccine for the HPV immunisation programme (WHC/2022/015)
- Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023 (WHC 2022/013)
- Donation and transplantation plan 2022 to 2026 (WHC/2022/12)
- Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023 (WHC 2022/013)
- Donation and transplantation plan 2022 to 2026 (WHC/2022/12)
- NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023 (WHC/2022/002)

As of the 24.06.2022 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 Numbe	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://du.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 April 2022 Committee Meeting

Regulatory Tracker

The Regulatory Tracker attached to this report is up to date as of the 24th June 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 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 are recorded on the attached tracker.

Following April's Committee Meeting no additional entries have been added to the register in the following areas:

- **Cardiff and Vale of Glamorgan Food Hygiene Ratings**
  Three additional/new entries have been added following inspections at UHW (x2) and Barry Hospital
- **Clinical Coding**
  A new entry, which incorporates 5 recommendations, 4 of which are complete, has been added following a Clinical Coding Audit undertaken by Digital Health Care Wales.
- **Welsh Water**
  Two additional entries have been added following Welsh Water inspections at University Hospital of Wales and St David's Hospital.

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:

Clinical Board	Directorate	Regulatory body/inspector	Service area	Initial - Inspection Date:	Title of Inspection/Regulation/Standards	Lead Executive	Assurance Committee or Group	Accountable individual	Next Inspection Date	Recommendation Narrative / Inspection outcome	Date for Implementation of recommendations:	Management Response / Update	RAG Rating	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES THERAPEUTICS AND TOXICOLOGY CENTRE														
ALL WALES QUALITY ASSURANCE PHARMACY														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	27.01.2020 - 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 13.06.2022		**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	8/6/22 32 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.		**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	Aroma Units , UHW	22.02.2022	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	A Food Hygiene rating of 4 was achieved with no major contraventions.	31.03.2022	An update was shared at the April Health and Safety Committee Meeting		**C**
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 will be 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 will be 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	Of the 21 recommendations 20 are recorded as complete. The remaining action, which relates to the review of contract documents is nearing completion as the CEF team await final documents from appointed solicitors.		**PC**
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.		**PC**
COMMUNITY HEALTH COUNCIL														
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.		**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**

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 Acocuntability. 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	01.02.2023	Minor deficiencies noted	01.10.2019	Programme received formal re-accredition notice - There are ongoing discussions with the executive board regarding a new facility for BMT/Haematology as the service will not achieve re-accredition post the next inspection cycle. **No update since November 2021**		**PC**
MEDICAL GENETICS														
MHRA														
CD&T	Pharmacy	MHRA	Pharmacy UHL	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	3 majors 2 others	31.03.2020	Descalated from MHRA Inspection Action Group 1st July 2020 Outstanding Estates issues to resolve to meet requirements of the regulator		**PC**
NATURAL RESOURCES WALES														
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
RESEARCH AND DEVELOPMENT														
UKAS														
Surgery	Perioperative	UKAS	Periopeative	15.07.2021	UKAS Re-Validation	Executive Director of Therapies and Health Science	QSE Committee	Executive Director of Therapies and Health Science	TBC	2 Minor recommendations noted.	15.07.2022	Re-validation. Audit Minor 1, was for audit of audits. We should have someone independent from HSDU to audit our audits, SSU Llandough will Audit HSDU and we will audit SSU. **Update**, Llandough SSU has audited UHW HSDU. HSDU are in the process of auditing SSU Llandough. all working instuctions have been ammended for future use and audits. Minor 2, not currently registered to MHRA. **Update**, HSDU is in the application process. update, HSDU are now registered to MHRA. all evidence of both minors has been compilled and ready to be closed out at the next audit.		c
WELSH WATER														
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	20.06.2022	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	Update following reinspection awaited		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	29.06.2022	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.	29.06.2022	Update following reinspection awaited		N/A
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:	Risk Management Review					Agenda Item no.	7.10
Meeting:	Audit and Assurance Committee		Public	x		Meeting Date:	05/07/2022
			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:

Internal Audit undertook an Audit of the Health Board's Risk Management processed and procedures in March 2021 and issued an overall Reasonable Assurance rating (a copy of the Audit Report was shared at the April 2021 Audit and Assurance Committee ("the Committee") meeting).

As part of the Health Board's response to that Audit a revised Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register) were prepared and subsequently approved at the Health Board's July 2021 Board meeting. The changes to the documents did not represent a substantial re-write of the content, instead they were included to bolster the original documentation and provide evidence of the Health Board's compliance with examples of best practice such as the ISO 31000 standards relating to risk management.

Since July 2021 Risk Management processes have continued to develop within the Health Board as processes and procedures have become more embedded within the Clinical Boards and Corporate Directorates.

Internal Audit completed a further review of the Health Board's Risk Management processes in June 2022 (A copy of the Report following that review is included as agenda item 9.1(ii) for the Committee meeting at which this report is being shared). That review found that *'The Health Board has progressed with the implementation of the recommendations raised in the 2020/21 audit of risk management, improvements are noted throughout this report.'*

Whilst progress has been made against the recommendations raised in the 2020/21 review, there is scope to improve the Health Board's processes and the following additional recommendations have been made:

1) 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 **(Priority – Low)**

2) 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 **(Priority – Medium)**.

3) Continued efforts should be made to provide risk management training to risk owners, to maintain momentum of risk management maturity within the Health Board **(Priority – Low)**.

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

Whilst efforts to continually improve the Health Board's Risk Management processes will continue to be made, including putting in place arrangements to adequately respond to the above recommendations, it is not thought necessary to amend the Health Board's existing Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register).

During 2022/23 it is hoped that an All Wales Datix digital risk management software solution will be agreed which should help to strengthen the Health Board's Risk Management processes. A further update on this work will be shared in September 2022.

Recommendation:

The Board are requested to:

1) Note the contents of this Risk Management Review update;
2) Receive assurance that the Health Board's Risk Management processes and procedures have received Reasonable Assurance from Internal Audit.
3) Agree that the Health Board's Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register) do not, at the time of the Committee meeting, require updating.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people		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	x	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

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: Yes/No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: Yes/No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Workforce: Yes/No
Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Legal: Yes/No
Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)
Reputational: Yes/No
Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Socio Economic: Yes/No
The Socio Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES* *(If this has been addressed in the main body of the report, please confirm)*
Equality and Health: Yes/No
Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)* *(If this has been addressed in the main body of the report, please confirm)*
Decarbonisation: Yes/No
If appropriate, has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made. *(If this has been addressed in the main body of the report, please confirm)*

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

Mohamed,Sarah
06/07/2022 13:17:46

Report Title:	Procurement Compliance Report - Single Tender Actions				Agenda Item no.	7.11	
Meeting:	Audit Committee		Public	X	Meeting Date:	20th June 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 (7)

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
Agency Staffing	£46,337.50	N/A	2 Months	Mental Health	No Procurement involvement in engaging with supplier.	Ongoing - STA being in put for compliance going forward
Prometheus Safe and Secure	£11,566.50	N/A	Ongoing	Mental Health	No Procurement involvement in engaging with supplier.	Ongoing - Procurement requested department submit an STA form for compliance going forward
Purchase of Restoreflow	£6,775.00	N/A	2 months	Surgery and Dental	No Procurement involvement, supplier issued kit and department utilised without placing order on Oracle.	Resolved – Supplier informed of No PO, No Pay policy and department advised to raise orders as per policy.
The Music Licence - PRS and PPL	£17,755.99	N/A	1 year	Executives – Corporate	Long standing licence for retrospective invoice. No Procurement involvement in original setup.	Ongoing – outstanding debit paid, licence on workplan and discussion.
Finders Fee to Doctors Relocate	£12,000.00	N/A	1 month	Medicine	Global shortage of Doctors, however, no Procurement involvement in recruitment via this supplier.	Resolved – Doctor now on payroll.
Court Action Invoices	£5,6,000.00	N/A	N/A	Children and Women	No Procurement involvement, Finance requested payment of invoice .	Resolved – One off invoice payment.
PMS Micad System	£9,312.72	N/A	1 year	Capital Planning, Estates and Facilities	No Procurement involvement in engagement.	Resolved – Contract on workplan for any future requirement.

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

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status

Other Non-Compliant Activity (1)

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
OSN Accommodation	£6,000.00	N/A	1 month	Executives – Nursing	Urgent accommodation required	Resolved – no further action

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
Car Parking Management	£177,081.53	N/A	4 months	Capital Planning Estates and Facilities	Payment of retrospective invoice for additional cost due to the decision to provide free parking within the hospital grounds due to Covid.	Resolved – no further action

Report of Single Tender/Quotations Actions

Retrospective – (2 Return)

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

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
PCIC	Womens Aid	IRIS GP Based DVA Programme	£12,000.00	Capability with existing equipment or service
PCIC	BAWSO	IRIS GP Based DVA Programme	£12,000.00	Capability with existing equipment or service

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 (8) requests during the period the 1st April 2022 to 31st May 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
Capital Planning, Estates and Facilities	Leaseplan	ALAS Leasplan Vehicles extension	£52,769.48	Urgent Operational Requirement
C,D&T	DQD Engineering	Maintenance of Water Generation System	£26,479.60	Sole Supplier of Goods or Services
Specialist	Fysicon	Fysicon Maintenance Contract	£69,302.50	Capability with existing equipment or service
Executives	The Maltings	Provision of Off-Site Document Storage and Retrieval Services	£18,319.70	Urgent Operational Requirement
Executives	The Prince's Foundation	International Young Health Leaders Institute Launch	£18,000.00	Sole Supplier of Goods or Services
PCIC	Voice Connect	Patient Partner Virtual Receptionist Service	£20,776.08	Sole Supplier of Goods or Services
C,D&T	Blueteq Limited	Production and Development of a Pricing and Access Scheme Administration System (PASAS) for NHS Wales	£75,000.00	Sole Supplier of Goods or Services
Medicine	Inhealth	Nursing and Decontamination Staff for Endoscopy Lists within UHL	£109,200.00	Urgent Operational Requirement

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	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

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:

Mohamed,Sarah
06/07/2022 13:17:46

Report Title:	Counter Fraud Progress Report			Agenda Item no.	7.1
Meeting:	AAC	Public		Meeting Date:	05/07/2022
		Private	X		
Status *(please tick one only):*	Assurance		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 and provided in written form at AAC on 5th May 2022. This report provides an update of all the work undertaken by the CF team at CAVUHB on behalf of CAVUHB between the dates 01/04/2022 and 20/06/2022 (Quarter 1) (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 fit 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.
Any ongoing key issues

Recommendation:

The Board / Committee are requested to: 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 which in turn can negatively affect patient care
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 workforce due to financial loss; demotivation; lack of morale.
Legal: Yes
Use Statutory legislation to conduct investigations and support prosecutions
Reputational: Yes
Negative publicity resulting in negative publicity that undermines public confidence in the Health Board.
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
06/07/2022 13:17:46

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
01/04/2022 - 20/06/2022

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 from the 1st April 2022 to the 20 th June 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 20 th June 2022, 85 days of Counter Fraud work have been completed against the agreed 440 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 and attending court.

This report builds upon the interim period 1 report that was delivered to AAC on 12th May which detailed the work covered until 25th April. This report provides full progress made within the CAVUHB counter fraud team from 1st April – 20th June (Quarter 1).

The breakdown of these days is as follows:

TYPE	Days
Proactive	15
Reactive	70

2. Progress

The Annual Counter Fraud Plan, the Annual Counter Fraud Report, and the NHS Counter Fraud Authority functional return have all been completed and

approved by Director of Finance, Audit Committee, (and in the case of the functional return) the Audit Committee Chair.

Staffing

On the 1st April 2022 the new Counter Fraud Manager commenced employment with CAVUHB. This means that the Counter Fraud department now has a team of four personnel. Three are fully accredited (ACFS) the fourth member of the team has now successfully completed the ACFS course. Certification is expected in July 2022. The new Counter Fraud Manager is a fully accredited LCFS and qualified fraud investigator. This team has the responsibility to provide the Counter Fraud service for five other NHS organisations and this staffing level allows for a maximum provision of 440 days Counter Fraud work per annum to Cardiff and Vale University Health Board.

Activity

Infrastructure/Annual Plan

During this reporting period, the main focus has been placed upon developing and getting underway the implementation the Counter Fraud Plan for 2022-2023. This plan has been written and approved at executive level and is now aligned fully to the NHSCFA requirements as stipulated in Government Standard 13. The plan states proposed actions throughout the year. In tandem with any investigation work that is referred and requires action, the main focus of the team in the first quarter of the reporting period (April-June) has been to review and improve the Counter Fraud infrastructure in relation to awareness of fraud in the NHS, awareness of the Counter Fraud Team, addressing any shortcomings in relation to reporting routes and contact for staff members, and identifying the presence and status of relevant policy documents. So far this has led to the following actions been undertaken -

a. The creation and implementation of a dedicated generic email address – the aim is for this to lead an additional reporting route open to staff that will compliment existing routes; will assist in recording activity generated as a

result of awareness work; and will double as a dedicated incident reporting and logging tool which automatically collects data and allows for accurate recording of outcome metrics. ***Complete***

b. The creation of a comprehensive activity database that will assist in maintaining a detailed record of work undertaken with a view to saving resource time in relation to corporate governance. ***Complete***

c. The creation of a new, up to date, interactive and dedicated Counter Fraud enquiry form and a separate Awareness session request form. Accessible by links and QR coding. These are easily available to all staff and aim to provide an additional, more effective, and speedy route to the team that compliments the national reporting line. The enquiry form is provided below (click on following link **Counter Fraud Enquiry Form**) ***Complete***

d. 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. ***Ongoing***

e. Review of CF digital presence – Counter Fraud have very little presence within CAVUHB digitally. Enquiries and meetings with Comms Department undertaken. Agreed that a bi-monthly newsletter will be completed by the team and forwarded to comms for inclusion in staff messaging that takes place. Whilst the newsletter is a useful method of updating staff with all things fraud it acts also as an awareness tool highlighting the presence of the team, the work it does and the easy methods that staff can use to make contact. Further to this all fraud alerts, bulletins to be shared with comms team in a timely manner and distributed accordingly by them throughout relevant CAVUHB staffing cohorts. Work is underway to develop a fit for purpose Intranet Site that can be accessed by all NHS organisations that a service is provided to. At this time the intranet pages are out of date by a number of years and very difficult to find. The new site is being developed on the Share point APP of Microsoft Office 365. Further to this, discussions have been held with the Communications Department with a view to getting a regular presence on the new Staff App that is due for roll out in the next few months. This strategy aims to build and re-enforce an anti-fraud culture throughout the organisation. ***On-going***

f. Joint working protocol with Internal Audit agreed with Head of Internal Audit and regular meetings scheduled throughout the year to assist in this protocol. Two meetings held. ***Complete***

g. Review of Counter Fraud e-Learning arrangements – whilst eLearning available on ESR – as previously reported it is not a mandatory module at this time and it not very accessible. Work is underway with the LED team at CAVUHB to develop a modern fit for purpose Conter Fraud learning page on the All Wales Learning @ Wales Platform. Access has now been gained and development of this platform by the CF team is underway and it is aimed that this will be up and running early in quarter 2. When complete this will be available to all CAVUHB staff as an education, learning and awareness tool. It will be signposted internally within the organisation and the aim is that staff can access all the available resources at the click of a button. ***On-going***

h. Counter fraud awareness sessions at Corporate Induction on hold at this time whilst as corporate induction in its traditional style is not being carried out. When the learning platform above is complete and operational it is aimed that signposting through the new corporate induction process will direct staff there to appraise themselves of fraud and fraud resources within the NHS. ***Ongoing***

Alerts/Bulletins

During this reporting period, **four fraud alerts** have been issued by the CAVUHB CF team:

1. To all relevant staffing cohorts in relation to a frequent attender at Hospitals (Restricted)
2. To all relevant finance staffing cohorts in relation to mandate fraud (Appendix 1)
3. To all staff in relation to a prevalent scam in relation to Dell Computers – referred to cyber-crime team and action fraud (Appendix 2)
4. To all staff in relation to a possible ESR phishing scam (Appendix 3)

Awareness Sessions

During this reporting period one general fraud awareness session has been delivered to CAVUHB staff – Directorate of Child Health.

Further arrangements are underway to deliver sessions to staff in relation to general fraud awareness and mandate fraud.

Newsletters

During the reporting period one newsletter has been produced, published and communicated to all staffing groups. (Appendix 4)

Fraud Prevention Notices and IBURN notices

During this reporting period one FPN has been issued by the NHS CFA. This was in relation to the risks associate with Credit Card terminal fraud taking place in the NHS. The FPN content was based upon offences of this nature and type being committed in other NHS Trusts in the UK. A brief investigation was carried out. Findings of this investigation were that the organisation does operate Credit Card Terminals but the weaknesses reported in the FPN that afforded the opportunity for exploitation were not prevalent within the Health Board. Best practice support materials issued to relevant stakeholders. Assurance provided that the advice given was already being followed. Reported upon CLUE database accordingly and closed.

During this reporting period one IBURN notice has been issued in relation to an Imposter acting as a consultant Doctor providing educational services externally to NHS providers. The IBURN notice raised issues in relation to patient safety and Fraud. Investigation carried out internally with patient safety team with a negative result. Further enquiries conducted with NWSSP Accounts Payable and Supplier Maintenance teams, provided further assurance that the suspected fraudster has not supplied any services to CAVUHB. IBURN notice issued to relevant stakeholders for future reference and the investigation recorded upon Clue accordingly and closed.

Referrals/Enquiries

During this reporting period the CAVUHB CF team have received 17 referrals via the online enquiry form from CAVUHB staff. These have been wide ranging in relation to a number of areas including, staff overpayment, email phishing attacks, working elsewhere whilst sick, and suspicions re an agency application/worker. Of these referrals eight (8) have been informally resolved with no offences being disclosed and no further action being taken by the team. Five (5) referrals have been promoted to investigation and reported upon Clue with formal investigation underway (As detailed below). Four (4) referrals remain open and not promoted to investigation awaiting findings of initial assessment being undertaken by directorate/HR.

Investigations

At 1st April 2022 there were nine (9) investigations open in relation to Cardiff and Vale Health Board as detailed in the below table.

Offence	Date Opened	Status	Date Closed	Outcome/Comments
Prescription Fraud	28/05/2020	Closed	08/06/2022	Criminal Conviction
Salary overpayment	21/09/2021	Closed	24/05/2022	No offences disclosed – Financial investigation showed money not spent and was returned upon request.
Salary Overpayment	09/07/2021	Open	NA	Monies being recovered via salary and therefore NFA re theft criminally. Further concerns discovered over log on times of employee. Enquiries ongoing by HR and await findings.

Overpayment of Salary	11/01/2022	Closed	24/05/2022	Not furthered to prosecution. Civil recovery via debt collection being made. NFA by CF team.
Overpayment of Salary	11/01/2022	Open	NA	Re-Payment Plan Arranged waits confirmation.
Overpayment of Salary	24/03/2022	Closed	19/04/2022	Financial Investigation carried out. Subject contacted and monies being re-paid via a plan.
Overpayment of Salary	24/03/2022	Closed	24/05/2022	Financial Investigation carried out. Monies repaid in full. NFA by CF team
Overpayment of Salary	24/03/2022	Closed	19/04/2022	Financial Investigation carried out. Monies repaid in full. NFA by CF team
Patient living overseas and using primary care pharmacy for prescriptions	30/11/2021	Closed	20/05/2022	Full investigation carried out. Subject legitimately using primary care and secondary care. Travels abroad for further private treatment for extended periods. No issues/No offences

NOTE: A full breakdown of the salary overpayment issues that have been referred to CF within the last 12 months is underway in order provide further detail in regard of the amounts of monies recovered as a direct result of CF involvement. This will be reported when complete.

As stated above the team have promoted 5 new referrals to investigation during this period as detailed below.

Offence	Opened	Status	Closed	Outcome/Comments
Working for an agency whilst on Sick Leave	04/04/2022	Open	NA	Allegation that a nursing employee on sick leave carrying out shifts for an agency. Enquiries ongoing
Running a business whilst on Sick Leave	12/05/2022	Open	NA	Enquiries ongoing. HR and directorate conducting initial assessment.
Overpayment of Salary	12/05/2022	Open	NA	Enquiries complete. No possiblility of furthering to a criminal prosecution due to the issues involved. Referred back to HR and directorate for a decision to be made whether to request repayment of salary.
Prescription Fraud – GP staff member issuing prescriptions to self	24/05/2022	Closed	26/05/2022	Enquiries complete. No offences disclosed after investigations carried out at surgery. Information received via reporting hotline anonymously and believed malicious.

Overpayment of Salary	30/05/2022	Open	NA	Enquiries commenced and financial checks commenced

Therefore at the time of report submission (20/06/2022) there are six (6) live fraud investigations being carried out in CAVUHB.

Other

Following an enquiry raised by the primary care (pharmacy team) in relation to suspicious claiming by a community pharmacist in relation to the pilot Compensatory Claiming mechanism a formal meeting was held. No offences of fraud disclosed but 'sharp practice' suspected. Fraud proofing advice provided only. This has led to approval from Welsh Government to add a declaration to the National Electronic Claim and Audit Form (NECAF) stating

"Making a false declaration on this form may constitute a criminal offence contrary to the Fraud Act 2006 which is punishable by a maximum penalty upon conviction of 10 years imprisonment. All instances of suspected fraud will be reported to the relevant Counter Fraud Team at your Heath Board for investigation."

It is aimed that this will act in a deterrent capacity when service claims are made by community pharmacies.

Appendices

Appendix 1

Fraud Alert - Recent Mandate Fraud Risk

Appendix 2

Fraud Alert - Dell Scam Phone Call - C

Appendix 3

Fraud Alert CAV ESR Email.pdf

Appendix 4

Fraud Newsletter May 2022.pdf

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

20 May 2022

Fraud Alert – Mandate Fraud

For attention of all staff working in NHS finance and payroll teams, particularly those responsible for setting up bank account details and processing bank payments:

Please be reminded that mandate fraud is a real risk to the organisation that has the potential, if successful, to cause substantial financial loss.

Recent attempts to change bank details have involved fraudsters impersonating the following legitimate supply companies:

Vanguard Healthcare Solutions, 4C Strategies Ltd, Inovus Ltd, Accomplish Group Ltd, Centre Great Ltd

Staff are reminded to be extremely vigilant in relation to changes to banking details relating to the companies named above and also to any other company/ supplier to your organisation.

Staff are to ensure that they follow the robust financial procedures in place and to refresh their knowledge using the guidance issued by the NHS Counter Fraud Authority Quick Guide.

Should any staffing group require an awareness input in relation to this area from the Counter Fraud Team then please click on the awareness session request form below.

Likewise, If you or your staffing group require a copy of the NHS CFA quick guide to mandate fraud please follow this LINK or email us at the below address.

Counter Fraud Enquiry Form (LINK)

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

Awareness Session Request (LINK)

Request an Awareness Session/ Input from Counter Fraud using the link above or QR code.

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

GIG CYMRU NHS WALES

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

12th April 2022

Fraud Alert

Social Engineering – Phone Calls Regarding Dell Computers

Information has been received at Cardiff and Vale Counter Fraud Department from a local Health Board regarding a recent suspicious phone call that had been made to a member of staff.

A member of staff reported they had received a telephone call from a person reporting to be from Dell computers. The caller was asking for details about their work's computer.

Staff should not provide any information about details of their computers or their login information to someone over the telephone.

You will only be contacted over the telephone by the ICT Department if you have logged an incident with the ICT Service Desk. If you have logged an incident there will be a call reference number (you would have received a confirmation email after logging the call) and you **must** ask the caller on the telephone to provide you with this (**do not read it out to them**). If you are suspicious about the person on the end of the telephone, immediately end the call, and report it to the ICT Department.

If you are worried about family members, friends or yourself being scammed there is plenty of advice available online at: ActionFraud National Fraud & Cyber Crime Reporting Centre | National Cyber Security Centre

Local Counter Fraud Team

If you would like more information about fraud or to raise a concern please contact one of your Local Counter Fraud Specialists by Email, Phone or drop into the office.

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

Nigel Price
Tel: 029218 36481
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Local Counter Fraud Specialist

Emily Thompson
Tel: 029218 36262
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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 any suspicions or concerns about fraud in the NHS to the NHS Counter Fraud Authority at https://cfa.nhs.uk/reportfraud or by calling 0800 028 4060 (available 24 hours)
All reports are treated in **confidence**, and you have the option to report **anonymously**. Alternatively, you can also speak to your LCFS.

Fraud Alert

Phishing Email—ESR

Information has been received at Cardiff and Vale University Health Board Counter Fraud Department from a member of staff regarding a recent suspicious email they had received.

A member of staff reported they had received a suspicious email alleging to be from NHS Electronic Staff Record (ESR) system stating that their bank details had been altered and if this was not done by them or to check the details to click a link in the email to check their details are correct.

If you receive a similar email please do **NOT click the link**, please report the email to the Fraud Department. If you wish to check your ESR system then please use existing links you have or enter the website address manually in the address bar.

Never click links in emails that you have any suspicion may not be genuine!

If you are worried about family members, friends or yourself being scammed there is plenty of advice available online at:

ActionFraud
National Fraud & Cyber Crime Reporting Centre

National Cyber Security Centre

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

CounterFraudEnquiries.CAV@wales.nhs.uk

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Counter Fraud Newsletter

May 2022

CAVUHB | Velindre | HEIW | PHW | NWSSP | DHCW

Local Counter Fraud Specialists (LCFS)

Welcome to the May 2022 edition of the Counter Fraud Newsletter

The Counter Fraud Department has gone through some changes recently, the contact details for all of the team members is on the second page of the newsletter. We have also recently introduced a generic email account for that can also be used to contact the team:

CounterFraudEnquiries.CAV@wales.nhs.uk

It is probably important at this point to remind everyone that although we are based in Cardiff and Vale UHB we do provide the counter fraud services to all six organisations listed above, so please do not be put off by the CAV email if contacting us from one of our other organisations!

Counter Fraud Enquiry Form (link)

- Click on the above link or scan the QR code to access our new form that can be used for any general enquiry to the counter fraud department and/or to report any concerns you may have in relation to a fraud or possible fraud being committed against the organisation.
- It is completely anonymous, we will only know your details if you choose to supply them.
- All enquiries are treated confidentially whether you provide your details or not.
- Providing your details often makes it easier to investigate a report.

Fraud Awareness Sessions (link)

- Click on the above link or scan the QR code to access a new form that allows you to request an input for your department/team/ organisation for Counter Fraud Awareness.
- These sessions can be in person or via Teams and can be a general awareness session or more specific to your needs (such as providing specific sessions on Mandate Fraud etc).

Fraudulent practice manager brought to justice by NHS counter fraud investigation

Julie Ann Stevenson, a 63-year-old former NHS Practice Manager at Castle Surgery, Neath, has been sentenced for the crime of defrauding the Practice and the NHS Pension Authority over an 18-month period, thus gaining in excess of £35,000 in remuneration and pension that she was not entitled to.

She was sentenced to 6 months' imprisonment, suspended for 12 months at Swansea Crown Court.

More details can be found here: Fraudulent practice manager brought to justice by NHS counter fraud investigation. nhs.uk)

Fraud E-Learning Package - ESR

There is an online Fraud Awareness learning package that can be accessed through ESR. Although this is not a mandatory package at this time it is a valuable course that will take under half an hour to complete.

It has been estimated that the NHS' vulnerability to fraud, bribery and corruption leads to a loss of £1.14 billion (2019-2020) we all have our part to play in protecting the organisation from this activity. You are encouraged to learn more by carrying out the learning provided.

The course can be accessed here: Fraud Awareness E-Learning

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

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Local Counter Fraud Specialist

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

Report Title:	**Revised Controlled Document Policy and Procedure**			Agenda Item no.	8.1
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	5 July 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Business				

Main Report
Background and current situation:

The Corporate Governance Directorate have responsibility to coordinate the production, publication and archiving of Cardiff and Vale University Health Board Policies and other Controlled Documents. The responsibilities and processes necessary to enable these activities are described in UHB 001 (Management of Policies, Procedure and other Written Control Documents Policy) and in UHB 242 (Written Control Documents – Development and Approval Procedure).

UHB 001 required review in accordance with its published review date. This review has occurred and has not resulted in any substantial alteration.

UHB 242 also required review in accordance with its published review date. Following review, the document has been amended to achieve the following:

- To provide a clearer definition of the various types of controlled documents to be used within the Health Board.
- To provide a clearer articulation of the process to be adopted when drafting new controlled documents.
- To update the document and reflect recent changes to committee titles and purpose.

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

The amendments to these documents are a necessary step in the improvement of controlled document management and are consistent with recommendations made in an internal audit of the Management of Health Board Policies and Procedures.

Recommendation:

The Committee are requested to:

APPROVE 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).

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	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	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Improved management of controlled documents provides greater access to potential risk control processes and procedures.
Safety: Yes
Improved management of controlled documents provides greater access to potential risk control processes and procedures.
Financial: No
Workforce: No
Legal: Yes
Improved management of controlled documents provides greater evidence of Cardiff and Vale University Health Board's statutory compliance.
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
06/07/2022 13:17:46

Reference Number: UHB 001 **Version Number:** 6	**Date of Next Review:** XXXX **Previous Trust/LHB Reference Number:** N/A

MANAGEMENT OF POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS POLICY

Policy Statement

Cardiff and Vale University Health Board (C&V UHB) has a responsibility to ensure compliance with legislative, statutory and regulatory requirements. Policies, procedures and other written control documents develop and describe our 'ways of working' and outline how staff should perform their roles to meet these requirements. A robust and clear governance framework for the management of documents is essential to minimise risk to patients, employees, contractors, the public and the organisation itself; therefore, the Health Board has developed a system to support the development or review, approval, dissemination and management of these documents.

This policy outlines the process for development, consultation, approval, dissemination, and review of key organisational documents such as policies, strategies, procedures, guidelines and protocols.

Policy Commitment

Our documents will be written in plain language so that all staff, stakeholders and where appropriate our patients and the people we serve, are clear about what is expected. It will be possible to find them easily on our internet and/or intranet sites. Where appropriate our documents will be available in the Welsh Language and they will also be supported by other media or format, for example podcasts.

Each document will have an "owner" who has responsibility for making sure that it is regularly reviewed and kept up to date.

A combined Equality and Health Impact Assessment will be completed for **all** policies (and where appropriate procedures and other written control documents).

Our staff and stakeholders will be actively consulted during the development of all policies (and where appropriate procedures and other written control documents).

There will be clear and appropriate methods for the approval of policies and other written control documents and a comprehensive register will be maintained for all such documents.

Supporting Procedures and Written Control Documents

This policy and UHB 242: Written Control Documents – Development and Approval

Procedure describe the following with regard to written control documents:

- The process for developing/updating documents
- The requirements regarding equality and health impact assessment
- Style and formatting
- Consultation and approval arrangements
- Recording, storage and archiving
- Communication and publication
- Any learning, education or development needs

Other supporting documents are:

UHB 142: Records Management Policy.
UHB 183: Records Retention and Destruction Protocol.
UHB 202: Safety Notices and Important Documents Management Policy.
UHB 228: Producing Written Information for Patients Guidance.
UHB 246: Information Governance Policy.

Scope

This policy applies to all of our staff in all locations including those with Honorary Contracts.

This policy relates to organisation wide key documents. However, its principles also apply to any local key documents to ensure that they are appropriately authenticated and regularly reviewed to ensure a reliable, accessible and valid source of best practice for staff.

Equality and Health Impact Assessment (EHIA)	The policy relies on the generic EHIA for Administrative Type Policies
Policy Approved by	Audit and Assurance Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Health System Management Board
Accountable Executive	Director of Corporate Governance

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	N/A	17/09/09	New policy
2	12/09	N/K	Minor amendments
3	06/11	07/11	Amendments throughout document to reflect changes in approval processes and recognise mechanism required to develop Directorate documentation.
4	01/07/14	08/07/14	Amendments to reflect new policy format
5	30/11/17	05/12/17	Change in titles Reference to new Equality and Health Impact Assessment launched in September 2016 Changes in supporting Procedure to reflect Committee changes
6	XXXX	XXXX	Changes in supporting Procedure to reflect changes in approval process.

Reference Number: UHB 242 **Version Number:** 3	**Date of Next Review: XXXX**

Written Control Documents - Development and Approval Procedure

Introduction and Aim

To ensure that Cardiff and Vale University Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe our "ways of working" in policies, procedures and other written control documents. In this regard, the Management of Policies, Procedures and Other Written Control Documents Policy (UHB 001) has been produced.

This procedure translates the principles from that policy into more detailed guidance, including individual responsibilities for developing and reviewing written control documents. This is summarised at Table 1: Steps Involved in Document Creation/Amendment (page 8).

Unless otherwise stated, the phrase *'key documents'* will be used in this procedure when a point is equally relevant to a range of control documents whether they be strategies, policies, procedures, guidelines etc.

Objectives

This procedure ensures consistency in the format, compilation, approval and dissemination of all control documents, so that they are:

- Developed and reviewed when required;
- "Owned" – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date.
- Written in plain language so that they can be understood and people are clear of what is expected.
- Subject to Equality and Health Impact Assessments (EHIA) where required;
- Recorded, stored and archived in accordance with the UHB Records Management Retention and Destruction Protocol;
- Appropriately co-produced and consulted on;
- Considered and approved by the appropriate forum/senior officer (with delegated powers);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and our Publication Scheme.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts.

In addition to the responsibilities detailed within the procedure, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

Equality and Health Impact Assessment	The procedure relies on the generic EHIA for Administrative-type policies.
Documents to read alongside this Procedure	UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy.
	UHB 142: Records Management Policy.
	UHB 183: Records Retention and Destruction Protocol.
	UHB 202: Safety Notices and Important Documents Management Policy.
	UHB 228: Producing Written Information for Patients Guidance.
	UHB 246: Information Governance Policy.
Approved by	Audit and Assurance Committee

Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Head of Corporate Governance

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	18/09/2014	24/09/2014	Content previously included within Management of Policies, Procedures and Other Written Control Documents Policy. The revised policy is in the new shorter format and this procedure has been written in support of the new policy.
1.1	10/12/2015	16/12/2015	Title of Appendix 2 corrected

2	30/11/2017	05/12/2017	Revised Procedure. Titles amended Reference to new EHIA that replaced EQIA Changes in Committee structure and inclusion of R&D
3	xxxx	xxxx	Revised to reflect change to UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy. Definitions moved from appendix to main body. Document Approval process revised. Committee titles updated.

Contents Page

Appendices

1. Definition of Terms

1.1 **Note**. These definitions are adapted from a range of sources. There are no single legal definitions and the terms can mean different things to different organisations.

1.2 **Strategy.** A long term plan designed to achieve particular goals or objectives. A strategy is often a broad statement of an approach to accomplishing these desired goals or objectives. A strategy may be supported by policies and procedures. Strategies always require an Equality & Health Impact Assessment (EHIA).

1.3 **Policy.** A formal written statement of intent, describing the broad approach or course of action that the Health Board is taking with a particular issue. The formulation of policies allows the Health Board to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff. An Operational Policy is a statement outlining the objectives, principal functions and modes of operation of an entire hospital or a department, particular service or activity.

Policies are usually underpinned by evidenced based procedures and guidelines. Policies are mandatory and usually require an EHIA.

1.4 **Procedure.** A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures set out the operational processes to be followed to meet objectives, usually the objectives required by a strategy or policy. They must include reference to any evidence used. Procedures are considered mandatory. The equality impact of a procedure that supports a policy may be covered by that policy's EHIA but consideration should always be given to the need for a specific EHIA.

1.5 **Protocols.** Protocols are an agreed framework that provides step by step guidance. They are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, and what the scope of the protocol is. If a protocol is not to be followed it is necessary to record the alternative action that is to be taken and the rationale for this. Protocols may have potential to impact on people with protected characteristics and therefore consideration should be given to conducting an EHIA.

1.6 **Guidelines.** Guidelines give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been recorded or justified.

1.7 **Standard**. A standard is a statement, reached through consensus, which clearly identifies the desired outcome. A standard is usually used within audit as a measure of success. Standards may be published as a standalone document or may be incorporated into a strategy or policy.

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive; however, it could prove difficult to defend a case if a standard is not adhered to.

2. Responsibilities

2.1 Executive and Clinical Board Directors

2.1.1 The delegated responsibilities of Executive and Clinical Board Directors are set out in the Scheme of Delegation. They have responsibility for:

a. Verifying that there is a need for a new written control document and ensuring that there is no duplication or conflict with other written control documents within their sphere of influence.

b. Ensuring that appropriate written control documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role).

c. Personally checking for accuracy of content prior to submission to a committee/group for approval.

d. Maintaining a list of up to date policies and written control documents, supported by the Head of Corporate Governance.

e. Ensuring that there are arrangements in place to capture, respond to and review documents when external organisations (e.g. Health and

Safety Executive, Royal Colleges) publish new and updated information which require action by the Health Board.

f. Ensuring that consultation has taken place and impact assessments, including the equality and health impact assessment, have been completed where necessary. Where these have not been undertaken a reason for this will be provided.

g. Ensuring that any training requirements specific to the document have been referenced.

h. Establishing an appropriate date for review of the key document.

i. Ensuring that, where a process of audit and/or review has been agreed, this is maintained and reported on.

2.2 Document Authors

2.2.1 Authors are employees who have been given the task of writing or reviewing a key document. Employment documents should always have at least two authors i.e. a management representative and a staff representative.

2.2.2 Authors are responsible for the review of their documents. If an author leaves the Health Board or takes up a non-related post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive Director and Clinical Board Director will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

2.2.3 Authors must:

a. Liaise with Executive or Clinical Board Directors to make sure policies and written control documents are implemented appropriately and, where necessary, compliance with these documents is formally audited.

b. Make sure that documents are reviewed in line with the review date or amended as a result of changes to practice, organisational structure or legislation.

c. Work with the Executive/Clinical Board Director and the Head of Corporate Governance to ensure appropriate engagement and consultation with relevant individuals and groups.

d. Inform the Executive or Clinical Board Director of any learning, education, development or resource issues needing to be addressed prior to the granting of approval.

e. Undertake the necessary impact assessments, including EHIA.

f. Consider the findings and make sure that appropriate action has been taken in response to EHIAs.

g. Send the approved document to the Head of Corporate Governance for publication within **five working days** of approval by Board or Committee.

2.4 Corporate Governance

2.4.1 The Director of Corporate Governance is responsible for ensuring that the Health Board has arrangements in place to ensure effective development and management of key documents.

2.4.2 The Head of Corporate Governance is part of the Director of Corporate Governance's team. He/she undertakes the function of organisation wide "Policy Process Manager" and can provide advice and assistance on any aspect of document development and review. He/she can be contacted on 029 21836691 (Extension 36691).

2.4.3 He/she maintains a register of all documents which are centrally recorded and will be able to advise if a document already exists. All of these documents are also published on the intranet, and most documents are also published on the UHB Internet Site.

2.4.4 The Head of Corporate Governance will arrange for draft documents to be shared with the Community Health Council during the Engagement and Consultation phase. He/she will also arrange for approved documents and the accompanying EHIA (if applicable) to be published on the intranet/internet as appropriate within **ten working days** of receipt from the author or Committee Secretary.

3. Process for Drafting or Revising Key Documents

3.1 Each pan-Health Board policy and written control document will be sponsored by a lead Executive Director. At Clinical Board/Directorate level written control documents will be sponsored by the appropriate Director or Clinical Board Director (see Appendix 2).

3.2 In accordance with the Equality Act 2010 (as may be amended), all strategies and policies will be subject to an EHIA (see Paragraph 6).

3.3 In the case of **employment policies**, (excluding those enforced from Welsh Government following national negotiations and other "All Wales policies"), staff representatives and management will jointly negotiate a draft policy for submission to the Resources and Delivery Committee (or another appropriate Committee if this is superseded) for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Board for final consideration and approval.

3.4 The development of policies and written control documents will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance.

3.5 Sources of information used should be appropriately referenced or acknowledged.

Table 1: Steps Involved in Document Creation/Amendment

Stages	Lead	Action	Additional Information
Step 1	Policy Author	**Identify the need for a new (or revised version of an existing) Policy or Key Document)** by completing the Key Document Approval Form at Appendix 1.	Approval obtained from the Corporate Governance Team following submission of the Approval Form
Step 2	Policy Author	**Carry out an Equality & Health Impact Assessment (EHIA)** The purpose of an EHIA is to identify and eliminate any negative effect that the key document may have upon groups, individuals or communities as a consequence of their race, gender, disability, religion or belief, sexual orientation, age, Welsh language, gender reassignment, pregnancy or maternity, marital or civil partnership status or human rights.	Support available from the Equality and Welsh Language Teams. See 'Definition of Terms' for guidance on the EHIA requirements for each Key Document type

		EHIA should start at the beginning of key document making or review. This enables equality considerations to be taken into account throughout the design or review. Responsible officers must therefore carry out the EIA process and start by screening the document for relevance to equality. The EHIA Process should be used to carry out the screening (see Appendix 2). Responsibility for completing the EHIA lies with the officer(s) responsible for the key document, however the Equality & Welsh Language Teams are able to support as required.	
Step 3	Policy Author	**Understand Key Document Format and Template Requirements** The drafted Key Document needs to comply with: • The Document Format at Paragraph 5. • The Template requirements at Paragraph 5. • As required the EHIA Format at Paragraph 6.	Advice available from the Corporate Governance Team
Step 4	Policy Author	**Draft the Key Document**	Advice available from the Corporate Governance Team
Step 5	Policy Author	**Engagement and Consultation** Engagement and consultation on all policies and written control documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should	See Paragraph 7. Allow at least 28 working days

		be co-produced with that target audience.	
Step 6	Executive Lead/Author	**Obtain Approval** Lead Executive to discuss with Head of Corporate Governance the process to be adopted for draft document approval by Board, committee or other appropriate group.	See Appendix 2.
Step 7	Executive Lead/Author	**Approval** Following approval the author of the document is responsible for submitting the final document to the Corporate Governance Team for publication via SharePoint and the Internet. In accordance with the Welsh Language Standards, some policies need to be made available in Welsh. This should take place once the final version is approved.	See Paragraph 4 for specific requirement
Step 8	Corporate Governance Team	**Publication** When the policy has been received from the Policy Author the Corporate Governance Team will update the master policy library and upload to intranet and internet as required.	
Step 9	Executive Lead/Author	**Review** Executive Leads/Authors are responsible for reviewing the key document in accordance with the review date set when published and/or changed circumstances requiring more immediate review. The Corporate Governance Team operate a Written Control Documents Tracker and will send reminders when review date is overdue.	See Paragraph 8 for specific requirement.

4. Approval for Key Documents

4.1 Some “All Wales” policies are developed by the Welsh Government or by Health Boards and Trusts working together. The Health Board is often mandated to adopt these documents. Where this is the case they will be reported to the Board or a Board Committee so that there is a record of their adoption.

4.2 Where policies relate to equitable access to safe and sustainable, high quality specialised and tertiary services (Relevant Services), the Board will delegate approval to the Joint Welsh Health Specialised Services Committee (WHSSC).

4.3 All other strategies and policies will be approved in accordance with the guidance provided at Appendix 2. In accordance with Standing Orders the Health Board's top-level organisation structure and corporate policies require Board approval; Lead Executives/Authors who feel that their draft policy requires deviation from the guidance in Appendix 2 should discuss with the Head of Corporate Governance.

4.4 Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc., an interim review may be undertaken. This will be agreed in advance with the Corporate Governance Directorate to ensure that the completion of an interim review does not expose the Health Board to an increased level of risk. The change will be reported to the next available meeting of the approving body. The Board will periodically receive an update on all controlled documents approved by committee or other appropriate group.

4.5 Once approved, documents will be published on the UHB Intranet and Internet sites. Under limited circumstances it may be necessary to redact information from a document prior to publication on the Internet e.g. direct dial telephone numbers within the Major Incident Plan. The Committee/ Group approving the document will determine if redaction is required. Where this has been agreed the reason and extent of redaction will be explained in the published document.

5. Document Format

5.1 Document templates have been developed which contain the mandatory sections for inclusion in policies and written control documents (See Appendix 3).

5.2 This Template must be used for all Health Board wide, Clinical Board or multi-departmental documents. Where a document is only applicable within a

single Department or, for example consists of a flow chart, an alternative format is acceptable and a "basic template" is also shown in Appendix 3. As a minimum the following principles must be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date for next review shown.
- Date of last review shown.
- Author's details.
- Pages numbered.

5.3 The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

5.4 Policies, procedures and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients or their families they will ensure that the content is explained to them by an interpreter, translated if necessary or available in accessible formats (e.g. e-readers for the visually impaired).

5.5 In accordance with the requirements of the Data Protection Act 2018 (as may be amended), the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

5.6 Certain key documents may require the collection and processing of personal data as defined and regulated by personal data legislation as applies in Wales and /or the UK (including, without limitation, the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR)). Authors and sponsoring Executive Directors must ensure that the proposed key documents complies with these requirements, liaising with The Digital and Information Technology Directorate as required.

5.7 If the Health Board is adopting an externally approved document (such an All-Wales Policy) it will not need reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a Health Board authored document.

6. Equality and Health Impact Assessments

6.1 The Equality Act 2010 requires the undertaking of Equality and Health Impact Assessments and all Health Board policies will require the completion of such **before** the policy is consulted upon.

6.2 These assessments determine whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that Cardiff and Vale University Health Board take into consideration the needs of all individuals who work for us and/or access our services.

6.3 Health Impact Assessment (HIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. HIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework.

6.4 Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further EHIA. If an EHIA has not been completed the reason for this will be explained at the beginning of the document. Where an EHIA has been completed the impact will be included in the document.

6.5 EHIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document. A generic EHIA for Administrative-Type Policies has also been produced and formally agreed and can be used in support of the review and development of such policy types. This is available on the Policies page of the Intranet.

7. Engagement and Consultation

7.1 Written control documents must not be written in isolation. Engagement and consultation on all key documents occur with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience.

7.2 The Health Board is developing a range of mechanisms to involve patients, carers and members of the public in its work. This will strengthen the stakeholder involvement with the Health Board, demonstrate our commitment to working with the local community, and develop our services and policies jointly. If required, authors should contact the Assistant Director of Patient Experience and the Assistant Director of Planning for advice and assistance in identifying the appropriate groups/individuals for co-production and consultation.

7.3 When a final draft has been developed the formal consultation can start. The consultation period should be a minimum of **28 working days.**

7.4 The policy author should send the document and equality and health impact assessment (if applicable) to the Head of Corporate Governance who will arrange for the documents to be uploaded onto the Health Board's Written Control Documents Consultation Page on the Intranet. He/she will also make sure that they are brought to the attention of appropriate consultees on a weekly basis. This will include the Community Health Council in accordance with mutually agreed principles.

8. Key Document Review

8.1 When drafting or reviewing a document the author should consult with the sponsoring executive to determine the most appropriate date for the key document to be reviewed.

8.2 Such consideration should be cognisant of any specific requirements imposed by statutory, regulatory or professional bodies, and the likelihood of a rapidly changing context or background to the key document.

8.3 The maximum 'life' of a key document before review will be two years from the date of publication.

Appendix 1

Key Document Approval Form

This form should be completed by the document author and sent to the Corporate Governance Department for approval before production of the document.

1. Key Document Category:	New	☐	Existing	☐
2. Key Document Type:	Choose an item.			
3. What is the reason for developing a new key document?				
• Improve or standardise organisational procedures				☐
• In response to learning from a complaint, incident or claim				☐
• In response to alerts, safety notifications, Welsh Health Circulars etc				☐
• Re-organisation of a service/department				☐
• New or amended legislation				☐
• Other (please specify)	Click here to enter text.			
4. What is the reason for amending an existing key document?				
• Routine review				☐
• Improve or standardise organisational procedures				☐
• In response to learning from a complaint, incident or claim				☐
• In response to alerts, safety notifications, Welsh Health Circulars etc				☐
• Re-organisation of a service/department				☐
• New or amended legislation				☐
• Other (please specify)	Click here to enter text.			
What Key Document need replacement/update?	Click here to enter text.			
Review type required:	Full Review	☐	Interim Review	☐
5. What will be/is the title of the key document?	Click here to enter text.			
6. What will be/is the aim of the document?	Click here to enter text.			
7. Which other key documents will be/are relevant to the document?	Click here to enter text.			
8. Please indicate which of the following will need to be considered/consulted when developing/reviewing this document:				
• Consent				☐
• Deprivation of Liberty Safeguards (DOLS)				☐
• Mental Capacity Act				☐
• Mental Health Act				☐
• Data Protection/GDPR				☐
• Safeguarding				☐

• Equality and Diversity				☐
• Welsh Language				☐
• Patient Safety and Concerns				☐
• Health and Safety				☐
• Risk and Regulation				☐
• Workforce and Development				☐
• Information Governance				☐
• Financial				☐
• Business Continuity/Emergency Planning/Major Incident				☐
• Other:	Click here to enter text.			
9. Who will be/is the sponsoring Executive Lead for this key document?	Click here to enter text.			
10. Lead Author Details:				
Name:	Click here to enter text.	Job Title:	Click here to enter text.	
Email Address	Click here to enter text.			

For Use by Corporate Governance:				
a. Date Received by Corporate Governance			Click here to enter a date.	
b. Permission to develop key document given?	Yes	☐	No	☐
c. Full or Interim Review approved:	Choose an item.			
d. If **NOT** permitted why? What actions must author take to gain permission?	Click here to enter text.			
e. Approved title and reference number for **NEW** Key Document	Click here to enter text.			
f. Identify any other external or UHB Key Documents to be signposted/referenced in the new/reviewed key document	Click here to enter text.			
g. General Advice and follow up actions:	Click here to enter text.			
Name of Approver:	Click here to enter text.			
Job Role:	Click here to enter text.	Date Approved:	Click here to enter a date.	
Date that Approval Form Returned to Author:			Click here to enter a date.	

Appendix 2: Approving Committee/ Group

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Capital	Strategy and Delivery Committee	Depending on subject – also see Health and Safety and Audit Committee re: Financial Control Procedures	Capital Management Group
Clinical Governance/Patient Experience/Quality and Safety	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	As required by the specific category
Consent to Examination or Treatment	Quality, Safety and Experience Committee	Depending on subject matter	Health System Management Board or Clinical Board Quality, Safety and Experience Sub Committee
Corporate Governance	Audit Committee		

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Counter Fraud	Audit Committee	Depending on subject matter	Corporate Governance to advise.
Data Protection	Strategy and Delivery Committee	Supporting procedures	Information Technology & Governance Sub Committee*
Employee Wellbeing and Stress Management	Health and Safety Committee	Health promotion and other documents	Corporate Governance to advise.
Employment/Human Resources/Workforce and Organisational Development Policies	Renumeration and Terms of Service Committee	All staff Medical and Dental Staff	Employment Policy Sub Group* Workforce Partnership Group*
Environmental Management	Health and Safety Committee	Waste Management	Waste Management Group
		Other environmental management issues	Corporate Governance to advise.

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Equality, Diversity and Human Rights	Board	Employment related procedures – all staff Employment related procedures – Medical and Dental staff only Patient Experience	Employment Policy sub-Group* Medical Director* Health System Management Board
Financial Governance	Audit Committee or Finance Committee	Some Financial Control Procedures	Heads of Finance Group//Director of Finance
Fire Policy	Board	Fire procedures	Fire Safety Group
Food Safety and Hygiene	Health and Safety Committee	Implementation procedures	Operational Services Management Group
Freedom of Information	Strategy and Engagement Committee	Supporting procedures	Health System Management Board
Fundraising and Investment Policies	Board	Supporting policies or procedures	Charitable Funds Committee

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Health and Safety Policy	Board	Supporting procedures	Health and Safety Committee
Infection Prevention and Control	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board
Information Governance	Strategy and Engagement Committee	Supporting procedures	Health System Management Board*
Information Management and Technology Policy	Digital Health and Intelligence Committee	Supporting procedures	Health System Management Board*
Intellectual Property/Commercialisation	Strategy and Engagement Committee	Supporting procedures	Health System Management Board*
Major Incident Plan	Board	Implementation procedures: If impacting on UHB/Site wide If only local impact at Clinical Board/Directorate	 Health System Management Board* Clinical Board Management Team*
Medicines Management	Quality, Safety and Experience Committee	Supporting procedures	Clinical Safety Group

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Mental Capacity related policies	Mental Health and Capacity Legislation Committee	Implementation Procedures	Health System Management Board
Mental Health Act related policies	Mental Health and Capacity Legislation Committee	Procedures relating to implementation of the Mental Health Act	Mental Health and Mental Capacity Legislation Committee or Mental Health Clinical Board Quality, Safety and Experience Sub Committee depending on scope
No Smoking Policy	Health and Safety Committee	Supporting procedures	Health System Management Board*
Nutrition and Catering	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board*

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Clinical and Non-Clinical Operational Policies with impact on more than one Clinical Board or the UHB as a whole.	Health System Management Board	Supporting procedures	Health System Management Board
Clinical and Non-Clinical Operational Policies with impact on a single Clinical Board or Directorate	Health System Management Board	Supporting procedures	Clinical Board or Directorate
Patient and Public Information	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board
Patient Experience, Quality and Safety/Clinical Governance	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	As required by the specific category
Performance and Delivery	Strategy and Delivery Committee	UHB wide/affecting more than one Clinical Board Clinical Board/Directorate specific	Health System Management Board Clinical Board or Directorate Management Group
Personal Safety/Violence and Aggression	Health and Safety Committee	Personal Safety/Violence and Aggression/	Operational Health and Safety Group

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Policies, Procedures and Other Written Control Documents Management Policy	Audit Committee	Written Control Documents Development and Approval Procedure	Health System Management Board
Public Engagement	Strategy and Delivery Committee	Supporting procedures	Health System Management Board*
Public Health including Interventions not Normally undertaken and Individual Funding Patient Requests	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board*
Quality and Safety/Patient Experience/Clinical Governance	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	As required by the specific category
Research and Development	Quality, Safety and Experience Committee	Supporting procedures	Research Governance Group
Risk Management and Board Assurance Framework Strategy	Board	Risk Assessment and Risk Management Procedures	Audit Committee
Scheme of Delegation	Audit Committee	Minor Changes to Scheme of Delegation	Management Executive
Service Planning	Strategy and Delivery Committee	Supporting procedures	Health System Management Board

Strategy and Policies		**Procedures and Guidelines** Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
Subject Area	**Approving Body**	**Sub-area where clearly defined**	**Approving Group/ Director**
Standards of Behaviour	Board		
Standing Financial Instructions	Board		
Standing Orders	Board		
Violence and Aggression/Personal Safety	Health and Safety Committee	Violence and Aggression/Personal Safety	Operational Health and Safety Group

Appendix 3

TEMPLATES FOR DOCUMENTS

The template is designed for use when developing policies, procedures and other written control documents. It may not be suitable for all documents but any deviation will be agreed with the Head of Corporate Risk and Governance. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Development - Microsoft Word Publishing - PDF Read only (this will be arranged by the Head of Corporate Risk and Governance after the reference number has been added.
Document Style	Corporate Policy Template Corporate Procedure Template Employment Policy Template Employment Procedure Template
Audit trail	Record information regarding consultation during development.
Body text	Arial 12
Headings	Arial 12 (Lower Case)
Tables and charts	Arial (size as appropriate)
Flow charts	Use Standard Flow Chart Symbols where possible
Use of bold	Headings only or to emphasise text
Alignment	Left Justified
Line spacing	Paragraphs – Single
Paragraph spacing	One line between paragraphs and section headings
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily
Staff Names	Use titles rather than names
Logo	Use UHB logo as incorporated in corporate template

Headers and footers	Arial 9
Margins	Top and bottom of page 2.54 cm, sides 3.17cm
Document Title	To be included in the header on every page after first page
Page numbering	To be included in the header on every page after first page. It will include the page number and total number of pages (page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems
Abbreviations	State in full in first usage with abbreviation in brackets
Printing	A4 / double sided
Hyperlinks	Hyperlinks should be considered for use in key documents when this will reduce the volume of a document or in any other way improve the reader's experience and understanding. However, consideration should be given to the anticipated longevity of a link to a site external to C&V UHB. If it is assessed that a link has reasonable potential to change it should not be used. All hyperlinks should be preceded or superseded with a full reference to the external information source to enable access if the hyperlink fails. **Hyperlinks in Approved Documents**: Authors are responsible for ensuring the accuracy of hyperlinks to external sites when submitting approved documents to Corporate Governance for publishing. If hyperlinks to existing C&V UHB published key documents are required these will be inserted by the Corporate Governance Team prior to publishing; authors should clearly indicate which key documents require this action.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.

Glossary of terms	All documents need to be user friendly. They will be read by staff and members of the public. Therefore all necessary abbreviations, technical terms, jargon and specific wording must be clearly explained to the reader. Where possible always use plain English. Information to help with this is available on the Plain English Campaign web site.
Version Control	Reference Number will be provided by the Corporate Governance Department. Documents to state 'Draft' as watermark whilst in development together with version number of draft e.g. Draft 1.

APPENDIX 4

REFERENCES

Cardiff and Vale NHS Trust, 2006. *Policy for the Management of Policies, Procedures and All other Written Control Documents*, *Ref No 68*

Cwn Taf Morgannwg University Health Board, 2021. *Policy for the Development, Review and Approval of Organisational Wide Policies*

Welsh Health Specialised Services Committee, 2010. *Memorandum of Understanding – Relating to Joint Committee of Welsh Health Specialised Services Committee*

Betsi Cadwaladr University Health Board, 2010, *Equality Impact Assessment – Policy for the Management of Policies, Procedures and Other Written Control Documents*

Cornwall and Isles of Scilly Primary Care Trust, 2008, *Initial Equality Impact Assessment Proforma - Policy for the Development and Ratification of Corporate Documentation*

Cornwall and Isles of Scilly Primary Care Trust, 2008, *Policy for the Development and Ratification of Corporate Documentation*

North East London NHS Foundation Trust, 2011, *Policy for the Drafting and Implementation of Procedural Documents and Equality Impact Assessment*

Metropolitan Police Service, 2011, *The Management of Policy Development in the Metropolitan Police Service and Equality Impact Assessment*

Cumbria Partnership NHS Foundation Trust, January 2013, *Document Development Policy*

NHS Scotland, Scottish Capital Investment Manual Glossary *http://www.scim.scot.nhs.uk/Index.htm*

Recovery of Services and Delivery of the Annual Plan 2021 – 2022

Final Internal Audit Report

June 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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Final report issued:	16th June 2022
Auditors:	Henry Wellesley, Audit Manager Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Caroline Bird, Interim Chief Operating Officer Abigail Harris, Executive Director of Strategic Planning Nicola Foreman, Director of Corporate Governance
Distribution:	Hannah Evans, Recovery and Redesign Programmes Delivery Director
Committee:	Audit & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

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 2021/22'.

Overview

We have issued an overall rating of substantial assurance on this area and are also able to provide substantial assurance for each of the individual objectives, as detailed within the Assurance Summary table.

Our report makes two low priority recommendations, which are forward looking given the review focused on 2021/22 arrangements. The recommendations can be taken forward to 2022/23 and relate to:

- The transparency of reprofiling recovery funding; and
- The timeliness of information contained within the Board Assurance Framework.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate governance arrangements have been established which provide effective oversight	Substantial
2	Deliverables outlined within the Addendum to the 2021/22 Annual Plan are regularly monitored	Substantial
3	The Board Assurance Framework adequately highlights the risk of delivery of the Annual Plan 2021/22	Substantial

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

Key Matters Arising

There are no key matters arising to report on this occasion.

1. Introduction

1.1 The review of 'Recovery of Services and Delivery of the Annual Plan 2021-2022' was completed in line with the Cardiff and Vale University Health Board's (the 'Health Board') 2021/22 Internal Audit Plan.

1.2 The NHS Wales Annual Planning Framework 2021–22, which was published on 14 December 2020, noted that, *"This framework is by necessity different from previous versions in that it requires organisations to provide an annual plan that builds on the quarterly operational planning arrangements of 2020/21. It seeks to set out short, sharp requirements for the coming year but also provide a guide for some of the longer term objectives that NHS Wales and the Welsh Government have committed to, which must not be lost sight of as we seek to build back stronger as part of medium to longer term recovery and stabilisation."*[1]

1.3 The 2020/21 Internal Audit Plan included an audit of the 'Annual Planning Process 2021-22' (CVU 2021-08), the final audit report was published on 28 May 2021, which reported substantial assurance.

1.4 A Special Board Meeting took place on 24 June 2021, where the Annual Plan 2021-22 was resubmitted for approval, the report noted, *"WG required the HEALTH BOARD to submit a Board approved 'draft' plan in March with the expectation that a final plan was resubmitted by the 30 June 2021. Guidance received from WG in late May requested that a draft of the updated plan was submitted by the 11 June 2021."*

1.5 The resubmitted Plan incorporated an Addendum, 'Planning for Recovery and Redesign', which included five programmes, supported by a number of schemes: 1. Primary and Community Care, 2. Mental Health, 3. Planned Care, 4. Unscheduled Care, and 5. Diagnostics.

1.6 The joint executive leads for the review are the Interim Chief Operating Officer and Executive Director of Strategic Planning.

Audit Risk

1.7 The Health Board had identified the following risk within the Board Assurance Framework, for which the Executive Director of Strategic Planning is the lead (March 2022):

- Risk of Delivery of Annual Plan 2021/22 - The Health Board will not deliver the objectives set out in the Annual Plan due to the challenge around recovering the backlog of planned activity.

[1] https://gov.wales/nhs-wales-planning-framework-2021-2022

Limitation of scope

1.8 This audit did not review the scheme deliverables, rather the mechanisms for monitoring, reporting and actions taken in response to the monitoring process.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements have been established which provide effective oversight of development and delivery of the recovery and redesign portfolio, ensuring that it is subject to scrutiny and review

Development and context of the Recovery and Redesign Addendum

2.1 The Health Board had a short window of time to develop the 'Recovery and Redesign Addendum' (the Addendum) to the Annual Plan 2021/22, approved by the Board in June 2021 and submitted to Welsh Government. The Addendum details the five programmes which are underpinned by a number of schemes. The schemes in the Annual Plan represented both that had already received financial support plus new schemes for which the UHB was requesting additional funding from WG to support return to pre-covid activity levels in order to improve access and reduce waiting times.

2.2 At the time of developing the Addendum, the Health Board was aware that there would be funding for recovery schemes, but there was no certainty about the amount of funds which would be made available or which schemes would be supported, we noted these discussions in the Portfolio Board minutes.

2.3 We were informed by management that, in the knowledge that funding would become available but would likely have the requirement that it would have to be utilised by the end of March 2022, a decision was made via Management Executive (and through to the Strategy and Delivery Committee) to progress some of the schemes at risk with the acceptance that there was some uncertainty of the eventual level of funding and which schemes would be funded by the Welsh Government. Management confirmed that these decisions were communicated to Welsh Government.

2.4 The Welsh Government announced recovery funding in tranches. The first tranche of money was announced in May 2021 and totalled £13.662m. A further £11.536m was confirmed on 29 September 2021. A total of £25.198m. The total ask of the Recovery Plan (as per the Addendum) was £37.236m. In October 2021, a further £2.208m was issued by Welsh Government which could be allocated against some of the unfunded recovery schemes.

Governance of Recovery and Redesign

2.5 To oversee recovery efforts the Health Board set up a Recovery and Redesign Portfolio Board, which has responsibility for overseeing the development and implementation of the Recovery and Redesign Programmes. The Health Board

appointed a Recovery and Redesign Programmes Delivery Director to oversee the Portfolio, as Senior Responsible Officer and chair of the Portfolio Board. The Interim Chief Operating Officer is the executive sponsor for the Portfolio.

2.6 The Portfolio Board first met in September 2021, membership was designed to reflect both clinical and corporate teams with responsibility for ensuring progression and implementation of the recovery programmes, designed to drive the Health Board's recovery from COVID-19 and to return to pre-Covid levels of activity.

2.7 The audit reviewed the documentation received by the Portfolio Board and was able to confirm that for each month the Board received Flash Reports (highlight reports), Dashboard Reports and Risks, Actions, Issues and Decisions (RAID) logs. Minutes were taken at each meeting and reviewed at the subsequent meeting. We were advised that in response to the winter pressures and the COVID Omicron variant, Portfolio Board meetings were stepped down at the start of 2022, but papers were still circulated.

2.8 We further confirmed that the Strategy and Delivery Committee was receiving copies of the Flash Reports and that the Committee through the Chair was providing updates to the Board.

Conclusion 1: Governance arrangements have been established which provide effective oversight of development and delivery of the Recovery and Redesign Portfolio. The Strategy and Delivery Committee are receiving updates from the Portfolio Board and provide a summary to the Board. (Substantial Assurance).

Objective 2: Deliverables outlined within the Addendum to the 2021/22 Annual Plan are regularly monitored, with assurance provided to the Board and where performance issues are encountered, appropriate rectifying action is undertaken

2.9 We note in paragraph 2.4 that funding for the schemes outlined in the Addendum were not confirmed in full until the end of September 2021. To ensure progress was made on the Recovery Programme schemes commenced before funding was confirmed, on the basis that some were at risk if funding was not received.

2.10 A sample of schemes were tested to confirm that monitoring and reporting to the Portfolio Board was taking place and that updates were provided to the Strategy and Delivery Committee. The schemes sampled are included below:

Recovery & Redesign Programme	Scheme	Description
Primary & Community Care	MDT Clusters	Multidisciplinary Teams (MDT) approach to the care of complex patients at home through provision of hub teams.

Recovery & Redesign Programme	Scheme	Description
	General dental services / Orthodontics	Additional capacity on weekends / evenings to address backlog.
	Oral Surgery – Transfer of extractions	Transfer of some extraction procedures from the acute hospital to community setting, to take pressure off secondary care.
	Eye Care Specialist Optometrists	Upskilling Optometrists with the Higher qualifications in Glaucoma, Medical Retina and Independent Prescribing. To assess outpatients with complex eye problems, thereby reducing pressures on secondary care.
Diagnostics	Endoscopy insourcing extension	Increase current insourcing contracts to increase provision.
	Mobile Theatre	A mobile endoscopy theatre based at UHL to provide additional capacity to deliver diagnostic and surveillance procedures and reduce the wait for patients.
Unscheduled Care	Same Day Emergency Care (SDEC)	The delivery of a comprehensive SDEC provides an alternative for emergency patients who would otherwise be admitted to hospital. Patients presenting with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward.
Planned Care	Gynaecology Treatment Room	Set up a gynaecology treatment pathway within current outpatient setting that will increase outpatient operating capacity and reduce waiting lists for treatment and diagnostics.

2.11 As schemes progressed it became apparent that delays in recruiting and procurement meant that the delivery of some schemes would slip. As an example, the drive to increase endoscopy activity, where the benefit was delayed due to delays in the contractor being able to deliver the mobile units, which meant that the benefit of the scheme was delayed into the 2022/23 financial year. We noted that some expenditure was reprofiled into areas such as increased insourcing where waiting lists were growing.

2.12 We reviewed all Dashboard and Flash reports which were produced from October 2021 to March 2022, and we are able to confirm the appropriate monitoring and reporting of the schemes. We interrogated the December to March reports to confirm that the expenditure was monitored and slippage within schemes was identified, so that the recovery funding could be utilised in other areas that would help increase activity to pre-COVID levels. The Portfolio Dashboard reports did not

outline where the slippage expenditure was being redirected to, although we did find evidence that there was a procedure in place to redirect funds which could not be utilised within 2021/22 for the schemes which they were originally allocated. *(Matter Arising 1 – Low Priority)*

2.13 We reviewed the Strategy and Delivery and Committee papers from October to March and confirmed that the Committee was receiving updates on the Recovery Programme and the risks to the programme, which were as noted above around recruitment and procurement.

Conclusion 2: In the most part, we found that there were systems and controls operating effectively for the monitoring and reporting of recovery schemes, but an inclusion within the latter reports of where slippage expenditure was being redirected would have provided more detail and completeness to users of the reports. (Substantial Assurance)

Objective 3: The Board Assurance Framework adequately highlights the risk of delivery of the Annual Plan 2021/22 and the associated controls and assurances, in addition to identifying the gaps in controls and assurances.

2.14 The March 2022 Board Assurance Framework (BAF), Risk 7 - Risk of Delivery of Annual Plan 2021/22 identifies that; *"There is a risk that the Health Board will not deliver the objectives set out in the Annual Plan due to the challenge around recovering the backlog of planned activity … not taking the opportunity to do things differently and the potential risk associated with the Medium Term Financial position all of which could impact upon delivery of the Annual Plan."*

2.15 We were able to confirm that the risk mitigation detailed in the BAF "Monitor implementation of Annual Plan and continue to report through Strategy and Delivery Committee and Welsh Government via monthly meeting", reflected the mitigation that we found to be in place during our testing of this area. However, we found that the 'Gaps in Assurances' was not entirely reflective of the position (as at March 2022), as it stated *"the Health Board is unsure on the timeliness of money being released from WG"*. This was no longer the case, at the end of September 2021 the Health Board was advised about the awarding of funding, and in November advised that funding would be recurrent for a further three years. *(Matter Arising 2 – Low Priority)*

Conclusion 3: In the most part, the BAF reflected the risk of delivery of the Annual Plan, however the 'Gaps in Assurances' required a refresh. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Transparency of reprofiling recovery funding (Operation)	**Impact**
We acknowledge that the Portfolio Board is no longer in place, as the Health Board transitions from COVID Recovery and Redesign to one holistic Operational Plan for 2022/23, with revised governance arrangements of the new Operational Plan Delivery Group. However, we did identify that there was opportunity for greater transparency of slippage of schemes and how funds were redirected to other recovery schemes. The Portfolio Dashboard reports did not outline where the slippage expenditure was being redirected, although we did find evidence that there was a procedure in place to redirect funds which could not be utilised within 2021/22 for the schemes for which they were originally allocated.	Potential risk of: • A lack of transparency on the reallocation of funding.
Recommendation 1	**Priority**
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.	**Low**

Agreed Management Action 1	**Target Date**	**Responsible Officer**
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.	July 2022	Hannah Evans, Recovery and Redesign Programmes Delivery Director

Matter Arising 2: Updating the Board Assurance Framework (Operation)	**Impact**
We reviewed the Board Assurance Framework (BAF), Risk 7 - Risk of Delivery of Annual Plan 2021/22 as at March 2022, and found that the 'Gaps in Assurances' had not been updated to reflect the position we found at the time of our review. The 'Gap in the Assurances' stated that *'the Health Board is unsure on the timeliness of money being released from WG'*. This was no longer the case by March 2022, in October 2021 the Health Board was advised about the awarding of funding and in November advised that funding would be recurrent for a further three years.	Potential risk of: • The current level of risk is not reflected in the BAF.

Recommendation 2	**Priority**
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.	**Low**

Agreed Management Action 2	**Target Date**	**Responsible Officer**
Agreed - This question is always 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.	From 1st July throughout the year	Director of Corporate Governance with relevant Executive Lead for BAF Risk.

Mohamed.Sarah
06/07/2022 13:17:46

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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Risk Management

Final Internal Audit Report

June 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:	Nicola Foreman, Director of Corporate Governance
Distribution:	Aaron Fowler, Head of Risk and Regulation
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 the risk management arrangements.

Overview

We have issued reasonable assurance on this area.

For three of the five objectives reviewed we have offered reasonable assurance, largely due to the continued efforts required by Clinical Boards and Corporate Departments to enhance their risk registers, as highlighted in the key matter arising below.

We also note that the tools available to management are lacking, in that risk registers are currently held in spreadsheets, which limits the visibility of risks and the ability to profile and aggregate risks across the Health Board. We make no recommendation in this area given an all-Wales solution is being developed but highlight the position, and the impact on the assurance we can offer against Objective 3.

Our report makes two further low priority recommendations, which are best practice in nature to support the Health Board's risk maturity.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⟺ 2020/21

Assurance summary[1]

	Assurance objectives	Assurance
1	Up to date Risk Management Strategy and Procedures.	Substantial
2	Risks are managed effectively at Clinical Board/Corporate Department level.	Reasonable
3	Risks are profiled and aggregated where possible.	Reasonable
4	Risks are consistently captured, scored and mitigated (where applicable).	Reasonable
5	Progress with internal audit recommendations from 2020/21 Risk Management audit.	Substantial

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

	Key Matter Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2	Enhancements required to Clinical Board and Corporate Department Risk Registers	2 & 4	Operation	Medium

1. Introduction

1.1 The review of Risk Management was completed in line with the 2021/22 Internal Audit Plan for the 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 Effective risk management is a key component of corporate and clinical governance, which is integral to the delivery of organisational objectives. *"The Board Assurance Framework provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'. It provides information on the controls and assurances in place to manage and/mitigate the risks identified and any further actions which are required"*.[1]

1.3 At the Board's meeting on 27 January 2022, the Corporate Risk Register (CRR) (item 8.1) and Board Assurance Framework (BAF) (item 7.1) were presented. The covering report accompanying the CRR noted, *"The Risk and Regulation Team continue to work alongside clinical boards and corporate departments to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management Strategy and Procedure."*[1]

1.4 An internal audit of risk management is undertaken annually, with a change in focus year on year. The 2020/21 review of risk management (audit reference CVU-2021-02) reported Reasonable Assurance. The review had focused on the governance and leadership, particularly the Risk Management framework, Board Assurance Framework and Corporate Risk Register. In this review for 2021/22 greater emphasis was placed on the local arrangements within Clinical Boards and Corporate Departments.

1.5 The Director of Corporate Governance is the lead for this review.

Audit Risks

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

- Lack of awareness of the Risk Management Framework and supporting processes;
- Risks are not managed in line with the Health Board's policy and procedure;
- Risk management arrangements operate in silos and fail to provide a comprehensive risk profile of the Health Board;
- Appropriate action is not taken because risks are not being escalated through the Health Board as appropriate; and
- Exposure to reputational damages due to inadequate identification, assessment and inclusion of risk in the risk registers.

[1] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/27-1-22-final-boardbook-v9-pdf/

2. Detailed Audit Findings

Objective 1: An up to date, comprehensive Risk Management and Board Assurance Framework Strategy has been approved by the Board, and documented risk management procedures underpin and support the effective delivery of the strategy.

2.1 The Health Board has developed a comprehensive 'Risk Management and Board Assurance Framework Strategy', which was most recently received by the Audit Committee[2], and approved by the Board in July 2021[3]. Our review of the latest approved Strategy confirmed that the document comprehensively outlines the following:

- Responsibilities for strategic and operational risk management for the Board and staff throughout the Health Board;
- Describes the framework in place for identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives;
- Defines the Health Board's approach to risk appetite;
- Sets out the training arrangements with respect to risk management; and
- Incorporates and references risk management best practice guidance.

2.2 The Health Board has documented Risk Management Procedures which underpin and support the effective delivery of the Risk Management and Board Assurance Framework Strategy. The Procedures were reviewed and approved at the same time as the Risk Management and Board Assurance Framework Strategy by the Board in July 2021.

2.3 It was noted that both the strategy and procedures had been reviewed and revised by the Risk and Regulation Team to incorporate risk management standards and best practice as recommended by us when we reviewed the risk management arrangements during 2020/21. We did note however, that the assurance approach taken by the Health Board in relation to the 'three lines of defence'[4] varied slightly from the best practice guidelines, which we will consider in further detail when we undertake a planned piece of work in 2022/23 relating to Assurance Mapping.

2.4 The risk management strategy and procedures are readily available to all staff and public via the Health Board's website.

Conclusion 1: We can confirm that the Health Board has developed a comprehensive 'Risk Management Board Assurance Framework Strategy' and 'Risk Management Procedures', which are routinely reviewed and revised by the Risk and Regulation Team, and approved by the Board. (Substantial Assurance)

[2] https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/06-07-2021-audit-committee-papers-v1-pdf/ (Item 8.5)

[3] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/board-papers-29-07-2021-v3-pdf/ (Item 7.1)

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/866117/6.6266_HMT_Orange_Book_Update_v6_WEB.PDF (page 33 of 48)

Objective 2: In accordance with approved policy and procedure there are effective processes in place to manage risks within the Clinical Boards and Corporate Departments, which includes the escalation of risks.

2.5 Meetings were held with risk owners/leads from the following sample of Clinical Boards and Corporate Departments to ascertain the risk management arrangements in place:

- Medicine Clinical Board;
- Children and Women's Clinical Board; and
- Capital and Estates Corporate Department.

2.6 During 2021/22 we also undertook an advisory audit within the Mental Health Clinical Board (2122.28), which gave us a depth of understanding of processes and the risk registers held, which also informed this review.

2.7 Discussions with our sampled risk areas and a review of risk registers confirmed that there was an adequate understanding of the Health Board's risk management framework and of the roles and responsibilities of staff in relation to managing risk. Appropriate mechanisms were confirmed as being in place to effectively identify and report on new or emerging risks. It was found that there are appropriate reporting channels to elevate the profile of risks identified and these include one to one meeting with line management, weekly/monthly operational team meetings and senior management meetings. We did identify issues when reviewing the risk information captured within Clinical Boards and Corporate Department risk registers, and this has been detailed under Objective 4 and referred to in Matter Arising 2.

2.8 Clinical Boards and Corporate Departments are responsible for reviewing their risk registers and selecting risks for escalation to the Corporate Risk Register for presentation to the Board on a quarterly basis. Health Board guidance states that these risks should either have a residual score of 20 and above, or should be risks which cannot be managed effectively at Clinical Board or Corporate Department level and thus the profile needs to be raised through the governance structure.

2.9 The escalation process has been in place for some time, however it was strengthened in 2021 by the Risk and Regulation Team. It had been considered that too many risks were being escalated to the Corporate Risk Register without having received the proper review and scrutiny and this was impacting the ability to maintain an accurate and up to date Corporate Risk Register. As such a 'check and challenge' process was introduced whereby Clinical Boards and Corporate Departments would provide candidate risks for escalation and these would be reviewed and assessed by the Risk and Regulation Team prior to inclusion to the Corporate Risk Register.

2.10 Following the check and challenge process, feedback is provided to the relevant areas by the Risk and Regulation Team. We were able to evidence the operation of the process. It was confirmed that the check and challenge process was in place

for January and March 2022, however the level of engagement by each area was not consistent throughout.

2.11 Whilst we note the clear improvements from the implementation of the check and challenge process, the effectiveness relies on the level of engagement by the relevant area and feedback. Identified areas of improvement are communicated individually to each area rather than being shared across the Health Board, which could be a missed opportunity for the Health Board to identify, share and enhance risk management practice consistently.

2.12 There are currently no risk management groups in operation, such as a network of risk champions or a steering group. We have observed in other public sector organisations that a Risk Management Steering Group has taken a key role in the agreement of escalation of risks to the Corporate Risk Register. The Health Board may wish to consider if there is value in creating such a group / network, to reduce some of the reliance currently placed on the Risk and Regulation Team. *(Matters Arising 1 - Low Priority)*

Conclusion 2: Whilst Clinical Boards and Corporate Departments are broadly adhering to the Risk Management Strategy and Procedures, there is still room for improvement within the risk registers held locally. Also, the arrangements to escalate risks from a Clinical Board or a Corporate Department were evident, but we have sighted alternative practices in other public sector organisations which the Health Board may want to consider. (Reasonable Assurance)

Objective 3: Clinical Boards and Corporate Departments effectively profile their risks, and aggregate them where appropriate, in support of governance and decision making requirements.

2.13 Whilst the Health Board has adequately documented the approach to risk profiling within the Risk Management Strategy and Procedures it was difficult to evidence this objective at a Clinical Board and Corporate Department. Currently, risk registers are held in spreadsheets and reside within each Clinical Board and Corporate Department, thus there is little visibility across the organisation and limited opportunity for risk aggregation. We acknowledge that management are aware of this issue, and it was also highlighted in the 2020/21 audit of Risk Management.

2.14 Currently, the Health Board is awaiting the rollout of an All-Wales web based risk management system, which is expected to aid the capturing and recording of risk management information, to facilitate risk profiling and aggregation. The risk solution falls within the 'Once for Wales Project', which the Head of Risk and Regulation, and Risk and Regulation Officer are members. The solution is expected to be rolled out through 2022/23, after a period of slippage.

Conclusion 3: Whilst we make no recommendations in this area, we are unable to offer substantial assurance given the lack of available tools to facilitate the effective profiling

and aggregation of risks. The 'Once for Wales – risks management module' has the potential to enhance this area, once rolled out. (Reasonable Assurance)

Objective 4: There are processes in place to ensure the consistency of capturing, scoring and mitigating risks.

2.15 The Risk and Regulation team have developed a risk register template which is annexed to the Risk Management and Board Assurance Framework Strategy and Procedures. At the time of the audit, risk registers were requested from a sample of Clinical Boards and Corporate Departments and the content was reviewed. On the whole we found the registers to be in keeping with the template.

2.16 On review of the content of the sampled risk registers we identified a number of gaps, which were reoccurring across the sample of risk registers. As stated within the Risk Management Strategy and Procedures, risk owners are responsible for reviewing and updating information within their risk registers to inform decision making. This is an area for improvement for the Health Board. *(Matters Arising 2 - Medium Priority)*

2.17 Our findings from reviewing the sampled risk registers were consistent with the feedback being provided by the Risk and Regulation Team, as part of the check and challenge process. Whilst some of the issues identified are housekeeping matters, there is a need to continue educating and training staff to ensure that the risk registers are being updated accordingly. The Risk and Regulation Team have provided risk management training in the past and this must continue where it is deemed appropriate. *(Matters Arising 3 - Low Priority)*

Conclusion 4: Momentum needs to continue to enhance the risk registers currently held by the Clinical Boards and Corporate Departments, where onus lies locally, and continued training by the Risk and Regulation Team will support the improvement agenda. (Reasonable Assurance)

Objective 5: The audit will identify the progress of implementing the internal audit recommendations raised in the 2020/21 audit of risk management

2.18 The Audit Committee is provided with regular updates on the implementation of internal audit recommendations via the 'Internal Audit Tracking' Report.

2.19 The Head of Risk and Regulation also presented a 'Risk Management System' report to the Audit Committee in February 2022, setting out the progress of the five recommendations raised in the Risk Management audit 2020/21.

2.20 We are satisfied that the internal audit recommendations raised in the 2020/21 audit of risk management have been implemented.

Conclusion 5: The Health Board has progressed with the implementation of the recommendations raised in the 2020/21 audit of risk management, improvements are noted throughout this report. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Facilitation of risk escalation to the Corporate Risk Register (Operation)	Impact
The means of Clinical Board and Corporate Department risks being escalated onto the Corporate Risk Register is facilitated by the check and challenge process instigated by the Risk and Regulation Team, which is a noted improvement in the past year, but places the Team as gate keepers to the Corporate Risk Register. In other organisations we have witnessed this being undertaken by a risk management steering group, with a mix of senior individuals and input from an independent member of the Board.	Poor visibility of new and emerging high-profile risks impacting the Health Board's ability to manage these appropriately.

Recommendation 1	Priority
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.	**Low**

Agreed Management Action 1	Target Date	Responsible Officer
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.	31.12.2022	Head of Risk and Regulation

Matter Arising 2: Enhancements required to Clinical Board and Corporate Department Risk Registers (Operation)	**Impact**
Gaps were noted when reviewing the content of risk registers for the sampled Clinical Boards and Corporate Departments. As stated within the Risk Management Strategy and Procedures, risk owners are responsible for reviewing and updating information within their risk registers to inform decision making. A summary of the issues found during our testing has been detailed below: • Some risk registers adopted individual layouts which were not consistent with the approved risk register template; • A number of risk registers omitted target dates and information on risk ownership for improvement actions relating to risks; • Target dates for improvement actions had lapsed and there was no information to suggest that these had been reviewed in a timely manner; • A number of risk descriptions suggested that the risk had already materialised and was in fact an issue rather than a potential risk which may or may not occur; and • Other gaps were noted such as no link to the strategic objectives, no assignment of risk owners and gaps in mitigating actions.	Poor decision making as risk management information is missing and/or not up to date.
Recommendation 2	**Priority**
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.	**Medium**

Agreed Management Action 2	Target Date	Responsible Officer
Recommendation Agreed – Feedback on Risk Registers will continue to be provided to Risk Leads. Such feedback will, moving forward, incorporate the detail referred to in this recommendation.	30.09.2022	Head of Risk and Regulation

Matter Arising 3: Risk Management Training	Impact
Matter Arising 2 identifies gaps within Clinical Board and Corporate Department risk registers, highlighting that there is a need to continue educating and training staff to ensure that the risk registers are being updated accordingly. We note that the delivery of training has been a challenge through the COVID-19 pandemic.	Limited risk management maturity and risk management culture within the organisation.
Recommendation 3	**Priority**
Continued efforts should be made to provide risk management training to risk owners, to maintain momentum of risk management maturity within the Health Board.	**Low**

Agreed Management Action 3	Target Date	Responsible Officer
Recommendation Agreed – Training will continue to be provided to staff both proactively through offers for training, and reactively in response to specific requests.	01.07.2022	Head of Risk and Regulation

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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Performance Reporting (Data Quality)

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Cardiff & Vale University Health Board

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Committee:	Audit & Assurance Committee

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Acknowledgement
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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.

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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 Performance Reporting (Data Quality).

The review specifically focused on the 'Integrated Performance Report' and the processes in place for its production and reporting.

Overview

We have issued reasonable assurance on this area.

We have made two medium priority recommendations which require management attention, both fall within objective two of this review and focus on the robustness of systems and processes to capture and validate the data within the Integrated Performance Report, specifically the Balanced Scorecard.

Whilst we found no fundamental data quality issues within our sample, we did note the absence of data completely for one indicator. The recommendations proposed, once implemented would enhance the clarity and completeness of the report.

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

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate governance arrangements for effective reporting of the Integrated Performance Report	Substantial
2	Robustness of systems and processes to capture and validate the data required to produce the Integrated Performance Report	Reasonable
3	Timely compilation of the Integrated Performance Report	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
2	Data accuracy and completeness of the Balanced Scorecard	2	Operation	Medium
4	Further enhancements to develop the Balanced Scorecard	2	Operation	Medium

1. Introduction

1.1 The review of Performance Reporting (Data Quality) was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Effective performance reporting is integral to the Health Board's overall management and assurance arrangements. Performance reporting should focus on continuous improvement and delivering improved outcomes, highlighting when action is required to meet expected outcomes aligned to overall strategy and ministerial priorities.

1.3 Through 2020/21 the Health Board has been developing an Integrated Performance Report, which was first presented in the public session of the Board in November 2021, previous performance reporting was disaggregated. The new report includes an emerging Balanced Scorecard, with indicators that bring together Quality and Safety, Finance, Workforce, Performance and Population Health for the Health Board.

1.4 As noted in the Integrated Performance Report presented to the Board on 27 January 2022, *"This report provides the Board with a summary of performance against a number of key quality and performance indicators. This will include areas where the organisation has made significant improvements or has particular challenges including the impact of COVID-19, together with areas where the Health Board is under formal escalation measures from the Welsh Government and/or where local progress is being monitored."*[1]

1.5 Audit Wales, through their Structured Assessment 2021 (phase two) reported on the Integrated Performance Report, *"The Board has started to receive and consider the Integrated Performance Report in public since November 2021. Whilst this is a positive development, there is scope to enhance the report by aligning the indicators to the four harms associated with COVID-19, as well providing stronger assurances to the Board on the actions being taken to sustain or improve performance."*[2]

1.6 The focus of our current review was to evaluate the processes for ensuring the quality of the data within the report, and not how the Health Board is utilising the report to address performance issues or drive improvements.

1.7 The Director of Digital and Health Intelligence is the lead for this review.

[1] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/27-1-22-final-boardbook-v9-pdf/
[2] https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/audit-080222-final-boardbook-v7-0-pdf/

Audit Risks

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

- Inaccurate and incomplete performance information;
- Health Board's exposure to reputational damages; and
- The service does not meet performance measures due to ineffective monitoring and governance arrangements.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements are in place to ensure effective reporting and oversight of the Health Board's Integrated Performance Report

2.1 The Director of Digital and Health Intelligence takes the lead on compiling the Integrated Performance Report, with information provided from key areas including, Quality and Safety, Finance, Workforce, Performance and Public Health.

2.2 The executive leads for the report, as listed in the cover reports to the Board include the Executive Director Nursing, Interim Chief Operating Officer, Executive Director People and Culture, and Executive Finance Director.

2.3 In advance of the Integrated Performance Report being presented to the Board, the Executive Management Team receive the report, as evidenced on 7 March 2022. Minutes of the meeting confirmed that it had previously been agreed that the draft report would be received by the Management Executive in advance of presentation at the Board. The minutes further confirmed that the report remains a 'living and developing' document. It was resolved at the meeting that the report would be taken to the Board and that further amendments would be made for future Board meetings.

2.4 A review of the Board papers highlighted that the Board have received the Integrated Performance Report on 25 November 2021, 27 January 2021 and 31 March, which included the emerging Balanced Scorecard.

Conclusion 1: The Integrated Performance Report remains under development, but we were able to evidence the oversight by the Management Executive Team and the reporting to the Board. (Substantial Assurance)

Objective 2: The robustness of systems and processes to capture and validate the data required to produce the Integrated Performance Report and the balanced scorecard

Guidance to support the compilation of the Integrated Performance Report

2.5 At the commencement of the review the Information Manager (Analytics Team) provided a copy of the draft 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting',

which has been under development through 2021/22, in tandem with the development of the Integrated Performance Report. We support the continued development and finalisation of the guidance to support key processes and to facilitate resilience. *(Matter Arising 1- Low Priority)*

Collation and submission of the Integrated Performance Report

2.6 We were advised that the Information Manager works with the respective thematic leads to collate the information to inform the Integrated Performance Report. We noted that the Quality and Safety section of the report involves input from a number of sources, and this was being streamlined at the time of our review, the Assistant Director of Patient Experience confirmed the revised approach.

2.7 There is a standardised Integrated Performance Report template in place. To minimise the risk of error and avoid transposition errors, we were advised that the Information Manager 'cuts and pastes' information received as opposed to typing into the template.

2.8 The Integrated Performance Report once collated is submitted to the Corporate Governance team for presentation at the Executive Management Team by the Director of Digital and Health Intelligence. The Information Manager incorporates any proposed amendments by the Executive Management Team in advance of preparing for submission to the Board.

Data validation of the Integrated Performance Report

2.9 Our audit testing to validate the data within the Integrated Performance Report was measured against the report presented to the Board on 31st March 2022.[3] Our sample extended across four of the five themes. We did not take a sample from the Population theme whilst this review was progressing, since we were also undertaking a review of 'COVID-19 Vaccination Programme - Phase 3 delivery (2122.10)', which the Public Health team were already actively contributing to.

2.10 We selected a sample of measures from the Balanced Scorecard contained within the Integrated Performance Report, as outlined below:

Scorecard Theme	Audit Sample
Finance	Deliver 2021/22 Draft Financial Plan
	Creditor payments compliance 30-day Non-NHS (Cumulative)
Performance	A&E 12 hour waiting times
	Mental Health 1a
Quality & Safety	Patient Satisfaction: 30 day complaints response compliance %

[3] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/ (item 6.11)

	Patient Experience: Mass Vaccination Centres and Other Hospital Environments
	Mortality: Risk Adjusted Mortality Index (RAMI)
	Mortality: Number of still births
Workforce	Staff Turnover Rate
	Achieve annual local sickness and absence workforce target (rolling 12 month)

2.11 Overall, for the measures sampled we were able to substantiate the accuracy of the data presented in the Balanced Scorecard. Although, we identified two instances from the 10 that were impacted by rounding / transposition anomalies, and one of the indicators could not be validated due to the absence of data. *(Matter Arising 2 – Medium Priority)*

2.12 We also observed from our audit sample that the data quality risks associated with the indicators are not all equal, some are at greater risk of error because of manual intervention. *(Matter Arising 3 – Low Priority)*

General observations outside of the audit sample

2.13 We undertook a general review of the Balanced Scorecard, beyond the audit sample and have identified points for consideration and enhancement to support the ongoing development of the report. *(Matter Arising 4 – Medium Priority)*

Conclusion 2: The Integrated Performance Report has been under development through 2021/22. Whilst acknowledging this, our recommendations made under this objective will support the future development of the report, and enhance the systems and processes in place to capture and validate the data, which feeds into the report. (Reasonable Assurance)

Objective 3: The timely compilation of the Integrated Performance Report for reporting to the relevant governance fora

2.14 There is a timetable in place for compiling the Integrated Performance Report for presentation at the Executive Management Team and Board, which covers the Board meetings through 2022/23. The timeline details the following:

- Digital and Health Intelligence team's start date for collation of Integrated Performance Report cycle;
- Deadline date of Integrated Performance Report submission to Corporate Governance for Executive Management meeting;
- Date of the Executive Management Meeting;
- Deadline date of Integrated Performance Report submission to Corporate Governance for the Board meeting (papers deadline); and
- Date of Board Meeting.

2.15 We were able to evidence the communication with key leads to confirm the timeline and any noted changes, such as the impact of bank holidays. Clear requests are made for statistics, graphs and full commentary for the required areas.

2.16 For the sample of indicators we selected for testing, we were able to confirm the timely submission to the Information Manager (Analytics Team), with the exception of one indicator which was not populated in the report, referred to in Appendix A, Matter Arising 2.

Conclusion 3: We were satisfied with the arrangements in place to ensure the timely compilation of the Integrated Performance Report for reporting to the relevant governance fora. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Guidance to support the compilation of the Integrated Performance Report (Operation)	**Impact**
The draft 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting', was in development at the time of the review and was close to completion, but was yet to be approved and published. Once finalised the document will direct and provide resilience to the compilation process of the Integrated Performance Report.	Potential risks of: • Inaccurate and incomplete performance information.
Recommendation 1	**Priority**
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'.	**Low**

Agreed Management Action 1	**Target Date**	**Responsible Officer**
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.	30-Sept-2022	David Thomas, Director of Digital & Health Intelligence

Matter Arising 2: Data accuracy and completeness of the Balanced Scorecard (Operation)	**Impact**
We selected a sample of indicators from the Balanced Scorecard held within the Integrated Performance Report presented to the Board on 31st March 2022. We attempted to verify the accuracy of the reported figures and we make the following observations from our sample of 10 indicators:	Potential risks of: • Inaccurate and incomplete performance information.

Scorecard Theme and Indicator	**Board Report**	**Source documentation**
Quality and Safety – Mortality Number of still births	Blank – no data reported against the indicator	No available information
Quality and Safety - Patient satisfaction 30 day complaints response compliance %	77%	76% (76.23%)
Workforce Achieve annual local sickness and absence workforce target (rolling 12 months)	6.70%	6.68%

We did observe the meeting of the Board on 31 March 2022 and the absence of data for the 'Number of still births' was highlighted, with the intention of being addressed going forward. The further two observations are minor in nature.

Recommendation 2	**Priority**
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.	**Medium**

Agreed Management Action 2	Target Date	Responsible Officer
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.	30-June-2022	Gary Williams, Information Manager

Matter Arising 3: Risks associated with defined indicators (Operation)	**Impact**
The sample of indicators we reviewed highlighted the various processes and systems in place to extract the required information to inform the Balanced Scorecard. Some figures were easily selected from system generated reports, in contrast others required adjustments such as adding figures from a number of reports and apportioning figures to a total population, for example the 'Mental Health Part 1a' indicator, and the 'Patient Satisfaction' indicator. Although we note the manual compilation of the Patient Satisfaction indicator is a temporary process, as a result of the upgrade of the Datix system. We acknowledge that there will be varying methods to determine the results reported in the Balanced Scorecard, but there is opportunity whilst the report in underdevelopment to flag the indicators most at risk and prone to error.	Potential risks of: • Inaccurate and incomplete performance information.
Recommendation 3	**Priority**
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.	**Low**

Agreed Management Action 3	Target Date	Responsible Officer
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.	30-June-2022	Gary Williams, Information Manager

Matter Arising 4: Further enhancements to develop the Balanced Scorecard (Operation)	**Impact**
Following a review of a sample of indicators, we also undertook a wider review of the Balanced Scorecard presented to the Board on 31 March 2022 and noted the following, which if addressed would enhance the clarity and completeness of the report: • Labelling of indicators - There was an error in the period title (Dec-21) within the finance section, which should have noted 'Jan-22'. • On review of finance source data we noted that the 'Remain within capital resource limits' indicator had a target limit of £59.239m, but the scorecard notes a lower target of £55.865m. • No target / RAG rating – There were a number of indicators which have no set target and therefore no associated RAG rating. The target field was blank, which appeared incomplete. • Clarity of description – Given the scorecard is within the public domain there are a number of indicators listed which would not resonate with a member of the public or lay person, for example 'Mental Health Part 1a or 1b' and the report is not accompanied by definitions or a key. • RAG ratings – there is a lack of clarity of the tolerances associated with the RAG ratings listed.	Potential risks of: • Inaccurate and incomplete performance information.

Recommendation 4		Priority
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.		**Medium**
Agreed Management Action 4	**Target Date**	**Responsible Officer**
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.	30-June-2022	Gary Williams, Information 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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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

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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

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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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