Public Audit Committee Meeting

Tue 08 November 2022, 09:30 - 13:00

Agenda

09:30 - 09:30
0 min

1. Welcome and Introductions

John Union

09:30 - 09:30
0 min

2. Apologies for Absence

John Union

09:30 - 09:30
0 min

3. Declarations of Interest

John Union

09:30 - 09:30
0 min

4. Minutes of the Committee meeting held on 6 September 2022

John Union

- 04 Draft Public Audit Minutes SeptemberMD - HIA adjustments.pdf (12 pages)

09:30 - 09:30
0 min

5. Action log following meeting held on 6 September 2022

John Union

- 05 Draft Public Action Log - NovemberMD.pdf (4 pages)

09:30 - 09:30
0 min

6. Any other urgent business

09:30 - 09:30
0 min

7. Items for Review and Assurance

7.1. Internal Audit Progress Report

Ian Virgil

- 7.1 Internal Audit Progress Report Cover.pdf (2 pages)
- 7.1a CV AC A&A Progress Report November 22.pdf (22 pages)

7.2. Taking Care of the Carers Update

Rachel Gidman

- 7.2 Taking Care of the Carers Update Cover Report.pdf (4 pages)
- 7.2a Updated AW Tracker Sept 2022.pdf (2 pages)
- 7.2b Updated AW Tracker Sept 2022.pdf (1 pages)
- 7.2c Updated AW Tracker Sept 2022.pdf (1 pages)

7.3. Audit Wales Update to include:

Wales Audit

7.3.1. Audit and Assurance Committee update report

7.3 C&VUHB AC Update (November 2022).pdf (10 pages)

7.3.2. 'Equality Impact Assessment – more than a tick box exercise'

7.3b Equality Impact Assessments - more than a tick box exercise.pdf (44 pages)

7.3.3. Estates follow-up review management response

7.3c CV Estates follow-up review management response (October 2022).pdf (4 pages)

7.4. Declarations of Interest, Gifts and Hospitality Report

Nicola Foreman

7.4 Declarations of Interest Gifts and Hospitality Tracking Report November 2022.pdf (4 pages)
7.4a - Appendix 1 - Draft Updated Register.pdf (1 pages)
7.4b - Declarations of Interest Register.pdf (5 pages)

7.5. Internal Audit Tracking Report

Nicola Foreman

7.5 Internal Audit Tracking Report - November 2022.pdf (4 pages)
7.5(a) - Appendix 1- Internal Audit Tracker November 2022 Aged High Priority Recommendations.pdf (3 pages)

7.6. Audit Wales Tracking Report

Nicola Foreman

7.6 Audit Wales Tracking report covering report - November 2022.NF.pdf (3 pages)

7.7. Assurance Mapping Phase 2

Nicola Foreman

7.7 Assurance Mapping Phase 2 Update.NF.pdf (4 pages)

7.8. Regulatory Compliance Tracking Report

Nicola Foreman

7.8 Regulatory Compliance Tracking Report November 2022.NF.pdf (4 pages)

7.9. Procurement Compliance Report

Catherine Phillips Claire Salisbury

7.9 Procurement Compliance Report.pdf (6 pages)

7.10. Counter Fraud Progress Report

Catherine Phillips Gareth Lavington

7.10 Counter Fraud Progress Report Cover Report.pdf (2 pages)
7.10a CAV Period 3 - 2022 Progress Report.pdf (12 pages)

7.11. Net Zero Carbon Report

Abigail Harris Ed Hunt

7.11 Decarbonisation – Audit Wales 5 Calls For Action.pdf (5 pages)

7.12. Review of Draft Charitable Funds Annual Report and Accounts

Catherine Phillips

- 7.12 Report - Health Charity Draft Accounts 21 22.pdf (3 pages)
- 7.12a C&V FHOT Annual Accounts 21 22.pdf (24 pages)

7.13. Annual Clinical Audit Plan Review

Jason Roberts/Meriel Jenney

- 7.13 Clincal Audit Audit Committee November 2022.pdf (4 pages)
- 7.13a Appendix 1.pdf (12 pages)
- 7.13b Appendix 2.pdf (2 pages)

7.14. UHB Policies and Procedures Review

Nicola Foreman Marcia Donovan

- 7.14 UHB Policies and Procedures Review.NF.pdf (3 pages)
- 7.14 Appendix 1 (Policies Plan).pdf (9 pages)

09:30 - 09:30
0 min

8. Items for Approval / Ratification

No items

09:30 - 09:30
0 min

9. Items for Information and Noting

9.1. Internal Audit reports for information

Ian Virgil

- 9.1 CV AC A&A Internal Audit Reports for Information cover.pdf (2 pages)

9.1.1. Follow-up: 5 Steps to Safer Surgery Final Report – Substantial Assurance

- 9.1a Follow Up Report - 5 Steps to Safer Surgery v1.0.pdf (6 pages)

9.1.2. Medical & Dental Staff Bank Final Report – Substantial Assurance

- 9.1b Final Internal Audit Report_Medical and Dental Staff Bank.pdf (14 pages)

9.1.3. Staff Wellbeing: Culture & Values Final Report – Reasonable Assurance

- 9.1c Final Internal Audit Report_Staff Wellbeing Culture and Values.pdf (24 pages)

9.1.4. Implementation of National IT Systems (WNCR) Final Report - Reasonable Assurance

- 9.1d IT Systems WNCR final IA Report.pdf (17 pages)

9.1.5. Digital Strategy Final Report – Reasonable Assurance

- 9.1e Digtial strategy final IA Report.pdf (15 pages)

9.1.6. Medical Equipment & Devices Final Report – Reasonable Assurance

- 9.1f Final Internal Audit Report_Medical Equip. Devices.pdf (18 pages)

9.1.7. UHL Endoscopy Expansion Final Report – Reasonable Assurance

- 9.1g UHL Endoscopy Expansion Final Report.pdf (25 pages)

09:30 - 09:30
0 min

10. Agenda for Private Audit and Assurance Committee

John Union

10.1. Private Audit Minutes – 6 September 2022

10.2. Counter Fraud Progress Update

10.3. Workforce and Organisational Development Compliance Report

10.4. Overpayment of Health Board Salaries – Verbal

10.5. Self-assessment of Internal Audit and Audit Wales

09:30 - 09:30
0 min

11. Any Other Business

John Union

09:30 - 09:30
0 min

12. Review and Final Closure

John Union

12.1. Items to be deferred to Board / Committee

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

Tuesday 7 February 2023 09:30am via MS Teams

09:30 - 09:30
0 min

13. Resolution

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].

Unconfirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 6 September 2022 at 9am
Via MS Teams

Chair:		
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Present:		
Mike Jones	MJ	Independent Member for Trade Union and Committee 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-Davies	WW	Deputy Head of Internal Audit
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Aaron Fowler	AF	Head of Risk and Regulation
Tim Davies	TD	Head of Corporate Business
Urvisha Perez	UP	Audit Wales
Rhodri Davies	RD	Audit Wales
Andrew Crook	AC	Head of People Assurance & Experience
David Thomas	DT	Director of Digital Health and Intelligence
Martyn Lewis	ML	IT Audit Manager
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
John Union	JU	Independent Member for Finance
Ceri Phillips	CP	UHB Vice Chair
Rachel Gidman	RG	Executive Director of People & Culture
Mark Jones	MJ	Audit Wales

Item No	Agenda Item	Action
AAC 6/9/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 6/9/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 6/9/22 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 6/9/22 004	**Minutes of the Meeting Held on 5 July 2022** The Minutes were received.	

	The Committee resolved that: a) The draft minutes of the meetings held on 5th July 2022 were a true and accurate record of the meeting.	
AAC 6/9/22 005	**Action Log – Following Meeting held on 5 July 2022** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 6/9/22 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 6/9/22 007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: <u>Section 2</u> • Two audits were scheduled for the September Committee. However, due to delays Internal Audit were not able to meet the deadline. <u>Section 3</u> • 5 audits have been completed. • The Waste Management Audit was the final piece of work that remained from the 21-22 plan and had now been finalised. <u>Section 4</u> • The table highlighted the current stage in producing the progress report. • 3 audits have been finalised from the 22-23 plan. • 13 pieces of work were in progress. <u>Section 5</u> • 3 additional audits have been proposed for inclusion to the 22-23 plan. • A follow up of the limited assurance reports have been agreed. • The audit of Stock Management within the Neuromodulatio Service had been added to the plan following agreement b the Committee at the May 22 meeting.	

	The Independent Member for ICT (IMI) queried the amount of work that was outstanding. Also, what assurance could be given to the Committee that the plan was still deliverable. The HIA responded that they did have resources in place to deliver the work before the end of 2022/23 to feed into the Head of Internal Audit Opinion. The HIA added that it was reliant on the Health Board being able to engage in the work. However, considering the Winter pressures, early discussions would need to take place with the Executives. The Director of Digital Health and Intelligence (DDHI) stated that there had been a delay with finalising one of the audits due to the availability of people. The DDHI queried whether there was a mechanism in place to prioritise critical audits. The Director of Corporate Governance (DCG) responded that there was a minimum number of audits that were required to obtain the Head of Internal Audit Opinion. The DCG added that the audits were under constant review. The IMI queried what the minimum number of audits required were. The HIA responded that there was not a definitive number. The audit plan needed to give sufficient coverage. <u>Waste management report</u> • The purpose was to give assurance with regards to compliance with the Waste Management legislation. • Reasonable assurance was given. • There had been significant challenges faced by the Health Board in regards to waste. • A number of areas of good practice were identified to develop. • 5 medium priority recommendations were made. • Section 9 included the management actions to deal with the recommendations. The Deputy Head of Internal Audit (DHIA) highlighted the following: <u>Integrated Medium Term Plan 2022-2025: Development process</u> • Substantial assurance was given. • The audit looked at the plans in place to develop the IMTP. • A number of small recommendations that were medium priority were made. • Two further low priority recommendations were also made.	

	Monitoring and reporting of staff sickness absence • Reasonable assurance was given. • The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to monitoring and reporting of staff sickness absence. Follow-up: Ultrasound Governance • The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Ultrasound Governance review that had provided limited assurance. • The two high priority recommendations raised were now complete. That moved the overall rating from a 'Limited' to 'Reasonable' Assurance, given the mitigation in risk. • Of the five recommendations made, only one medium priority remained incomplete and was a work in progress. • The outstanding recommendation would remain on the Tracker. Stock Management - Neuromodulation Service (Specialist Services CB) • Reasonable assurance was given. • This audit was not included in the plan initially. • However, the Internal Audit team were approached by the Clinical Board. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports, were considered. b) The proposed additions and adjustments to the planned timings for the identified 2022/23 audits were approved.	
AAC 6/9/22 008	**IT Service Management Verbal Update** The DDHI updated the Committee on the following: The verbal update related to the limited assurance report which had been carried out on the ITIL compliant services. 1) Service desk and service design. – 3 recommendations were made. – It was originally agreed that they would be completed by September. Those recommendations had now been met. – The business case had been approved for additional resourcing. – The intention was that all Digital staff would go onto the ITIL training.	

2) Lack of documented guidance

- 2 recommendations were made around procedures and guidance.
- Those recommendations had now been completed.
- Management were now working on the Ivanti system.

3) Call classification and prioritisation

- There were a few recommendations.
- Calls should be drawn up and training provided. That had now been completed.
- The free text fields that were applicable have been removed.
- Call type and priority fields had been completed on the new Ivanti System.

4) Call status monitoring

- The process to ensure call activity was maintained had been completed.
- The team was looking to procure a piece of software for reporting. The proposal was that this would be added to the system in September.

5) Service catalogue

- Service Catalogue setting out the service level had now been added onto the system.
- The Service Level Agreements (SLAs) were not being formally enforced yet but were being reported on. There was a piece of work to do with individual departments regarding SLAs.

6) Call resolution

- There were 2 actions to complete. Both had now been added.

7) Problem management

- This had been postponed. However, master incident had been installed. This was another method of collating incidents.
- The team would look at whether it would address the challenge.

8) Knowledge management

- The FAQs and knowledge-based information was available on the portal and was being expanded as more customer feedback was received.

The HIA commented that it was positive to see that the recommendations were being addressed.

	The HIA added that they would be completing a separate audit to look at the Ivanti system and would use that audit to give assurance on the implementation of the recommendations from the IT Service Management Audit. The DDHI stated that they would be taking formal standing reports on Ivanti system through the DHIC Committee. The IMI stated that the Health Board would not see the full benefit of the actions for a while. It was important to recognise that it was a journey and the change in behaviour would take time. **The Committee resolved that:** a) The IT Service Management Verbal Update was received.	**IA** **DDHI**
AAC 6/9/22 009	**ChemoCare IT System – Verbal** The DDHI highlighted the following: • There were a number of actions with timescales. • There had been a delay mainly with the DHCW building interfaces and getting it signed off. • The changes were scheduled to take place at the end of October. • The Digital Team was running on Version 5 at the moment. • The first recommendation to create an SLA breach log with an annual review had started. • The second recommendation related to an activity to implement post Version 6 had been pushed back to October. • Section 2 – Looked at the database. – All 6 actions related to the upgrade. – The first 2 related to servers and they had been procured. – The Digital Team was currently awaiting the Version 6 upgrade. – The remaining actions relied on the upgrade and had been paused. • Section 3 – Looked at user training logs. - The refresh training was currently underway. • Section 4 – Looked at user management. - The SOP had been updated to reflect current roles.	

	- Generic accounts on the Paediatric system had been actioned and was now complete. The DDHI stated that the Audit was taking place in November. The IMI queried whether it was realistic to do a follow up in November as there could be set backs. The HIA stated the key was to do the follow up before the year-end to feed into the Head of Internal Audit opinion. The DCG queried the impact of the delay and whether there was any risk. The DDHI responded that he had checked with services and had spoken to Pharmacy teams and there were no real risks. **The Committee resolved that:** a) The ChemoCare IT System verbal update has been received.	
AAC 6/9/22 010	**Audit Wales Update to include:** • Audit of Accounts' Addendum Report • Estates Follow Up Review Rhodri Davies (RD) updated the Committee on the following: • There were two main pieces of work that were ongoing. • The 21/22 Annual Accounts were certified on 17 June 202 • The other piece of work that was being undertaken was or the Charity audit 21-22. The audit plan was issued at the Board of Trustee (BOT) meeting last Thursday. Audit Wale were looking to commence the work late October. Urvisha Perez (UP) updated the Committee on the following: • The Estates Management follow up review was now complete. • Exhibit 3 showed the work that was currently underway. • The field work for this year's Structured Assessment was progressing well. Audit Wales were looking to bring the report to the November Audit Committee. <u>Audit of Accounts' Addendum Report</u> • Recommendations that followed the Annual Accounts. • 8 recommendations were made this year and were set out in paragraph 2 of the Report along with the management responses. <u>Estates follow up review</u> • Audit Wales found that the Health Board was taking steps for estates improvement.	**Audit Wales**

	• It was a follow up review of the 7 recommendations. 2 were complete, 1 was ongoing, and 2 had been superseded. There was no progress in 2 of the recommendations. **The Committee resolved that:** a) The Audit Wales Update was discussed and noted.	
AAC 6/9/22 011	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the report and highlighted the following: • There had been a modest increase in submissions since July 2022. • The Risk and Regulation Team was undertaking a piece of work with Welsh Government which focussed on healthcare practitioners and how to record their interests. • Between now and the next update a cleanse would be done. • DOI recorded on the Health Board website had not changed a lot. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The Declarations of Interest, Gifts, Hospitality & Sponsorship Register was approved.	
AAC 6/9/22 012	**Internal Audit Tracking Report** The HRR presented the report and highlighted the following: • The Risk and Regulation Team met regularly with Internal Audit. • There had been an increase in recommendations from 91 to 115. • Of the 115 recommendations listed within the Tracker, 31 were recorded as completed, 58 were listed as partially complete and 26 were listed as having no action taken or reported since the July Committee meeting. • The request was that the outstanding actions be targeted at future Committee meetings. The HIA advised that there was a need to move reports forward and to give focus to recommendations that have been on the Tracker for a long period of time. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit was noted. b) The progress which has been made since the previous Audit and Assurance Committee Meeting in July 2022 was noted.	

AAC 6/9/22 013	**Audit Wales Tracking Report** The HRR presented the report and highlighted the following: • The Tracker recorded 24 Audit Wales recommendations brought forward from the Audit and Assurance Committee in July 2022, all of which were partially complete. • That represented an increase of 7 entries which were attributed to the 'Review of Quality Governance Arrangements' Audit which was presented to the July Committee meeting. • A review of all outstanding recommendations had been undertaken with the Executive and Operational Leads for each recommendation since July 2022. • That work will continue and be reported at each Audit and Assurance Committee to provide regular updates on the status of recommendations. Urvisha Perez (UP) requested an offline discussion about the new process. **The Committee resolved that:** a) Assurance from the progress which has been made in relation to the completion of Audit Wales recommendations was noted. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	**DCG/HRR/AW**
AAC 6/9/22 014	**Assurance mapping** The DCG presented the report and highlighted the following: • The Risk and Regulation Team had been trying to develop an assurance map together with Internal Audit. • Internal Audit have completed an advisory report. • The Risk and Regulation team was looking to introduce those recommendations. • Phase 2 would involve completing an audit which would come to the Audit Committee and Board in November. • It was a huge piece of work. However, once it was in place it would just involve keeping it up to date. **The Committee resolved that:** a) The Assurance Mapping Update was noted and it was agreed that a further update, following implementation of the opportunities identified by Internal Audit, would be shared at the November Audit and Assurance Committee Meeting.	**DCG**

AAC 6/9/22 015	**Regulatory Compliance Tracking Report** The HRR presented the report and highlighted the following: • This was a tool used to monitor compliance with Welsh Health Circulars and recommendations made by Health regulators. • Since the July meeting, there have been 3 completed entries which were removed from the Tracker. The DCG stated that the Health Inspectorate Wales reports were now being reported at the Quality Safety Experience Committee and tracked through the Audit Committee. **The Committee resolved that:** a) The assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations was approved. b) The continuing development of the Legislative and Regulatory Compliance Tracker was noted.	
AAC 5/7/22 016	**Procurement Compliance Report** The Executive Director of Finance (EDF) presented the report and highlighted the following: • The Procurement Team was currently doing improvement work which would be discussed in the Private session of the Committee meeting. **The Committee resolved that:** a) The contents of the Report were noted. b) The contents of the Report were approved and agreed.	
AAC 5/7/22 017	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LCFS) presented the Report and highlighted the following: • A lot of time had been spent on developing the infrastructure of the Counter Fraud Team (CF Team). • The CF Team had developed Fraud awareness tools, such as posters placed throughout the organisation. • There had also been a pop-up Fraud session in the Health Board. • 1 member of the CF Team had left and the recruitment process to fill that post had started. By the end of Quarter 3 the CF Team should be back up to speed. • 2 prevention fraud notices have been issued. They have had no impact on the Health Board. • The CF Team have issued one local fraud alert in relation to a phishing scam targeting • 2 fraud sessions have been delivered to the overseas Nurses and Primary Care team.	

	• 9 referrals have been made. None were progressed to formal investigation. • 6 formal investigations have been opened to start. The Independent Member for Trade Union (IMTU) commented that the posters for Counter Fraud are really helpful. The screen savers were also a deterrent. **The Committee resolved that:** a) The contents of the report were noted.	
AAC 5/7/22 018	**Procedure for Internal and External Tracking Reports Update** The DCG updated the Committee on the following: • The plan was to bring in people who are not responding to chasers or have long standing recommendations on the tracker to the Committees. • That would help to improve the process. **The Committee resolved that:** a) The amendment of the of the Committee work plan to reflect the reduction in frequency with which the Internal Audit, Audit Wales and Legislative and Regulatory Recommendation Trackers are reported to Committee was approved.	
	Items for Approval / Ratification	
AAC 5/7/22 019	**Internal Audit reports for information:** i. Monitoring and Reporting of Staff Sickness Absence ii. Ultrasound Governance Follow-up (CD&T CB) iii. Integrated Medium Term Plan 2022 – 2025: Development Process iv. Stock Management – Neuromodulation Service (Specialist Services CB) v. Waste Management	
AAC 5/7/22 20	**Agenda for Private Audit and Assurance Committee** i. Private Audit Minutes – 14 June 2022 and 5 July 2022 ii. Counter Fraud Progress Report (Verbal) iii. Workforce and Organisational Development Compliance Report iv. Overpayment of Health Board Salaries (Verbal) v. Procurement Influenceable Spend Report and Improvements	
AAC 5/7/22 021	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	

AAC 5/7/22 022	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
	Date and time of next committee meeting Tuesday 8 November 2022 at 9am via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
6 September 2022
(For the Meeting 8 November 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 22/5/4/007	IT Service Management Report	David Thomas to provide an update on the IT service Management Report actions.	David Thomas	6/9/2022	Complete An update was provided at September Committee.
AAC 22/2/8/023	Meeting with Audit Wales	Independent Members to meet with Audit Wales virtually.	Nicola Foreman	6/9/2022	Complete The Meeting between the Committee IMs and Audit Wales scheduled to take place before Audit meeting took place in September and is scheduled to take place before each Audit Committee meeting this financial year.
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	6/9/2022	Complete An update was provided at September Committee and the item is scheduled to be presented to the Committee on 8 November 2022 (see agenda item 7.2).

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	Complete An update was provided at September Committee.
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	Complete An update was provided at September Committee.
AAC 5/4/22 010	Review System of Assurance	A high- level assurance map to be provided to Board.	Nicola Foreman	6/9/2022	Complete An update was provided at September Committee.
AAC 14/6/22 008	Audit Wales ISO 260 Report	A follow up report would go to the September meeting.	Audit Wales	6/9/2022	Complete An update was provided at September Committee.
AAC 5/7/22 009	The Estates Review audit	Aiming to present these in September meeting.	Audit Wales	6/9/2022	Complete An update was provided at September Committee.
AAC 5/7/22 009	The Orthopaedic Services: Follow up	Aiming to present these in September meeting.	Audit Wales	6/9/2022	Complete An update was provided at September Committee.
		Actions in Progress			
AAC 22/2/8/009	Audit Wales Report: Taking Care of the	Nicola Foreman to agree timescales with Rachel Gidman and Claire Whiles regarding	Nicola Foreman	8/11/2022	Update by 8 November 2022

	Carers' – Management Response	when to take the recommendations off the Tracker.			On the agenda for November's Committee meeting. Agenda item 7.2
AAC 6/9/22 008	IT Service Management Audit Report	Internal Audit will be undertaking an audit in relation to the Ivanti system.	Internal Audit	8/11/2022	Update by 8 November 2022 Date to be confirmed regarding when the Ivanti system audit will be carried out.
AAC 6/9/22 014	Assurance mapping phase 2	Nicola Foreman will bring this to the November meeting.	Nicola Foreman	8/11/2022	Update by 8 November 2022 Agenda item 7.7
AAC 6/9/22 010	Field work for structured assessments	Audit Wales will bring this to the November meeting.	Audit Wales	8/11/2022	Update by 8 November 2022 Agenda item 7.3
AAC 6/9/22 013	Audit Wales Tracking Report	An offline discussion about the new process to be held between Audit Wales, Director of Corporate Governance and Head of Risk and Regulation.	Audit Wales/Nicola Foreman and Aaron Fowler	8/11/2022	Update by 8 November 2022
Actions referred to Board / Committees					
AAC 5/4/22 010	Review System of Assurance	A high- level assurance map to be provided to Board.	Nicola Foreman	29/9/2022	Completed An update was shared at the Board meeting on 29 September 2022.
AAC 5/7/22 015	Risk Management Review	An update report relating to the Risk Management Review is scheduled to go to Board in July 2022.	Nicola Foreman	28/7/2022	Completed This Matter was considered and agreed by Board at its July meeting.

AAC 6/9/22 008	IT Service Management	Standing reports regarding the Ivanti System are to go to the Digital Health Intelligence Committee	David Thomas	8/11/2022	Update by 8 November An update to be shared at the next Audit Committee.
AAC 6/9/22 014	Assurance mapping Phase 2	Phase 2 Assurance mapping to be presented to Board in November.	Nicola Foreman	7/2/2022	Update by 7 February 2023 Matter due to be presented to full Board at its meeting on 24 November 2022.

Report Title:	**Internal Audit Progress Report**				Agenda Item no.	7.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	08/11/22	
			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 the Audit & Assurance Service 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 & Assurance 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 & Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee 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 reports from the 2022/23 plan have been finalised since the September 22 meeting:

- Follow-up: 5 Steps to Safer Surgery – Substantial Assurance
- Medical & Dental Staff Bank – Substantial Assurance
- Staff Wellbeing: Culture & Values – Reasonable Assurance
- Implementation of National IT Systems (WNCR) - Reasonable Assurance
- Digital Strategy – Reasonable Assurance
- Medical Equipment & Devices – Reasonable Assurance
- UHL Endoscopy Expansion – Reasonable Assurance

The progress report includes details of proposed contingency adjustments to the 2022/23 plan, in anticipation of increased pressures on the Health Board over the winter period and the potential impact this may have on delivery of the plan. Proposed amendments to the planned timings for two audits are also included.

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 contingency adjustments to the 2022/23 plan and proposed amendments to timings.

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:

Mohamed,Sarah
03/11/2022 16:33:19

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee November 2022

NWSSP Audit and Assurance Services

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

Contents

1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2022/23 Internal Audit plan.

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

The plan for 2022/23 was agreed by the Audit & Assurance Committee in April 2022 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

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

Audit	Current Position	Draft Rating	Reason
Administration Services (Mental Health CB)	Planning		Delay in receiving information from management to be able to commence the audit
Endoscopy Insourcing (Medicine CB)	Draft	Reasonable	Delay in completing fieldwork due to waiting for provision of information
Medical Records Tracking (CD&T CB)	Work in Progress		Delay in commencing audit due to the availability of Internal Audit resources
University Hospital Llandough – Engineering Infrastructure	Work in Progress		Delay in completing fieldwork due to waiting for provision of information.

3. Outcomes from Completed Audit Reviews

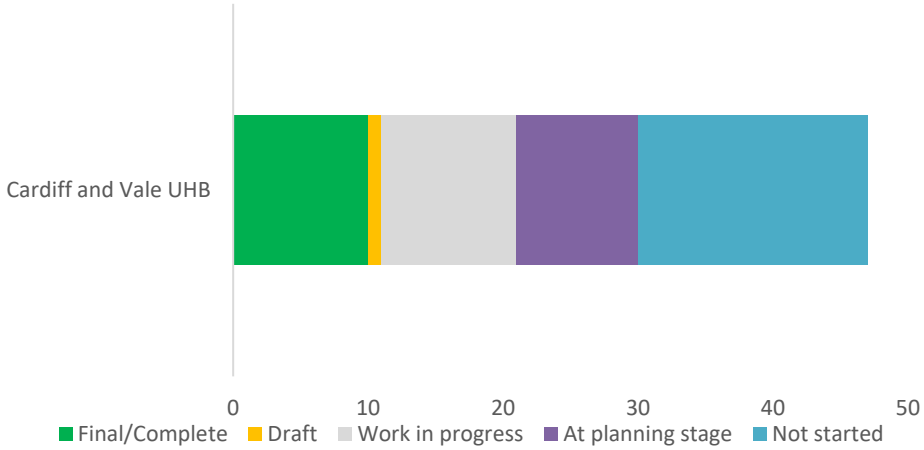
Seven assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Follow-up: 5 Steps to Safer Surgery	Substantial	
Medical & Dental Staff Bank		
Staff Wellbeing – Culture and Values	Reasonable	
Implementation of National IT Systems (WNCR)		
Digital Strategy		
Medical Equipment & Devices		
University Hospital Llandough – Endoscopy Expansion		

4. Delivery of the 2022/23 Internal Audit Plan

There are a total of 47 reviews within the 2022/23 Internal Audit Plan, and overall progress is summarised below.



From the illustration above it can be seen that ten audits from the 2022/23 plan have been finalised so far this year and one has reached the draft report stage.

In addition, there are ten audits that are currently work in progress with a further nine 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.

5. Changes to the 2022/23 Plan

At the Audit Committee meeting in September 2022, the Independent Members queried the deliverability of the Internal Audit plan given the potential pressures that may be faced by the Health Board over the winter period.

Whilst Internal Audit resources are currently in place to allow delivery of the full plan, it was agreed that it would be prudent to consider contingency arrangements which will allow for reasonable adjustments to be made to the plan if and when required.

We have therefore undertaken an exercise to identify those audits that are potentially lower risk or less critical to the delivery of the annual opinion. It is proposed that the identified audits will initially be rescheduled to the end of the 22/23 plan but with the possibility that they could be removed or deferred into 23/24 if required.

The audits that have been identified so far are detailed within the following table, along with the rationale for identification.

Audits Identified	Lead Exec Dir	Rationale
Reporting of Covid Deaths	Nursing	The audit wouldn't be of particular value at the current time given the implementation of the Medical Examiner role and the different Covid position.
Implementation of People & Culture Plan	People & Culture	The majority of the implementation plan has already been reviewed as part of the Staff Wellbeing audit.
Application of Local Choices Framework	Chief Executive / COO	Unclear on the potential scope or benefit in current position / lack of comparability to other organisations.
Regional Planning Arrangements	Strategic Planning	Focus would be on identifying lessons to take forward into future regional planning so not a key risk area in the current year.

The identified audits have been shared with the Senior Leadership Board (SLB) for review, and comments have been requested, along with consideration of any additional audits that could be added to the list.

Pending SLB feedback and Committee approval, the four identified audits have been rescheduled to the end of the 22/23 plan (as detailed in Appendix A). The ongoing situation will be monitored and if the full delivery of the plan is not achievable then the identified lower risk and less critical audits will be removed and considered for inclusion in the 23/24 plan. This will ensure that the remaining audits within the plan provide sufficient coverage of key risk areas to allow for the provision of a full Head of Internal Audit Opinion for the year.

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

- Medical Staff Additional Sessions – Move from Q3 to Q4 at the request of the Medical Director, due to ongoing consultation on national guidance; and
- Recovery of Services – Move from Q3 to Q4 following discussion with the COO and Managing Director of Non-acute Services.

6. Final Report Summaries

6.1 Staff Wellbeing - Culture and Values

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Staff Wellbeing – Culture and Values'.

Overview

We have issued reasonable assurance on this area.

The findings of our audit have highlighted that the Health Board has clear plans in place of how it intends to support staff wellbeing, principally driven by the People and Culture Plan 2022 – 2025. The Plan is now moving into the delivery phase and our recommendations focus on the mechanisms and means of evaluation to support the implementation of the ambitious aspirations. The majority of our recommendations reflect this, and sit within objective three.

We make further recommendations around references within the Board Assurance Framework, and the need to verify source material signposted on the new SharePoint site.

Low priority recommendations are detailed within Section 2 and Appendix A of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Documented set of values	Substantial
2	Acceptable and unacceptable workplace behaviours	Reasonable
3	Governance arrangements to manage and monitor wellbeing	Reasonable
4	Risks are captured and monitored	Substantial
5	Engagement with all staff	Reasonable
6	Training and resources are available to all staff	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Out of date references to the former Values and Behaviours Framework	2	Operation	Medium
2	Completeness of the People and Culture Plan's Priority Action Plan	3	Design	Medium
3	Tracking and monitoring the People and Culture Plan	3 & 5	Design	Medium
4	Terms of Reference for the Strategic Wellbeing Group	3	Design	Medium
6	Monitoring and delivery of the Wellbeing Plan	3	Design	Medium
7	Cultural assessment toolkit	3 & 5	Operation	Medium
10	Board Assurance Framework: Staff Wellbeing Risk (Occupational Health)	6	Operation	Medium

6.2 Follow-up: 5 Steps to Safer Surgery

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the 'Five Steps to Safer Surgery' Audit (CVU-2122-16) that was undertaken as part of our 2021/22 work programme, which reported 'Limited' assurance.

Overview of findings

Significant progress has been made in addressing the seven recommendations arising from the previous internal audit, completed in October 2021. Management acted promptly to review and update guidance documentation and to strengthen the monitoring of compliance within this area.

Agreed actions relating to all recommendations have been addressed and closed. Our review of documentation and discussions with lead staff confirmed a number of key actions which mitigated the risks posed in the initial audit, which include:

- Senior management took a key role in leading the actions to be taken to address the recommendations;
- A new risk assessment has been undertaken and is continuously reviewed by senior staff;
- Procedures have been updated and reissued to staff; and
- New modules have been implemented within the TheatreMan system to address the original findings from the audit.

The outcome of the follow up review does not aim to provide assurance against the full scope and objectives of the original audit. Rather the 'Substantial' assurance opinion reported, provides an assurance level against the implementation of the agreed action plan only.

Follow-up Report Classification

		Trend
Substantial 	**Follow up:** All high, medium and low priority recommendations implemented	⇧

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Current Progress
1	Lack of evidence to demonstrate compliance with Five Steps to Safer Surgery	High	Complete
2	Incomplete patient files to evidence Five steps to Safer Surgery (Steps 2, 3 & 4)	High	Complete
3	Observations from Theatre Visits	Medium	Complete
4	Culture towards 'Five Steps to Safer Surgery'	Medium	Complete
5	Procedures require update to support Five Steps to Safer Surgery	Medium	Complete
6	Risk Assessment to be finalised	Medium	Complete
7	Visibility of themed issues associated with Five Steps to Safer Surgery	Low	Complete

6.3 Implementation of National IT Systems (WNCR)

Purpose

To evaluate and determine the adequacy of the systems and controls in place within the Health Board for the implementation and use of national IT systems.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- There is no overall programme for uptake of national systems within the Health Board;
- There is no project plan for the roll out of WNCR across the Health Board; and
- There has been no baselining work to enable the Health Board to demonstrate the benefits of WNCR.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Programme in place	Reasonable
2	Plan for WNCR	Limited
3	Testing	Substantial
4	Readiness Assessment	Substantial
5	Lessons Learned	Substantial
6	Benefits	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	National Systems Plan	1	Operation	Medium
2	Project Governance	2	Operation	Medium
3	Project Plan	2	Operation	Medium
4	Benefits	6	Operation	Medium

6.4 Digital Strategy

Purpose

To ensure that the refreshed Digital Strategy meets the needs of the UHB and there is a roadmap for delivery.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The roadmap should be enhanced with greater detail;
- The resources for completion of the roadmap should be fully defined;
- The level of funding allocated to Digital should be reviewed to ensure that the organisational strategies and transformation can be realised;
- Attendance from Clinical Boards should be sought at DHIC; and
- The Programme Channel Boards should be re-invigorated.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Appropriateness of Strategy	Substantial
2	Roadmap	Reasonable
3	Resources	Reasonable
4	Governance	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Roadmap Detail	2	Operation	Medium
2	Resources	3	Operation	Medium
3	Funding	3	Operation	Medium
4	DHIC	4	Operation	Medium
5	Channel Boards	4	Operation	Medium

6.5 Medical and Dental Staff Bank

Purpose

The overall objective of the audit was to review the effectiveness of the processes and controls operating within the Health Board's new Medical and Dental Staff Bank managed by Medacs Healthcare.

Overview

We have issued substantial assurance on this area.

A framework agreement is in place for the Medical and Dental Managed Bank Service. We found that robust processes are operating to ensure appropriate employment checks are completed and terms & conditions are issued for all bank staff. Bank shifts are verified and authorised prior to payment and regular performance reporting and monitoring is undertaken.

There is only one key matter requiring management consideration, which relates to the timeliness of shifts entered on the Envoy system. From our review, a third of our sample identified that available shifts had been added to the system retrospectively, after the shift had taken place.

We also raise two low priority recommendations which are detailed within Section 2 and Appendix A of the report.

Report Opinion

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Objectives	Assurance
1	Approved contract in place for the managed service of the Medical and Dental Staff Bank	Substantial
2	All Bank staff have had appropriate employment checks	Substantial
3	Terms of Engagement is issued to all Bank Staff	Substantial
4	All completed Bank shifts are verified and authorised	Reasonable
5	Reports on bank usage and costs are produced	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Retrospective requests for Bank Shifts entered on the Envoy system	4	Operation	Medium

6.6 Medical Equipment & Devices

Purpose

The overall objective of this audit was to review the arrangements in place for recording, monitoring and replacing medical equipment and devices.

Overview

We have issued reasonable assurance on this area.

The Health Board has an up to date policy and procedure in place, with effective processes for the purchase and maintenance of Medical Equipment and Devices. Risk assessments are being undertaken on new items and actions are taken following reported incidents.

We make a number of medium priority recommendations within our review which relate to:

- The increased awareness and dissemination of the updated Medical Equipment Policy and Procedure;
- Formal approval of the Policy by Quality, Safety and Experience Committee;
- The accuracy of location and presence of loaned and substantive medical equipment as stated within the Medusa database;
- Absence of medical equipment contamination documentation; and
- Available evidence to support training undertaken of equipment prior to first use.

A further low priority recommendation which is best practice in nature is captured within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policy and Procedures	Reasonable
2	Procurement and Contract Monitoring	Substantial
3	Inventory and Records Management	Reasonable
4	Operational Arrangements	Reasonable
5	Risks and Incidents	Substantial
6	Training	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Awareness of the revised Policy and Procedure	1	Operation	Medium
2	Quality, Safety & Experience Committee approval of the revised Policy (UHB 082 v.5)	1	Operation	Medium
4	Medusa Medical Equipment Database: Accuracy of Equipment Location	3	Operation	Medium
5	Management of Loaned Medical Equipment	3	Operation	Medium
6	Completion and submission of contamination status clearance certificates	4	Control Design	Medium
7	Evidence of training in use of medical equipment prior to first use	6	Control Design	Medium

6.7 University Hospital Llandough – Endoscopy Expansion

Purpose

The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Endoscopy Expansion Project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Overall Audit Opinion and Overview

Reasonable assurance has been determined at this stage of the project.

Contractual arrangements were appropriately approved; however, they have deviated (for both contractor and advisers) from the requirements determined within the approved Business Justification Case (BJC); with no amended procurement strategy approved.

Despite this issue, with the agreed arrangements, a robust project governance structure was in place with continual liaison and effective reporting to the relevant forums.

At the date of fieldwork (8 weeks into the construction programme) the Project Manager was reporting a delay of seven weeks. This is due to the ongoing structural redesign due to the originally appointed structural designer going into administration. There is a risk that this could be further extended and will need to be monitored and managed appropriately by the UHB.

Key matters requiring management attention, include:

- The management of the risks associated with the changes to the defined procurement strategy (and associated contract forms).

Other recommendations are within the detail of the report.

Report Classification

Reasonable Assurance

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	Project Governance	Reasonable
2	Design Development	Reasonable
3	Procurement	Substantial
4	Contract Management	Reasonable
5	Project Management	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
1.1	Approval of the Senior Responsible Officer role.	1	Operation	Medium
1.2	Inclusion of assignment to key project roles within the Procedure Manual for Managing Capital Projects.	1	Operation	Medium
4.1	Inclusion of updates from the Principal Designer into established reporting mechanisms.	1	Operation	Medium
6.2	Retrospective approval of the amended contractual arrangements with the main contractor.	3	Design	Medium

6.3	Inclusion of the Contract strategy decision-making process at the Procedure Manual for Managing Capital Projects.	3	Design	Medium

Future Assurance Matters[2]		Assurance Objective	Control Design or Operation	Recommendation Priority
5.1	Application of the design control process, as per the Procedure Manual for Capital Projects.	2	Design	Medium
6.1	Amendments/virement from approved business cases to be documented, reported to an appropriate forum and approved.	3	Operation	Medium
7.1	Limitation period afforded under the contract arrangements.	4	Design	Medium

[2] Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken at this project, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2021/22 Plan							
Monitoring and Reporting of Staff Sickness Absence		*People & Culture*			*Final*	*Reasonable*	*September*
Capital Systems Management		*Finance*			*Work In Progress*		*February*
2022/23 Plan							
IMTP 2022-25: Development Process	37	Strategic Planning	Q1		Final	Substantial	September
Follow-up: Ultrasound Governance	26	Therapies & Health Science	Q1		Final	Reasonable	September
Stock Management – Neuromodulation Service (Specialist Services CB)	42	COO	Q1		Final	Reasonable	September
Staff Wellbeing – Culture & Values	07	People & Culture	Q1		Final	Reasonable	November
Follow-up: 5 Steps to Safer Surgery	18	Medical	Q1		Final	Substantial	November
Implementation of National IT Systems (WNCR)	20	Digital & Health Intelligence	Q1		Final	Reasonable	November
Digital Strategy	21	Digital & Health Intelligence	Q2		Final	Reasonable	November
Medical & Dental Staff Bank	06	People & Culture	~~Q1~~	Q2	Final	Substantial	November
Medical Equipment & Devices (Deferred from 21/22)	25	Therapies & Health Science	Q2		Final	Reasonable	November
Endoscopy Insourcing (Medicine CB)	31	Chief Operating Officer	Q3	Q2	Draft	Reasonable	February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Core Financial Systems	02	Finance	~~Q4~~	Q2	Work in Progress		February
Assurance Mapping	05	Corporate Governance	~~Q1~~	Q2	Work in Progress		February
Charitable Funds	13	Finance	~~Q3~~	Q2	Work in Progress		February
Estates Assurance – Decarbonisation (Deferred from 21/22)	15	Finance	Q2		Planning		February
Administration Services (Mental Health CB)	29	Chief Operating Officer	Q2		Planning – Brief agreed October start		February
Community Patient Appliances (Specialist Services CB)	33	Chief Operating Officer	Q2		Planning - Brief agreed November start		February
Medical Records Tracking (CD&T CB)	34	Chief Operating Officer	Q2		Work in Progress		February
Financial Reporting & Savings Targets (Deferred from 21/22)	12	Finance	~~Q2~~	Q3	Work in Progress		February
New IT Service Desk Tool	22	Digital & Health Intelligence	Q3		Work in Progress		February
PCIC CB – GMS Access (Deferred from 21/22 plan)	30	Chief Operating Officer	Q3		Planning-Brief Agreed November start		February
Management of Locum Junior Doctors (Women & Children's CB)	35	Chief Operating Officer	~~Q4~~	Q3	Work in Progress		February
QS&E Governance (Deferred from 21/22 plan)	03	Nursing / Medical	Q3		Planning		April
Nurse Staffing Levels Act	10	Nursing	Q3		Planning – Brief agreed with November start		April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Cyber Security	24	Digital & Health Intelligence	~~TBC~~	Q3	Planning – Brief agreed December start		April
Strategic Programmes / Recovery & Redesign Governance Arrangements	36	Strategic Planning	Q3				April
Commissioning – IPFR Process	38	Strategic Planning	Q3				April
Risk Management	01	Corporate Governance	Q4				April
Inclusion & Equality Team	08	People & Culture	Q4				April
Capital Systems	*14*	*Finance*	*Q4*				*April*
Medical Staff Additional Sessions	16	Medical	~~Q3~~	Q4	Planning		April
Clinical Audit (Follow-up)	17	Medical Director	~~Q2~~	Q4			April
Performance Reporting	19	Digital & Health Intelligence	~~Q3~~	Q4			April
Data Warehouse	23	Digital & Health Intelligence	Q4		Planning-Draft Brief Issued		April
Consultant Job Plans (Surgery CB)	32	Chief Operating Officer	Q4				April
Management of Health Board Policies	04	Corporate governance	Q4				May
Recovery of Services	27	Chief Operating Officer	~~Q3~~	Q4			May
Implementation of People & Culture Plan	09	People & Culture	~~Q3~~	Q4	Moved to end of plan		May

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~~	Q4	Moved to end of plan		May
Application of Local Choices Framework	28	Chief Executive / COO	~~Q2~~	Q4	Moved to end of plan		May
Regional Planning Arrangements	39	Strategic Planning	~~Q3~~	Q4	Moved to end of plan		May
ChemoCare IT System Follow-up	43	Digital & Health Intelligence	TBC				TBC
Network & Information Systems (NIS) Directive Follow-up	44	Digital & Health Intelligence	TBC				TBC
Nurse Bank (Temporary Staffing Department) Follow-up	45	People & Culture	TBC				TBC
Shaping Our Future Hospitals Programme	40	Strategic Planning	Q1-4		Work in Progress		n/a
Development of Integrated Audit Plans:	*41*	*Strategic Planning*					
• *Development of Genomics Partnership Wales*			*Q3*		*Work in Progress*		*February*
• *University Hospital Llandough – Endoscopy Expansion*			*Q2*		*Final*	*Reasonable*	*November*
• *University Hospital Llandough – Engineering Infrastructure*			*Q2*		*Work in Progress*		*February*

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
IMTP 2022-25: Development Process	Substantial	Final	20/07/22	10/08/22	26/07/22	27/07/22	G
Follow-up: Ultrasound Governance	Reasonable	Final	03/08/22	24/08/22	18/08/22	18/08/22	G
Stock Management – Neuromodulation Service (Specialist Services CB)	Reasonable	Final	02/08/22	23/08/22	19/08/22	19/08/22	G
Staff Wellbeing – Culture and Values	Reasonable	Final	30/08/22	20/09/22	10/10/22	12/10/22	R
Follow-up: 5 Steps to Safer Surgery	Substantial	Final	01/09/22	22/09/22	05/09/22	06/09/22	G
Digital Strategy	Reasonable	Final	28/09/22	19/10/22	19/10/22	20/10/22	G
Medical Equipment & Devices	Reasonable	Final	30/09/22	21/10/22	21/10/22	24/10/22	G
Medical & Dental Staff Bank	Substantial	Final	11/10/22	01/11/22	21/10/22	24/10/22	G
Implementation of National IT Systems (WNCR)	Reasonable	Final	28/09/22	19/10/22	24/10/22	25/10/22	R
University Hospital Llandough – Endoscopy Expansion	Reasonable	Final	13/10/22	03/11/22	25/10/22	26/10/22	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	April 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2022/23	A	85% 11 from 13	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	91% 10 from 11	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	80% 8 from 10	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 10 from 10	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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

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Report Title:	**Taking Care of the Carers Audit – Progress Update**				Agenda Item no.	7.2	
Meeting:	**Audit Committee**		Public	x	Meeting Date:	08/11/22	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	**Executive Director of People and Culture**						
Report Author (Title):	**Assistant Director of Organisational Development, Wellbeing and Culture**						

Main Report
Background and current situation:

NHS staff continue to experience huge strains to their mental and physical health, exacerbated by the Covid Pandemic and the challenges of meeting increasing demand for services and addressing waiting lists.

In October 2021, Audit Wales published the report, 'Taking Care of the Carers? How NHS Bodies supported staff wellbeing during the COVID-19 pandemic.", the second of two publications highlighting COVID-19 related themes from their structural assessment work of NHS bodies.

The 'Taking Care of the Carers Audit' enables the UHB to respond, provide assurance and outline actions on the six recommendations resulting from the report. This paper presents a progress update of how the UHB continues to support staff wellbeing, and how it will ensure a focus upon supporting and safeguarding staff in the future.

The UHB provided a management response to six recommendations:

- R1: Retaining a strong focus on staff wellbeing
- R2: Considering workforce issues in recovery plans
- R3: Evaluating the effectiveness and impact of the staff wellbeing offer
- R4: Enhancing collaborative approaches to supporting staff wellbeing
- R5: Providing continued assurance to boards and committees
- R6: Building on local and national staff engagement arrangements

Completed by the People and Culture department, the response is underpinned by the key themes and objectives outlined in the People and Culture Plan.

- Theme 1: Seamless Workforce Models
- Theme 2: Engaged, Motivated and Healthy Workforce
- Theme 3: Attract, Recruit and Retain
- Theme 4: Building a Digitally Ready Workforce
- Theme 5: Education and Learning
- Theme 6: Leadership and Succession
- Theme 7: Workforce Shape and Supply

This paper, along with the attached tracker documentation provides a progress update following the initial response that was brought to Audit Committee in February 2022.

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

The UHB has been asked to provide a progress update following the management response to six recommendations:

R1: Retaining a strong focus on staff wellbeing

R2: Considering workforce issues in recovery plans
R3: Evaluating the effectiveness and impact of the staff wellbeing offer
R4: Enhancing collaborative approaches to supporting staff wellbeing
R5: Providing continued assurance to boards and committees
R6: Building on local and national staff engagement arrangements

The Audit Wales tracker outlines the work undertaken, and the current and future actions and priorities that will support the wellbeing of every individual who works at the UHB. Working collaboratively with colleagues across the UHB, and TU Partners, the 'People and Culture Plan' provides further alignment and a pathway to supporting our staff at every step in their career journey, from attraction through to exit, work experience through to retirement.

The UHB continues to ensure effective governance arrangements around supporting staff wellbeing through the provision of progress and update reports via established routes including Strategic Wellbeing Group, Strategy and Delivery Committee, Local Partnership Forum, Management Exec, Board Development. This will be further enhanced following the introduction of the Wellbeing Strategy and Framework. This is due for presentation to Strategy and Delivery Committee in quarter 4.

Progress Highlights – Update on Actions

- Staff room refurbishments completed. Over 30 staff rooms identified and work completed by Capital, Estates and Facilities. Rest and recuperation, including access to an appropriate physical environment, is one of the proposed priority areas of the Staff Welfare work led by Welsh Government. The UHB continues to actively contribute as part of the group with Executive Director input and has submitted a response to the priorities from the Local Partnership Forum.
- Leadership and Management Development is integral to support staff wellbeing and engagement. Management Development Programmes continue to be delivered across the UHB focusing on compassionate and inclusive approaches. The Acceler8 Senior Leadership Programme has successfully delivered the first Cohort, and the Collaborate Leadership Programme starts in October 2022.
- Leadership and Management bite-size masterclasses will be rolled out from November 2022 to support effective team working and support managers in developing a culture of compassionate leadership during challenging times. Content will be informed by feedback and need, and priority areas identified to ensure ease of access.
- Bespoke leadership and management development and support designed to support areas of greatest need, includes an OD Programme of work in EU.
- Listening to staff remains a priority to ensure the UHB is able to respond and focus on areas of greatest need. Listening and feedback exercises inform action planning and intervention, along with collaborative working with Clinical Boards and Staff Groups. Work to date includes targeted work with Nursing, Midwifery and ODPs; Medical Workforce and areas including EU. Holistic approaches also include 'Ask Suzanne / Exec' open access sessions, and focused visits to teams and departments.
- Peer support development continues with the trial of MedTRiM and Schwartz Rounds. Med TRiM training dates are scheduled for November 2022, and Schwartz round training in quarters 3 and 4 for Clinical Leads; Steering Group Members. Nominations for facilitators will commence January 2023.
- Specific work has been designed for priority areas, this has included a Wellbeing Programme for EU staff co-designed and delivered by the Employee Wellbeing Team and Clinical Psychology.
- Wellbeing Resources and support continue to be designed and provided to staff and managers. Work to date includes:
    - Inner Wellness Webinars;
    - Regular workshops on Compassionate Self-Care, Stress Awareness; Stress Risk Assessment Guidance for Managers; Wellbeing Champion Training; Wellbeing

Conversations; Assertiveness Training; Menopause; Low Mood; Mental Health Management; Long Covid Peer Support Group.
    - Drop in sessions on wards / community areas following requests from staff groups.
- Wellbeing resources continue to be developed to support all staff, along with bespoke interventions and targeted support.
- As the 'cost of living crisis' causes concern, the UHB has been working with colleagues across Wales to identify resources and effective signposting through working in partnership with regulated organisations. A series of roadshows will run across the UHB in November 2022 and a resource page has been developed to support staff.
- Further engagement work is being undertaken to understand what would support staff with cost of living.

Priorities and Focus to Support Staff

Supporting staff wellbeing, and taking care of the carers, requires a systemic, holistic and joined up approach. The themes of the People and Culture Plan provide a reminder of this as the UHB considers ways of working, policies and procedures, long term planning and innovative ways of attracting staff, retaining staff, developing staff and supporting staff.

Having mechanisms and ways to recognise the challenges facing the organisation and our people within it, enables the UHB to respond effectively and focus attention in the areas of the greatest need. During the Winter the focus will be on:

- Recruitment
- Retention
- Wellbeing

The UHB will maintain an overall focus on supporting staff, while targeting required resource to areas of greatest need.

Both the monitoring and reporting upon progress of the People and Culture Plan, along with regularly revisiting the Taking Care of the Carers actions, will enable effective governance and assurance that the UHB is 'Taking care of the carers', while ensuring the planning and delivery of the highest quality of care for our patients and communities.

Recommendation:

The Committee is requested to:

a) **note** the progress update to date.

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	x	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	x

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
Health, wellbeing and retention of staff.
Safety: Yes/~~No~~
Health and wellbeing of staff, quality of service delivery.
Financial: Yes/No
Workforce: Yes/~~No~~
Attraction, retention of staff. Sickness absence. Working relationships.
Legal: Yes/~~No~~
Duty of care.
Reputational: Yes/~~No~~
Attraction, retention of staff. Culture and behaviours.
Socio Economic: Yes/~~No~~
Health inequalities experienced in the workforce.
Equality and Health: Yes/~~No~~
Health inequalities experienced in the workforce.
Decarbonisation: ~~Yes~~/No

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

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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 staff wellbeing. Over the past 6 months the UHB has introduced a range of both UHB wide, and targeted support. This has included: •maintaining additional capacity of the Employee Wellbeing Services; •developing a practical, supportive wellbeing element to VBAs and regular 1-2-1s, including simplified paperwork and assistance in recording VBAs; •continued delivery of effective inductions and targeted pieces of work continue to be developed; •Wellbeing Retreats have run throughout July-October; •Med TRiM training is scheduled for November 2022; •over 30 staff rooms have been refurbished and refreshed; •progress is being made on Schwartz Rounds with training anticipated to commence in December 2022 following confirmation of clinical leads; •13 hydration stations are currently being discussed at Water Safety Group. The overarching direction for this has been set by 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.
2021-22	Mar-25	Taking Care of the Carers	R2/6	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	Executive Director of People and Culture	Executive Director of People and Culture Assistant Director of Organisational Development Assistant Director of Resourcing	PC	The impact of COVID-19 on the health and care system continues to take its toll on both the delivery of services and the wellbeing of our staff. With many COVID restrictions lifted, the challenges of increasing service demand, waiting lists and financial strain continue. The People and Culture Plan sets out the themes and areas of focus for the next three years, with a clear ambition to improve the wellbeing, inclusion, capability and engagement of our workforce. This Plan is aligned with the Operational plan; thereby ensuring a whole-system approach. The specific developments under the People and Culture Plan are reported upon monthly and progress is documented in a flash report. Ongoing review of actions and priorities continue, informed by direction provided by WG, feedback from colleagues and workforce data. Recent engagement exercises with staff have included a Wellbeing Survey for the Medical Workforce (closed 31st July 2022), and the launch of a three month engagement platform (Winning Temp) aimed at our Nursing and Midwifery Staff and ODPs. Feedback from these exercises will inform response and priorities to ensure safe, effective and high quality healthcare. Focused work is currently in development to support priority areas through 'Winter pressures', ensuring safe and compassionate care, the areas of focus are: Recruitment; Retention and Wellbeing (including support around the 'Cost of Living crisis'). The capacity of staff is being addressed by implementing comprehensive recruitment and retention plans to ensure the UHB is maximising opportunities to attract and retain staff.
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 captured in a quarterly report which informs the progress reports on the People and Culture Plan. Base-line information is collated in all areas where targeted interventions are being developed, to ensure an effective means of measuring impact and outcomes. The development of the Wellbeing Framework will also incorporate tools and templates to ensure that interventions, projects etc are effectively measured. The People and Culture Team are working with Innovation and Improvement to shape monitoring and evaluation. The collation of staff feedback through a range of mechanisms which include Winning Temp Platform; Medical Workforce Wellbeing Survey; TU Partners feedback via exit interviews; People and Culture feedback Exit interviews; is being analysed to ensure targeted intervention to support staff wellbeing and retention.
2021-22	Nov-23	Taking Care of the Carers	R4/6	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Recent developments in this area include Cardiff and Vale's participation and involvement in the All Wales Staff Welfare Group, looking at ways to support and improve the wellbeing of NHS colleagues across Wales. Part of this involvement is the sharing of the work CAV are doing around Wellbeing Retreats; hydration and physical environment work. Work continues to progress, and the UHB now has representation on the working groups that have stemmed from the over-arching steering group. The UHB has recently worked in collaboration with TU Partners to write a response to the Welfare Group proposals and await further information. The UHB is also involved in additional All Wales Groups looking at a range of areas including: All Wales Staff Wellbeing; Freedom to Speak Up; Research Collaboration with Cardiff University and UHB colleagues on healthcare workers resilience and wellbeing; Retention Group etc.

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	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	Reporting, feedback and update mechanisms include: • Quarterly updates to the Board / more regular reports for management executive team meetings • Updates and discussions at Local Partnership Forums and LNCs. • Update, discussion and feedback at Clinical Boards • Bi-monthly Wellbeing Strategy Group meetings - latest update 05/10/2022 • Ongoing evaluation of staff wellbeing offer, including access, impact and value awaiting OH Services evaluation. • Feedback and discussion at staff networks to inform priorities / direction of travel • Attendance of AD of OD at key strategy meetings / COVID recovery meetings to ensure staff wellbeing at forefront of decisions ; EHIA completion to support policy / process and decision making - EHIA Process currently being reviewed in partnership with Innovation and Improvement Team to embed in organisational programmes of work. All Wales work on EHIAs under discussion. Recent staff feedback regarding wellbeing / experience includes: • Winning Temp Engagement Platform – closes 25th October 2022 (Nursing, Midwifery and ODPs) • Medical Workforce Wellbeing Survey – closed 31st July, results currently being analysed alongside Consultant Wellbeing Survey and MES results • TU feedback from exit interviews • P&C Team feedback from exit interviews (EU) MES Workshops took place in March and April 2022, follow up focus groups scheduled for November 2022 led by the Medical Director and AD of Organisational Development. Communication plan in development re Winning Temp findings to ensure key themes acknowledged and actions taken. Wellbeing retreats accessed July to October, five held to date - informal feedback very positive with further engagement to obtain more meaningful feedback scheduled for November 2022 working with The Fathom Trust. Analysis of the Medical Workforce Wellbeing Survey is being finalised. This information to be triangulated with other engagement outputs (MES; other surveys) to inform wellbeing priorities via the Executive Medical Director and to support Retention, Wellbeing and Recruitment priorities.
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 - the timing here has moved to quarter 4 (as per update from HEIW) • Medical Engagement Scale - follow up online engagement sessions in March/April 2022; focus groups and visits to targeted areas planned in November 2022 and a follow-up wellbeing survey took place June-August 2022. Findings are being triangulated to support ongoing priority areas. • 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, work being undertaken to establish TORs; consistent practices; UHB support and identification of new network groups • 4,000 voices campaign (on-site visits / staff groups / teams etc) • Live, online 'Ask the CEO / Exec etc' sessions held bi-monthly • Localised engagement aligned to specific strategic projects, e.g. Shaping our future clinical services • Development of a working group to support co-production of the Anti-Racist Wales action plan

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

Count of Age	**Column Labels**						
Row Labels	**Date not Specified**	**Due Date Not Reached**	**over 6 Months**	**Over One Year**	**under 3 months**	**(blank)**	**Grand Total**
Audit of Accounts Report Addendum - Recommendations					3		3
Audit of Financial Statements Report Addendum - Recommendations				1			1
Clinical Coding Follow-up From 2014 not yet completed	2					4	6
Follow-up of Operating Theatres		5					5
Implementing the Wellbeing of Future Generations Act			7				7
Structured Assessment 2018				1			1
Grand Total	**2**	**5**	**7**	**2**	**3**	**4**	**23**

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

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Archwilio Cymru
Audit Wales

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

Date issued: November 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.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

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

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 Charitable Financial Statements	We have issued the 2022 Audit Plan, which the Charity's trustee members have considered. We anticipate starting the audit around late November, pending receipt of the draft financial statements. The Charity Commission's deadline for the certified financial statements is 31 January 2023.
Audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements	We expect to start audit planning in January 2023.

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit and Assurance Committee
Review of Estates: Follow-up of Recommendations	The report was considered by the Committee in September 2022, with the management response pending and due to be considered by the Committee in November 2022.

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
NHS Structured Assessment Executive Lead – Director of Corporate Governance	The Structured Assessment examines the existence of proper arrangements for the efficient, effective, and economical use of resources. The 2022 Structured Assessment will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Managing the workforce, digital resources, the estate, and other physical assets	Current status: Report drafting Planned date for consideration: February 2023
Orthopaedic Services: Follow-up	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges and consider the impact of the pandemic and	Current Status: We are preparing an all-Wales summary report and considering preparation of a

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
Executive Lead – Chief Operating Officer	orthopaedic service recovery. Therefore, reporting was moved to 2022.	discrete Annex for each Health Board. Planned date for consideration: February 2023
Review of Unscheduled Care Executive Lead – Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.	Blog and data tool published in April 2022 Project brief issued in August 2022 and fieldwork started in September 2022. Planned date for consideration: TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
All-Wales thematic on workforce planning arrangements	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	We are currently scoping this work with a view to starting work at the Health Board in spring 2023. We will update the committee as work progresses.
Primary Care Services - Follow-up Review (Local Work 2022)	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made a number of recommendations to the Health Board. This work will follow-up progress against these recommendations.	We are currently scoping this work. We will update the committee as work progresses.

Good Practice events and products

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

5 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee. Materials are available via the link below. Details of future events are available on the GPX website.

NHS-related national studies and related products

6 The Audit and Assurance Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Administration and Public Accounts Committee to support its scrutiny of public expenditure.

7 **Exhibit 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
Equality Impact Assessment: More than a tick box exercise? **Please see Appendix 1**	September 2022
NHS Wales Finances Data Tool - up to March 2022	August 2022

Appendix 1 – key messages from recent national publications

Equality Impact Assessments: More than a tick box exercise? (September 2022)

8 Our work looked at the overall approach to undertaking Equality Impact Assessments in public bodies in Wales. We concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015.

9 We focussed primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail.

10 Our findings highlight examples of good practice in aspects of the Equality Impact Assessment process across the public bodies we looked at. However, there are areas for improvement around the following themes:

- Greater clarity over which type of policies must be impact assessed.
- Greater clarity about the arrangements for assessing the impact of collaborative policies and practices.
- Greater clarity about expectations to consider the Public Sector Equality Duty as part of an integrated impact assessment.
- Better monitoring of the actual impacts of policies and practices on people.
- A shift in the mindsets and cultures to move Equality Impact Assessments away from being seen as an add-on 'tick box' exercise.

11 Our report makes several recommendations for Welsh Government to address and one to public bodies requiring them to review their approach to Equality Impact Assessments considering the findings within the report and detailed guidance available on the Equality and Human Rights Commission and Practice Hub.

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

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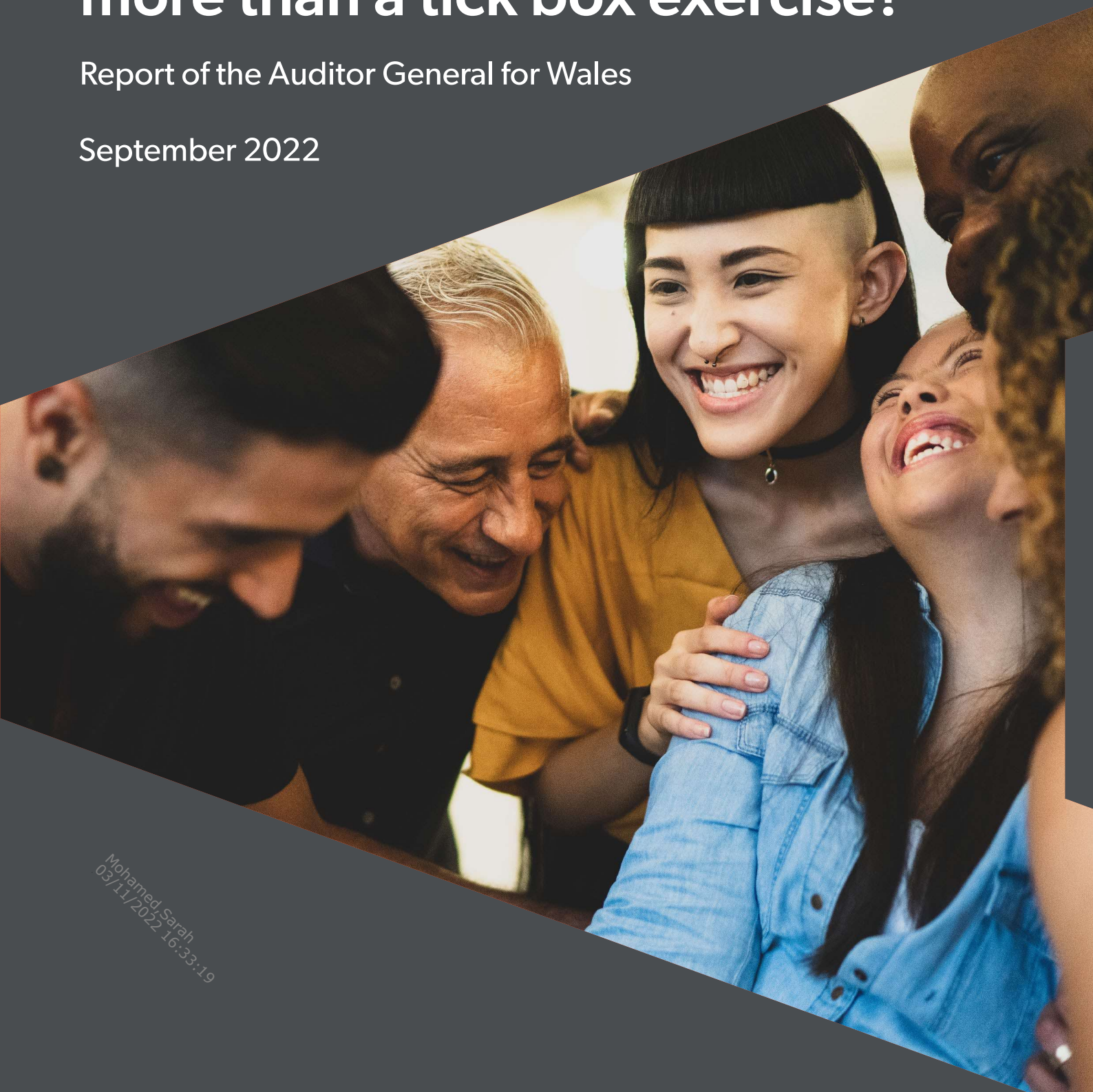
Audit Wales

Equality Impact Assessments: more than a tick box exercise?

Report of the Auditor General for Wales

September 2022



This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

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.

For further information, or if you require any of our publications in an alternative format and/ or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Auditor General's foreword

Discrimination and inequality continue to impact on the quality of life and life chances of people in Wales. My Picture of Public Services 2021 report highlighted that the COVID-19 pandemic had amplified some of the entrenched inequalities in our communities. Black Lives Matter, MeToo and other social movements have brought issues of discrimination and inequality to the forefront of public policy and debate.

Equality Impact Assessment (EIA) is an important part of the approach to tackling inequality in Wales. EIAs help public services meet their legal duties to avoid discrimination in the decisions they make and to promote equality of opportunity and cohesion.

Done well, EIAs are more than a means to show compliance. They support the growth of a mind-set and culture that put issues of equality at the heart of decision-making and policy development.

Our work shows that within individual public bodies there are good examples of aspects of the process of conducting an EIA. Through this report, I want to help all public bodies learn from those that are doing well and trying new approaches.

However, what we have seen and heard tells us that public bodies in Wales tend to use their EIAs defensively. Too often, they seem like a tick box exercise to show that the body has thought about equality issues in case of challenge. While legal challenge is of course an important risk to manage, this approach means public bodies are not using EIAs to their full potential, especially in terms of promoting equality and cohesion.

I hope this report will be of interest to anybody involved in public services and with an interest in tackling inequality and promoting equality. However, I want this work to be more than interesting. It needs to have an impact. Specifically, I expect:

- the Welsh Government to respond to the recommendations to work with partners to improve and update the overall approach to EIAs;
- all public bodies to respond to the recommendation that they review their own approaches to EIAs, including mindset and culture, drawing on the findings of this report; and
- those involved in scrutiny to use this report to challenge their organisation's overall approach to EIAs and the quality of individual EIAs used to inform their decisions.

I am pleased to say that this work has already had positive impacts. Our fieldwork questions have prompted some public bodies to check aspects of their own arrangements. And we have shared emerging findings with some public bodies that were updating their approach to EIAs. Closer to home, at Audit Wales, we are looking closely at our own processes and procedures to reflect the lessons identified in this work.

Adrian Crompton
Auditor General for Wales

Key facts

We set out below some key facts about the population in Wales in the context of the nine protected characteristics under the Equality Act 2010.

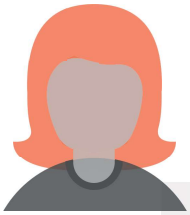
26,754 pregnancies during 2021[8]

16.5% aged under 15[1]

3.9% people who identify as gay, lesbian, bisexual or other[6]

7.8% people from a Black, Asian or minority ethnic community[5]

50.1% people with religious belief[4]



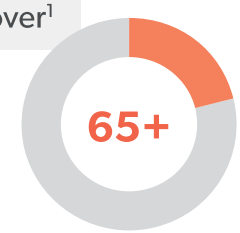
22.1% 16 to 64 year-olds identifying as disabled[2]

51.1% women[1]

48.1% people aged 16 and over who are married or in a civil partnership[3]

59% of transgender women and **56%** of transgender men said they avoided expressing their gender identity for fear of a negative reaction from others (UK)[7]

21.3% aged 65 and over[1]



3,107,500 population of Wales[1]

Sources:

1 Office of National Statistics (ONS), Population and household estimates, Census 2021, June 2022

2 StatsWales, Disability by age and sex (Equality Act definition) (2018-2020)

3 StatsWales, Marital status by age and sex (2018-2020)

4 StatsWales, Religion status by age (2018-2020)

5 ONS, Population estimates by ethnic group, England and Wales December 2021 (data for 2019)

6 StatsWales, Sexual identity by year, 2019

7 Government Equalities Office, National LGBT Survey, July 2018 (survey ran for 12 weeks from July 2017)

8 StatsWales, Initial assessment indicators for Wales, by mother's age, 2021

Key messages

Context

1 Tackling inequality is a long-standing goal of the Welsh Government. It features prominently in the 2021-2026 Programme for Government which includes the objective to 'celebrate diversity and move to eliminate inequality in all of its forms'[1]. The Well-being of Future Generations (Wales) Act 2015 makes 'A more equal Wales' a national goal. It defines this as 'a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances)'.

2 Equality Impact Assessment (EIA) is an important part of the approach to tackling discrimination and promoting equality in Wales. The Equality Act 2010 introduced the Public Sector Equality Duty (PSED) across Great Britain (**Exhibit 1**). The Welsh Government has made its own regulations[2] setting out some Wales specific duties that bodies listed in the Act need to follow to meet the PSED. Public bodies subject to the Act must assess the likely impacts of proposed policies or practices or proposed changes to existing policies or practices on their ability to meet the PSED. In doing so, they must comply with specific requirements to engage with groups likely to be impacted and monitor actual impacts.

1 Welsh Government, Programme for Government: update, December 2021
2 The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Exhibit 1: the Public Sector Equality Duty and protected characteristics

The PSED requires public bodies, in exercising their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act and the Wales specific duties apply to public bodies including councils, NHS bodies, fire and rescue services, national parks, education bodies (further and higher education bodies and maintained schools), and the Welsh Government and some of its sponsored bodies.

3 An EIA can provide evidence that the body has met the PSED. There have been legal challenges to decisions based on the lack or adequacy of an EIA. Moreover, EIAs support good policy and decision-making more generally by:

- **ensuring decisions impact protected groups in a fair way** – EIAs can demonstrate what, if any, action could be taken to mitigate the impact on one or more protected groups negatively affected by a decision and to promote equality and cohesion;
- **support evidence-based policy or decision-making** – EIA is a clear and structured way to collect, assess and present relevant evidence to support decisions; and
- **making decision-making more transparent** – EIAs must be published where they show there is or is likely to be a substantial impact.

4 As well as the PSED, the Equality Act 2010 included provision for a new socio-economic duty for public bodies[3]. The socio-economic duty came into force in Wales on 31 March 2021. It requires that public bodies, 'when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'. The Welsh Government advises public bodies to consider the socio-economic duty as part of existing processes, including impact assessments. We are currently reviewing local government's work to tackle poverty, including aspects of the socio-economic duty and the lived experience of people experiencing poverty.

About this report

5 We looked at the overall approach to undertaking EIAs in public bodies in Wales. To focus our work, we concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The main groups covered by the PSED that we did not include were the education bodies – further and higher education institutions and maintained schools – and Corporate Joint Committees.

6 We focused primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail. **Appendix 1** has more detail on our audit approach and methods. Where we identify individual bodies' practices, this is not to say that they are necessarily alone in having good or interesting practices in that area.

7 Parts one to three of this report set out the findings from our consideration of the EIA process at the 44 public bodies. Below, we set out the main areas for improvement we identified. These include issues that go beyond how public bodies are conducting specific parts of the processes and offer insight about the overall approach to assessing the impacts of policies and practices and the underpinning mindset and culture.

8 The Welsh Government is currently reviewing the PSED Wales specific regulations. We have framed our key improvement areas and recommendations in the context of the opportunity the review offers to clarify aspects of the overall approach to EIAs in Wales.

3 The duty lay dormant on the statute book as the UK Government did not commence it. The Wales Act 2017 gave new powers to the Welsh Ministers and allowed them to commence the duty in Wales. It covers most types of public bodies subject to the PSED.

Key improvement areas

9 Positively, there are examples of good practice in aspects of the EIA process across the public bodies we looked at. There is also non-statutory guidance from the Equality and Human Rights Commission (EHRC)[4] and on the Equality Impact Assessment In Wales Practice Hub (the Practice Hub) about the detailed processes for conducting an EIA. Many public bodies use this guidance to shape their approaches. However, there are areas for improvement (**Exhibit 2**).

Exhibit 2: key improvement areas for EIA

	Greater clarity over which type of policies and practices must be impact assessed
	Greater clarity about the arrangements for assessing the impact of collaborative policies and practices
	Greater clarity about expectations to consider the PSED as part of an integrated impact assessment
	Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect
	More engagement and involvement of people with protected characteristics
	Better monitoring of the actual impacts of policies and practices on people
	A shift in the mindsets and cultures to move EIA away from being seen as an add-on ‘tick box’ exercise

4 Equality and Human Rights Commission, Assessing Impact and the Equality Duty: A Guide for Listed Public Authorities in Wales, October 2014; and Equality and Human Rights Commission, Technical Guidance on the Public Sector Equality Duty: Wales, August 2014.

Greater clarity over which type of policies and practices must be impact assessed

10 There is scope for the Welsh Government, working with partners, to clarify its expectations around which type of policies and practices must be impact assessed. As drafted, the Welsh specific duties require public bodies to assess all new policies or practices, or those under review. However, the EHRC's non-statutory guidance recognises that 'policies and practices' is a broad category and says public bodies may need to prioritise. It introduces the concepts of 'proportionality' and 'relevance', which it says public bodies can apply through a process known as 'screening'.

11 We think the current position is open to interpretation in terms of whether proportionality and relevance mean public bodies should: (a) prioritise big decisions, like budget decisions or major service change; or (b) prioritise decisions that are likely to have a big impact on certain groups, for example, small scale decisions could have a large impact on one section of the population. Further, many bodies have interpreted proportionality as determining the amount of work needing to be done to assess impacts, rather than whether a policy or practice needs an EIA.

12 The EIAs or screening decisions that public bodies publish are usually those that go to their boards or cabinets. They therefore tend to be at the more strategic or impactful end of the scale. While we did not examine in detail practices at individual bodies, we think there is a risk that public bodies may be informally filtering out smaller scale policies and practices that do not require decisions from boards or cabinet, even though they may impact on people with protected characteristics.

Greater clarity about the arrangements for assessing the impact of collaborative policies and practices

13 There is scope to clarify how public bodies should do EIAs in an environment of increasing collaboration. The law places duties on individual public bodies. Since the legislation came into force, public bodies are increasingly developing plans and delivering services through collaborative arrangements. The Welsh Government updated the legislation to extend the PSED and Wales specific duties to Corporate Joint Committees in local government, but there are other collaborative arrangements not covered. These include Public Services Boards and Regional Partnership Boards as well as multiple service specific collaborations.

14 The Welsh Government has not produced stand-alone guidance on the use of EIAs by collaborative arrangements, although guidance for Public Services Boards highlights EIA requirements for individual public bodies[5]. The EHRC's 2014 guidance predates the creation of many of these arrangements and offers high level advice that there should be a shared approach but does not say how this should work in practice.

Greater clarity about expectations to consider the PSED as part of an integrated impact assessment

15 Increasingly, public bodies are integrating their EIAs with other impact assessments. While there is no legal requirement to integrate assessments, the Welsh Government's guidance on the Well-being of Future Generations (Wales) Act[6] emphasises the opportunities for bodies to integrate their approach to different duties, including those under the Equality Act 2010. Many of the equality officers[7] we spoke to said that integrating impact assessments led to a streamlined process and a more rounded approach to thinking about impacts. The key downside can be that the assessment is longer and can appear daunting. Our review of EIAs also identified a risk that integrated impact assessments dilute the focus on the impacts of policies and practices on people with protected characteristics.

16 Public bodies are inconsistent in what they include in an integrated impact assessment. Mostly, they collate separate assessments in one document, rather than produce a truly integrated analysis of impacts. There is no specific guidance to support public bodies in conducting integrated impact assessments. Many equality officers would welcome clearer guidance from the Welsh Government about its expectations.

Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect

17 There are examples of EIAs that clearly identify likely impacts on groups of people. However, many EIAs we reviewed were descriptive. They identified that a policy or practice might impact on a group of people. But they did not show how it would impact people's lives in practice. This makes it more difficult for decision-makers to assess how important the likely impacts are and if any mitigating measures proposed would be sufficient.

5 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 3: Collective Role (public service boards)), February 2016.

6 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 2: Individual Role (public bodies)), February 2016.

7 We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

18 In general, public bodies tend to identify negative impacts that they need to mitigate where possible. They are less likely to identify potential ways that the policy or practice could positively promote equality of opportunity and cohesion, even though this is a requirement of the PSED.Few public bodies have fully grasped the complexity of identifying likely impacts of policies and practices. None of the EIAs we looked at considered what is known as 'intersectionality'; the way that different protected characteristics combine. For example, while an EIA may identify impacts for Muslim people, it may not recognise that impacts could be very different for a Muslim woman compared to a Muslim man.

19 Many public bodies are thinking about how to identify the cumulative impacts of multiple decisions but few are doing so. Most do not have supporting systems that would enable those conducting EIAs to access the information needed about other decisions.

20 Most public bodies' formal processes and guidance say they will start thinking about impacts very early in the policy development process. However, many of the equality officers recognised that in practice EIAs often start late in the process, sometimes very shortly before a decision is due to be taken. This reduces the scope to shape the policy or practice and to mitigate impacts.

More engagement and involvement of people with protected characteristics

21 There are examples of public bodies seeking views from people with protected characteristics and drawing on their lived experience as part of the EIA. However, some third sector bodies are concerned that this does not happen nearly enough. We found that where public bodies seek views these often form part of a broader open consultation rather than focussing on specific groups with protected characteristics.

22 Some third sector organisations said that listening to people with protected characteristics was the action that would most improve EIAs. National representative public bodies could not always respond to the number of requests to take part in EIAs they receive and did not always have knowledge or information to respond to local issues.

Better monitoring of the actual impacts of policies and practices on people

23 Public bodies need to do more to monitor the impact of policies or decisions on protected groups. Equality officers at individual public bodies identified very few examples of public bodies monitoring the actual impacts of a policy or decision once implemented. Those examples put forward generally reflected broader monitoring of a policy's objectives rather than whether the impacts identified in the EIA materialised or whether there were other unanticipated impacts.

A shift in the mindsets and cultures that moves EIA away from being seen as an add-on 'tick box' exercise

24 From what we have seen there has not been a sufficient change in the mindset and culture in public services to put issues of equality at the heart of policy making. The mindset revealed by the EIA is often defensive: using EIAs to prove the body has paid due regard to equality in case of political or legal challenge. Often, the EIA seems like an additional 'tick box' exercise to be complied with rather than a tool to promote equality.

4 Recommendations

Recommendations

Clarifying the scope of the duty to impact assess policies and practices

R1 There is scope for confusion about which type of policies and practices must be subject to an assessment for their impact on the public sector equality duty. **The Welsh Government should clarify its interpretation of the duty, including whether and how it expects public bodies to apply any test of proportionality and relevance.**

Building a picture of what good integrated impact assessment looks like

R2 Many public bodies carry out integrated impact assessments that include consideration of the PSED alongside other duties. But practice is inconsistent and often involved collating multiple assessments in one place, rather than being truly integrated, **to help maximise the intended benefits of integrated impact assessments, the Welsh Government should work with key stakeholders with an interest in the areas commonly covered by integrated impact assessments and those with lived experiences, to share learning and work towards a shared understanding of what good looks like for an integrated impact assessment.**

Recommendations

Applying the equality duties to collaborative public bodies and partnerships

R3 The public sector landscape has changed since the introduction of the PSED and the Welsh specific duties, with an increasing focus on collaborative planning and delivery. **The Welsh Government should review whether it needs to update the Wales specific regulations to cover a wider range of collaborative and partnership arrangements. These include public services boards, regional partnership boards and other service specific partnerships.**

Reviewing public bodies' current approach for conducting EIAs

R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. **Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.**

Supporting arrangements for conducting EIAs

01

1.1 Conducting an EIA can be complicated. Good support can help make the process of conducting EIAs easier and more effective by having a clearly spelled-out approach and process, underpinned by clear guidance and training. And public bodies can have expert advice to hand to support those involved in assessing the impacts of decisions.

Setting out the organisation's approach to EIA

What we looked for

A clearly spelled-out approach to EIA for the organisation, including whether the EIA should form part of a wider integrated impact assessment.

What we found

Almost all public bodies had a set process for conducting an EIA, although these vary from a stand-alone EIA to producing integrated impact assessments covering a wide and varying range of other legal duties and policy priorities.

Strategic equality plans

1.2 All 44 public bodies met the requirement to produce a Strategic Equality Plan (SEP). The SEP must include an organisation's equality objectives, how they will measure progress on meeting objectives, and how they will promote knowledge and understanding of the general and specific duty. The SEP must also set out the public bodies' arrangements for assessing the likely impact of policies and practices on their ability to meet the PSED. However, in our review of SEPs we found that only 17 of the 44 bodies did so and to varying degrees of detail.

1.3 A few public bodies have gone further than simply describing arrangements. For example, Conwy County Borough Council's SEP describes in detail its process for EIA, how its Cabinet uses EIAs to support decision-making, and scrutiny committees' role in ensuring the quality of EIAs. The Council's SEP also explains how it has used EIAs to inform its equality objectives.

Organisational approach – integrated and stand-alone assessments

1.4 Nearly all public bodies (42 of 44) have a set process for undertaking EIAs. Most said that they put information on intranet sites, alongside supporting documents, contacts and most often a Word template for completion. Our review of EIAs found no standard format across public bodies, although most closely followed the approach set out in the Practice Hub. Members of the North Wales Public Sector Equality Network[8] have worked together to develop a standard template which most members of the network have adopted at least in part.

1.5 In around two-thirds (30 of 44) of public bodies we spoke to, the EIA forms part of a wider integrated impact assessment. There is no common approach to integrated impact assessments and no national guidance on what should be covered. There are some assessments that public bodies commonly include alongside the PSED (**Exhibit 3**). Some include other legal duties as well as policy priorities and practical considerations, such as finance. For example, the Welsh Government's integrated impact assessments sometimes cover climate change impacts, health impacts and economic impacts as well as a wide range of other legal duties, depending on the nature of the policy or practice.

8 The North Wales Public Sector Equality Network is an informal network of public bodies working together to advance equality. Representation includes North Wales local authorities, Betsi Cadwaladr University Health Board, North Wales Police and Police Authority, North Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, and Snowdonia National Park Authority.

Exhibit 3: assessments commonly included in an integrated impact assessment alongside the EIA

Well-being of Future Generations	The Well-being of Future Generations (Wales) Act 2015 introduced seven well-being goals for Wales. It also established the sustainable development principle and five ways of working – long-term, integration, involvement, collaboration, and prevention – to demonstrate application of the principle. An integrated impact assessment may also include an assessment of the policy or practice against the seven goals, public bodies' individual well-being objectives and/or the five ways of working specified in the Act.
Welsh Language	The Welsh Language (Wales) Measure 2011 declares that the Welsh language has official status in Wales. It makes provision to promote and facilitate the use of the Welsh language and to treat Welsh no less favourably than English through the Welsh language standards. Part of applying the standards means that public bodies must consider the effects their policy decisions on the Welsh language.
Environmental impacts	There are various duties to carry out environmental impact assessments depending on the nature of the proposed policy or practice. These range from strategic assessments of plans and programmes to assessments of projects that potentially impact on habitats and biodiversity.
UN Convention on the Rights of the Child	The Rights of Children and Young Persons (Wales) Measure 2011 embeds consideration of the United Nations Convention on the Rights of the Child and the optional protocols into Welsh law. The UN Convention consists of 41 articles, which set out a wide range of types of rights including rights to life and basic survival needs, rights to development including education and play, rights to protection, including safeguarding from abuse and exploitation, and rights to participation and express opinions.

Socio-economic	The Socio-economic duty came into force on 31 March 2021. When making strategic decisions, such as deciding priorities and setting objectives, public bodies must consider how they can reduce inequalities associated with socio-economic disadvantage.

1.6 Most integrated impact assessments involve collating separate impact assessments into a document template. Few seem to be a truly integrated impact assessment. Some public bodies are trying to make the connections between assessments and reduce duplication. For example, Carmarthenshire County Council, Powys County Council, Gwynedd Council, Denbighshire County Council and Wrexham County Borough Council have each developed, or are developing, an IT solution to bring together the relevant information needed to inform an integrated impact assessment.

1.7 Very few public bodies solely assess the impact on the PSED even when they do not consider their assessments to be integrated. In those public bodies that report having a standalone EIA process, the EIA often also includes Welsh-language and socio-economic impacts.

1.8 Previous research has found length is a barrier to the use of impact assessments in decision-making[9]. It was hard for us to judge any EIA or integrated impact assessment as too long as many factors affect the length including the nature of the policy or decision and the number of assessments undertaken. We reviewed some documents that were very long; for example, the integrated impact assessment of the Welsh Government's remote working policy was 45,000 words (average reading time 2.5 hours). The majority for which a word count was easily identifiable ranged between 2,500 and 7,500 words (average reading time 8 to 25 minutes).

1.9 Most public bodies that have chosen not to integrate their assessments had considered the option. Reasons for not integrating assessments included a concern that there would be insufficient regard to the PSED. This may be a valid concern. Our review suggests that, in some cases, the PSED is covered in limited detail and appeared secondary to other considerations even though all the public bodies we spoke to who conduct integrated impact assessments felt they sufficiently covered the equality element.

9 Grace, C., Reducing Complexity and Adding Value: A Strategic Approach to Impact Assessment in the Welsh Government, Public Policy Institute for Wales, February 2016.

Specialist support and expertise

What we looked for

That there is specialist support and expertise available in the organisation to those conducting EIAs.

What we found

In most cases, policy leads are responsible for conducting EIAs and can access support from colleagues with knowledge in equality related issues and an in-depth understanding of the organisation's process for conducting an EIA.

1.10 In almost all public bodies, responsibility to undertake an EIA lies with the lead officer developing or reviewing a policy or practice. This is partly pragmatic, due to the number of EIAs public bodies conduct. Equality officers told us this approach meant that EIAs benefitted from policy leads' expertise on the topic area. However, they identified drawbacks, including the difficulty of ensuring consistency, getting EIAs started at the right time and ensuring quality.

1.11 All public bodies have equality officers (or equivalent) with knowledge in general equality issues and a detailed understanding of the organisation's EIA process. In all public bodies, staff conducting EIAs can ask equality officers for guidance when required. EIAs are mostly conducted without the input of an equality officer. The process at Aneurin Bevan University Health Board is one exception to this, where the first step for anyone who thinks they need to undertake an EIA is to contact the Equality Diversity and Inclusion specialist to discuss the proposed policy or practice and agree what actions they need to take, with ongoing support also provided. In smaller public bodies, where an EIA is more likely to relate to staff policies and decisions, the lead for conducting the EIA is frequently an HR officer who is also the equality officer.

Guidance to support those conducting an EIA

What we looked for

That there is guidance to support those conducting an EIA, setting out what they need to do and when, in line with the duties and their organisation's chosen approach.

What we found

There is non-statutory national guidance and support available setting out some good practice in the stages of an EIA, although there are gaps, notably in terms of integrated impact assessments. Most public bodies have also produced their own guidance to support their EIA process.

External guidance

1.12 The Welsh Government has not published statutory guidance on the application of the PSED in Wales or the Welsh specific duties. The EHRC published non-statutory guidance on the Welsh specific duties in 2014. Welsh Government guidance encourages public bodies to integrate different duties. But there is no specific national guidance on how to conduct integrated impact assessments and what should be included.

1.13 The Welsh Government, Welsh Local Government Association, and NHS Centre for Equality and Human Rights jointly developed the Practice Hub in 2015-16. This online resource provides information and support to public bodies in Wales to undertake EIAs. It provides a detailed eight step guide to good practice in undertaking EIA and gives information on the Welsh specific duties.

Internal guidance

1.14 Internally, most public bodies have produced guidance to support their EIA process. The format and detail of the guidance and quality vary across public bodies. Some provide step-by-step guidance which outlines the process and steps for completing an EIA. Some embed practical information and links within templates.

1.15 A few public bodies do not provide guidance on their individual processes. Some of these provide direct one-to-one support from an equality officer (or equivalent) to the individual completing the assessment. Others signpost staff to the external guidance on the Practice Hub.

Training

What we looked for

That training on conducting an EIA is available for staff involved in developing EIAs and those that use them for decision-making.

What we found

Most public bodies offer training to those involved with EIAs through a variety of media.

1.16 Around two-thirds (31 of 44) public bodies we spoke to provide formal training to officers who are likely to complete or have an interest in EIA. This training frequently extends to elected members, board members and decision-makers.

1.17 Methods of training vary. Some offer face-to-face delivery of training, with much of this via video calls since the start of the COVID-19 pandemic. Many public bodies include online modules and e-learning tools on equality, and EIAs as part of their general staff training. Those public bodies that do not offer formal training nevertheless provide one-to-one support to individuals conducting EIAs and upskill them through the process.

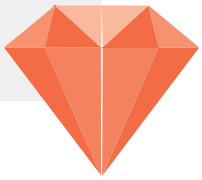
Quality assurance

What we looked for

An approach to ensuring the quality of the EIA process.

What we found

Half of public bodies had an approach to quality assurance, which varied from a simple sign-off on individual EIAs to more comprehensive peer learning to support improvement of the whole EIA process.



1.18 Half (22) of the public bodies have a quality assurance process in place for their EIA. The approach varies greatly. For some, quality assurance is about the quality of individual EIAs. Some require an EIA to be signed off by a senior officer. In Cardiff and Vale University Health Board, the lead officer conducting the EIA will work with an equality officer and a representative from Public Health Wales to review and interrogate the content of the EIA during its development. Other public bodies have begun to take a 'peer review' approach to developing EIA with input from experts from across the organisation.

1.19 A small number of public bodies use quality assurance to test the quality of their overall approach. For example, the Arts Council of Wales conducts an annual sample review of EIAs and uses the findings to improve the process.

Assessing impacts

02

2.1 The Wales specific duties require listed public bodies to assess the likely impact of proposed policies and practices, or those under review, on their ability to comply with the PSED. In doing so, they must have regard to certain types of information that they hold and meet specific requirements to engage with people or organisations that represent people with one or more protected characteristics. EHRC guidance and the Practice Hub set out in detail the steps public bodies can take to fulfil these requirements.

Screening

What we looked for

A clear approach to determining if an equality impact assessment is required.

What we found

Just over half of public bodies have a process for screening although many have stopped using screening, some due to risk of confusion or 'gaming' by staff.

2.2 There are no statutory exemptions setting out policies and practices that do not need to be assessed. However, the EHRC guidance and the practice hub include a 'screening' process to determine which policies or practices should have a full EIA.

2.3 Just over half (24 of 44) of public bodies we spoke to said that they have a screening process. Screening is most often a document template which an officer developing or reviewing a process or policy uses to determine whether they anticipate any impact on protected groups. The approach ranges in practice from a separate short impact assessment to a set of screening questions at the beginning of the full assessment template which determine whether to proceed with the full EIA.

2.4 Where a body decides it does not need a full EIA, they will usually retain a copy of the screening tool as evidence that it has considered the PSED. Most public bodies with a screening process will document the decision not to go ahead with a full EIA in the supporting papers that go to the cabinet or board.

2.5 Most often, the policy lead keeps the detailed record of screening. However, a few public bodies are trying to strengthen practice and ensure central records are maintained. For example, Cardiff Council has developed an online assessment tool to support policy leads through the process and encourage consideration of impact at the earliest stages of policy development. As well as sending advice and guidance to the officer completing the online assessment, the tool also sends a copy of the screening information to the equality officers.

2.6 The 20 public bodies who do not have a screening process had often consciously removed the screening step. Many said screening was an unnecessary step, as there are very few of their decisions that will not have potential to impact on the PSED. Some public bodies said that there was also scope for confusion, with lead officers completing a screening form, thinking it was an EIA. Others were concerned that some officers may 'game' the process: tailoring their responses to screening in a way designed to result in a decision that no further assessment was required.

2.7 Those public bodies that do not have a screening process usually provide additional guidance or a process chart, clarifying when to conduct a full EIA. All public bodies also offer the lead officer an opportunity to consult with an equality officer.

Timing

What we looked for

EIAs being started at an early stage to inform the development of a policy or decision.

What we found

All public bodies intend to carry out an EIA as early as possible, but many recognise this is often not the case in practice, and in some cases EIAs are very late in the policy development or decision-making process.

2.8 All 44 public bodies intend that EIAs should be started as early in the development or review of a policy as possible. But many public bodies acknowledged that this often does not happen in practice.

2.9 The timing of EIAs is affected by whether policy leads know that they are required to do an EIA and if resources – staff and time – are available at the appropriate point. Sometimes, if public bodies must make decisions very quickly, they either do not do an EIA or do them late in the decision-making process. This can be too late to consider changing a policy to lessen any possible negative impact or to build on positive impacts.

2.10 Decisions at the start of the COVID-19 pandemic were often made without an EIA. This reflected the urgency of decisions but meant that the impact on vulnerable people was not formally assessed. In August 2020, the Senedd's Equality, Local Government and Communities Committee[10] recommended that the Welsh Government should ensure that each major policy or legislative decision is accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since August 2020 has published dozens of impact assessments related to the COVID-19 pandemic on its website.

10 Senedd Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020.

2.11 In most public bodies, papers accompanying decisions that go to cabinets or boards contain a box or section that refers to consideration of the equality duties. This serves as a backstop to prevent public bodies from making decisions without any regard to the duties, even though this generally would be very late in the process.

Use of evidence

What we looked for

Use of a range of evidence to support the assessment, including the views of those likely to be impacted and data on lived experience.

What we found

Public bodies use a mix of evidence, although there are gaps in available data on some protected characteristics and the inclusion of the views and lived experiences of people with protected characteristics is patchy.

Quantitative data

2.12 EIAs need a sound evidence base to inform their conclusions. The depth and detail of the information base vary across organisations and by assessment The depth of information and analysis often depends on the scale of the decision and the availability of relevant and specific evidence.

2.13 All public bodies expect to include some quantitative data, such as demographic information or service level data. Around two-thirds (29 out of 44) of public bodies include at least some examples of internal information sources and point to publicly available data in their guidance and templates. Some go further. For example, Merthyr Tydfil County Borough Council includes in its guidance a detailed list of sources where policy leads can find relevant evidence, with embedded links to external data sources.

2.14 There are some significant data gaps in the data that is available to public bodies. Generally, there is little information available about some protected characteristics, particularly sexual orientation, gender reassignment, and pregnancy and maternity. Data that is available at a national level is sometimes not available at a health board, council, or ward level, which makes it difficult for public bodies to understand their local populations with protected characteristics.

Qualitative information

2.15 The inclusion of qualitative information based on the views and experiences of people with protected characteristics is also patchy. When introducing new policies or changing services public bodies often undertake a consultation exercise. In the examples we saw, these were often targeted to the public in general, and it was difficult to see if the public body had sought to engage specifically with people from protected groups.

2.16 Nonetheless, we did see examples of EIAs where evidence from engagement with groups was covered. For example, when Snowdonia National Park Authority undertook an EIA on its communication and engagement strategy, the assessment considered how the strategy could engage with people who speak languages other than English or Welsh. It also considered impacts on those who were digitally excluded, a group that is more likely to include older people and more women than men.

2.17 Some respondents to our general call for evidence said that drawing more on the views and experience of people with protected characteristics would improve the quality of EIAs. This includes engaging with individuals and grassroots organisations as well as national organisations representing protected groups. Some respondents said that public bodies should do more to publicise consultations by a range of means, including but not restricted to social media.

2.18 Some all-Wales third sector bodies responding to our call for evidence said that they were often asked to provide views for EIA and that some cannot respond to all the requests they receive. Sometimes they do not have information on local services and impacts.

2.19 A few public bodies are trying to draw on the lived experience of people with protected characteristics through different forms of consultation. Some use existing networks for staff with protected characteristics to understand different perspectives. Others, draw on existing relationships with third sector groups to understand the lived experience.

Identifying and mitigating likely impacts

What we looked for

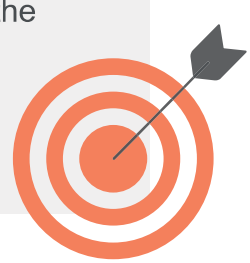
Clear identification of likely impacts, including positive impacts in promoting equality, as well as negative ones.

Some consideration of cumulative impacts arising from other decisions that impact the same group or groups and how different protected characteristics combine (intersectionality).

Clear recommendations for mitigating negative impacts that have been acted on before the decision is made.

What we found

While there are examples of public bodies identifying specific impacts, often EIAs describe impacts in very broad terms. Very few identify the cumulative impacts of multiple decisions on groups or consider how different protected characteristics intersect. Very few can show how recommendations for mitigating impacts are followed through.



Specific impacts

2.20 Positively, our review of EIAs found examples of public bodies clearly identifying specific likely impact of policies or practices on protected groups. However, many EIAs included statistics to describe the population of people with protected characteristics without being clear how the policy or practice would likely impact on them. We also observed a tendency for EIAs to focus on negative impacts, thereby missing positive impacts and opportunities to improve cohesion and reduce inequalities.

2.21 We found that most EIAs reviewed provided data and information on each protected group separately. For example, the EIA on Conwy County Borough Council's Older Peoples' Domiciliary Care Finance and Commissioning Project set out the likely impact on people with each protected characteristic.

2.22 Most public bodies' approaches to EIA involve making recommendations to overcome negative impacts. Public bodies should incorporate mitigating actions into the policy development process, recognising it is not always possible to mitigate all negative impacts, such as with reductions in service. Very few public bodies have a process in place to track whether they have implemented the mitigating actions, after a decision is taken. In Hywel Dda University Health Board, the EIA has an associated action plan with a review date. In Aneurin Bevan University Health Board the Equality, Diversity, and Inclusion specialist keeps a database of actions arising from EIAs for monitoring purposes.

Intersectionality

2.23 Increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. However, we did not see examples of such nuanced understandings of inequality in the examples we reviewed.

Cumulative impacts

2.24 Public bodies in Wales make many decisions each year that, taken together, can be very detrimental to people from protected groups. For example, one respondent to our call for evidence gave the example of how individual decisions to reduce or close facilities and services such as public toilets, library services, day centres, and bus services had a cumulative impact on many older people who use the services. They said that, while each individual decision might not be significant, together they meant that some older people were becoming isolated.

2.25 The few instances we found where public bodies have begun to give thought to cumulative impacts tend to be when public bodies are making several decisions at the same time. For example, councils usually undertake a cumulative approach to assessing the impacts of their proposed budget each year. Individual service changes being proposed because of budget changes are assessed simultaneously allowing a better overview of potential impacts for the budget.

2.26 Typically, however, public bodies make decisions separately. One of the respondents to our call for evidence to decision-makers highlighted that it is difficult in principle to predict the likely impacts of multiple decisions in a complex landscape. Practically, the ability to take account of impacts from other decisions relies on the policy lead knowing about other decisions within an organisation and having access to the EIAs. A small number of public bodies are trying to address this information gap by using an IT solution to undertake the EIA (**paragraph 1.6**). This way, the assessment of impact for each policy change and decision is held centrally, making it easier for policy leads to bring together the information.

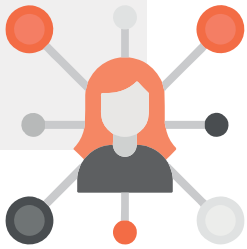
Decision-making

What we looked for

That the EIA and likely impacts it identifies are considered at the point of decision-making.

What we found

Equality officers' views varied around the extent to which their organisations prioritised the EIA in decision-making. Most respondents to our general call for evidence said public bodies did not pay sufficient regard to protected characteristics. The small number ofresponses from decision-makers suggest a view that the EIA is seen as a 'tick box exercise'.



2.27 The consideration given to EIAs in decision-making varies across public bodies in Wales. In general, equality officers felt that decision-makers take assurance in knowing that the policy lead has completed an EIA. Decision-makers will have access to a summary or the complete EIA accompanying each decision in their cabinet or board papers.

2.28 The equality officers we spoke to had mixed views over the extent to which their organisations placed sufficient weight on the EIA in decision-making. Over three-quarters of respondents to our general call for evidence who answered the question (29 of 37) disagreed that public bodies in Wales give appropriate due regard to people with protected characteristics when developing policies or making changes to services.

2.29 Generally, equality officers were not aware of instances where decision-makers challenged the content or recommendations of an EIA at the point of decision. Most felt that the accompanying EIA should have considered and shaped the policy sufficiently that there would be no need for such challenge at that late stage.

2.30 We only received ten responses to our call for evidence from decision-makers. While it is hard to draw conclusions from such a limited evidence base, it is notable that three of the ten referred to EIAs being used like a ‘tick box’.

Reporting and monitoring impacts

03

3.1 Public bodies must publish reports of the assessments where they show a substantial impact (or likely impact) on their ability to meet the PSED. They must also monitor the actual impact of the policies and practices subject to an equality impact assessment.

Reporting

What we looked for

Public information about decisions and a clear description of how the EIA has influenced the decision-making.

What we found

Most public bodies publish some of their EIAs as part of a wider set of papers and they are often not easy to find.

3.2 Almost all public bodies in Wales publish their EIAs, at least in part. Typically, they publish EIAs with decision-related papers, such as cabinet or board papers. There is usually a section on the body's website which holds all the papers for each meeting and is accessible to the public[11]. There are a few exceptions in some of the smaller public bodies, who do not routinely publish their EIAs.

3.3 It can often be difficult to find EIAs which relate to a specific decision on public bodies' websites. The EIAs which feature more prominently and are easier to locate often relate to strategic decisions such as budgets or key corporate strategies. Newport City Council have tried to bring EIAs into a central location on their website to make them more easily accessible, while recognising that this approach relies on the individuals completing EIAs sharing them for publication, which sometimes does not happen.

11 In some instances, bodies do not publish EIAs if they form part of a paper that is held back from publication due to its confidential or sensitive nature. However, these EIAs can sometimes be obtained via a Freedom of Information request if someone has a particular interest in seeing them.

Monitoring impacts

What we looked for

A clear approach to monitoring the impacts of the decision after it is implemented, including those identified as part of EIA as well as any unexpected impacts.

What we found

Very few public bodies monitor the impact of the decisions in the context of the PSED.

3.4 Some public bodies require those completing EIAs to identify a review date when monitoring is supposed to occur. We saw examples where EIAs set out plans for monitoring. For example, a Powys Teaching Health Board EIA included plans for monitoring service use after a change in surgery opening hours and for and independent evaluation of the service change. Also, Conwy County Borough Council's EIA for its review of domiciliary care included detailed arrangements for monitoring the impact using data and information that are routinely reported, including individual feedback from people receiving care.

3.5 However, equality officers had seen little evidence of the impact of policies and practices being monitored in light of the EIA. Those public bodies that outlined a monitoring process were often referring to the monitoring of an implementation of a policy or practice against its objectives or targets, not the impact that the decision had on people with protected characteristics.

3.6 In general, public bodies do not consider the impacts of policies and practices in terms of the PSED until there is another decision due on the same policy or practice. At that point, the body conducts a new EIA. Many of the equality officers we spoke to seemed unsure about how, in practice, they would monitor the impact of a decision on protected groups and would welcome more guidance.

Challenging EIAs

What we looked for

That the organisation identifies and applies lessons from any challenge to decisions on the basis of equality or the quality of the EIA.

What we found

Many equality officers did not think there had been any challenges to EIAs conducted by their organisation, but where there has been challenge some public bodies are using it as a learning opportunity.

3.7 Decisions made by public bodies can be challenged based on the EIA. Public bodies that do not have a clear record showing that they have considered the likely impacts of their decisions for people with protected characteristics leave themselves open to challenge. This could potentially include a judicial review. Some equality officers did not know what process someone would use to challenge an EIA. The majority said that any challenges would go through their general complaints process, with the involvement of the relevant service, equality officers and legal team.

3.8 Many equality officers thought there had not been any challenge to an EIA conducted by their organisation. Those that were aware of challenge taking place said that it was something that happens infrequently. Almost half of respondents to our general call for evidence who answered the question (17 of 35) said they had challenged some aspect of an EIA. We do not know if this was a formal or informal challenge.

3.9 Equality officers who had experienced challenge to an EIA said their organisation can resolve the issues either by making changes to a policy or practice, or by providing evidence that they had considered the impacts. Respondents to our general call for evidence gave examples of issues they raised being resolved. For example, one had objected to the EIA conducted on a new bus interchange because the council had not sought the views of people with protected characteristics on the proposals. Following their intervention, people with low vision visited the site and suggested changes to make the interchange more accessible.

3.10 While there are positive examples of public bodies responding to challenge, several respondents to our general call for evidence who had challenged aspects of an EIA reported not receiving any response to their challenge. A few equality officers told us that their organisation had learnt from the experience of having an EIA challenged. One had used examples of challenge from other public bodies to inform its EIA training as a particularly useful way of making impacts more easily understood to lead officers conducting EIAs.

Appendices

1 Audit approach and methods

1 Audit approach and methods

Audit approach

Our main aim was to provide insight about the approach to EIAs undertaken across the public sector in Wales. We wanted to highlight good practice and identify opportunities to improve. To help shape our thinking about what good practice to look for, we drew heavily on existing guidance materials, in particular that produced by the Equality and Human Rights Commission (EHRC) and the Equality Impact Assessment in Wales Practice Hub hosted by Public Health Wales NHS Trust.

We set out to explore to what extent public bodies have integrated their approach to undertaking EIAs, including the new socio-economic duty and the cumulative impact of decisions. We also explored what difficulties public bodies experience that affect the quality and timeliness of EIAs. We looked at how public bodies monitor the impact of decisions on their population. Each of the sub-sections in the main body of this report describes what we were looking for through our work.

In looking across the public bodies, we focused on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is the external auditor of each of these bodies, which include local authorities, health boards and some NHS trusts, national parks, and fire and rescue services. They also include the Welsh Government and some of its sponsored bodies. Our audit coverage did not include education bodies – further education, higher education or maintained schools – that are subject to the PSED. It also did not include the four Corporate Joint Committees (CJCs) established by the Local Government and Elections (Wales) Act 2021 and which are subject to the PSED.

Audit methods

Document review: We reviewed documents from each of the 44 public bodies, including those relating to the equality plans and details of the organisation's EIA process. We also reviewed details of their process for integrated impact assessments. We reviewed a sample of 29 EIAs provided by public bodies: 11 by local authorities, eight by health bodies, two fire and rescue, two national parks and six by the Welsh Government or its sponsored bodies.

Interviews: We interviewed the equality officers or their equivalent in each of the 44 bodies. We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

Call for evidence: We sought wider views about people's experience of EIAs through a call for evidence between October 2021 and June 2022. We publicised this generally and in particular to third sector organisations. We received 40 responses, 23 from individuals and 15 responding on behalf of an organisation (two did not say).

We also sought the views of decision-makers through a separate call for evidence open between February and June 2022. We received ten responses (eight from individuals working in local authorities, one health and one fire and rescue).

While the responses we received to the calls for evidence are not necessarily representative of individuals, the third sector or decision-makers, they have provided useful detail which we have included through the report and which informed our overall analysis.

Stakeholder engagement: The EHRC is responsible for promoting and enforcing equality and non-discrimination laws. We met with officials in the EHRC Wales Team regularly throughout our work, discussing our scope and emerging findings. We also met with the Welsh Local Government Association's equality network and the Chair of the All-Wales NHS Equality Leadership Group. We interviewed officials from the Welsh Government with responsibility for equality policy.

Wider audit intelligence: We drew on existing intelligence from our local financial and performance audit work, where that was relevant to equality impact assessments.

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Management response

Report title: Estates Follow Up Review – Cardiff and Vale University Health Board

Completion date: October 2022

Document reference: 3083A2022

Recommendation	Management response	Completion date	Responsible officer
Develop a fully-costed Estates Management Strategy R1 The Health Board could not provide a copy of its estate management strategy, which it reported was agreed in 2017. However, the Health Board is currently in the early stages of developing a new estates strategy. The new strategy should clearly set out: • a baseline assessment of the condition of the current estate and the total resources (including	A copy of the estate's strategy based on the operational team requirements was provided, but this strategy dealt with service delivery and did not review, in depth, the outlined areas contained within this audit recommendation. The Estates Strategy going forward will provide the following as outlined within the recommendation. In the interim and immediate; it will state how the estate will be maintained, based on current workforce and funding, until the baseline assessment has been completed. The strategy will outline, where necessary, the prioritisation of work in relation to patient safety, health and safety, structural integrity and statutory compliance against the backdrop of available budgets and workforce.	March 23	Director of Estates and Facilities

Recommendation	Management response	Completion date	Responsible officer
workforce) needed to maintain it against available resources; • how the estate will be maintained and resourced to the required standard in the short- and medium-term; and • plans for maintaining and investing in the current estate whilst implementing its estates investment programme.	It will indicate that a baseline assessment will be completed and programme of completion provided. The baseline assessment will include a condition survey review in accordance with Estatecode, six facet survey or similar. This survey information will then be used to assess, prioritise and re-align the workforce, required to maintain the site, dependent on the highlighted risks within the survey, and the available budget within the Health Board, in the short- and medium-term. It is anticipated that the survey information will take approximately 18 months to procure and complete. A further period of implementation will be essential if workforce changes are required as a result of the outcome. This detail will be provided within the Estate Strategy.		
Introduce a system to inspect a percentage of repairs each month R2 We found that the Health Board is yet to develop a system to inspect a percentage of repairs each month. This	Agreed. MiCAD interrogation and monthly reports set up.	Complete	Head of Estates and Facilities

Recommendation	Management response	Completion date	Responsible officer
is an essential element for any estate maintenance service, providing vital assurance that work is being carried out in compliance with the relevant safety and quality standards. The Health Board should introduce a monthly inspection regime by March 2023.	Initial agreement of content of inspections and form they will take. Initial KPI's developed and monitoring commencement. Review of forms and KPI's.	October 2022. November 2022. February 2023.	
Strengthen performance management R3 We found that the Health Board is continuing to develop KPIs for its estates and facilities services but is yet to establish a suitable format to report the information internally and up to the Board for assurance. By March 2023, the Health Board should ensure that: • relevant estates and facilities KPIs are included in the integrated	Agreed. Current KPI formats are being assessed along with content. Once KPI content is agreed and data capture refined, information will be presented to the Board with bi-monthly performance feedback at the Service Board meetings. The KPI's will help inform and be linked into the Estates Strategy when completed.	December 2022. January 2023	Head of Estates and Facilities

Recommendation	Management response	Completion date	Responsible officer
performance report which is received by the Board; and • the KPIs are linked to the new estates strategy.			

Mohamed,Sarah
03/11/2022 16:33:19

Report Title:	Declarations of Interest, Gifts and Hospitality Tracking Report			Agenda Item no.	7.4
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	08.11.2022
		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 required by the Audit and Assurance Committee ("the Committee") an update on Declarations of Interest, Gifts, Hospitality and Sponsorship will be provided at each Committee meeting for noting and approval of the approach taken by the Corporate Governance Directorate.

Since November 2021 the procedure for Declarations of Interest has required employees to make a single declaration of interest during their period of employment, only altering it if their circumstances change (for example undertaking secondary employment). The procedure for declarations of Gifts, Hospitality and Sponsorship has remained unaltered and staff are required to make relevant declarations on an 'as required' basis.

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 have delivered a 'Declarations of Interest Power Hour' and will continue to deliver further sessions to provide guided examples 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.

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:

Since the September Audit and Assurance Committee Meeting, the Health Board's Corporate Archivist has undertaken a review of the Declarations of Interest, Gifts and Hospitality Register and compared this document with the records held in ESR.

At the September Committee meeting the following declarations were noted:

- 481 Declarations of Interests, Gifts, Hospitality and Sponsorship
- 1212 'No Interest' Declarations

As of the 28th October 2022 ESR holds the following records:

- 205 Declarations of Interests, Gifts, Hospitality and Sponsorship
- 618 entries recording 'No Interest' be declared.

It is believed that the true, accurate figure, lies somewhere between these two numbers.

The existing register includes both paper and ESR submissions that have been received since April 2020. Given the nature of the paper records received, it is not possible to compare this detail with the live data included with ESR and it is likely (though yet to be confirmed) that some of this data will be out of date due to staff departures and other changes to records that have not been recorded within ESR.

A full reconciliation exercise can be undertaken to ascertain whether those employees who have made a paper declaration remain employed by the Health Board, however this is a time-consuming and administratively heavy exercise that has the potential for errors in calculation. It is believed that running two separate systems of record keeping will increase the likelihood of error in the reporting of declarations.

It is proposed that the most accurate method of recording data in relation to Declarations of Interest, Gifts, Hospitality and Sponsorship is to move to an entirely ESR based approach.

ESR has now provided the Corporate Governance Directorate with the ability to run daily reports that provide the detail of the full Health Board Staff establishment, including new starters and leavers and all those who have submitted a declaration of interest.

The Corporate Archivist has also prepared a report that is able to accurately report those individuals who have declared an interest in a more easily accessible format than has previously been shared with the Committee. An extract of this data is attached as Appendix 1 for reference purposes.

Whilst a complete move to ESR reporting will reduce the number of declarations currently recorded it is believed that the strength of the assurance provided by this data will be far greater than that previously provided. Primarily this is because the Corporate Governance Directorate will now have live data to corroborate the accuracy of the information held within the register via ESR staff records as opposed to having to cross reference two systems of data to arrive at a current figure.

Assuming that the Committee are willing to support a complete move to ESR reporting, the following support will be provided to inform the Staff Population of the change and to encourage an influx of declarations:

1) A daily ESR Banner update advising **ALL** staff of the requirement to declare interests via ESR. At present the banner only requests declarations from Staff Members of Band 8A and above.
2) A rolling Screen Saver to advise all staff of the requirement to declare interests via ESR.
3) Additional reminders and communications inline with the Communications Plan already established.

In the meantime 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/

Recommendation:

The Committee are requested to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour

- **APPROVE** the proposal for a complete move to ESR for the recording of Declarations of Interest, Gifts, Hospitality and Sponsorship.

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	

Level of Risk Score 1 (Low) Score 2 (Medium) Score 3 (High)	Name	Job title/Role	Category of interest	Interest situation	Interest Description	Comments	From	To (Leave blank if ongoing)
1	Adams, Miss Lisa Marie	Physiotherapist	Financial interests	Clinical private practice	I work one evening a week in a private Msk physiotherapy clinic	Ongoing work	06/04/2017	08/04/2022
1	Addy, Dr Charlotte Louise	Consultant	Financial interests	Sponsored events	Support for educational lectures/activities from Gilead/Chiesi		11/03/2022	
1	Agarwala, Ms. Emma Caroline	High Intensity Therapist	Financial interests	Outside employment	I work a couple of hours per week for Canopi offering CBT to social and health service staff. I offer some private EMDR supervision to staff working in England I have previously (and may in future)		11/10/2022	10/10/2023
1	Ahuja, Mr. Sashin	Consultant	Financial interests	Sponsored events	Chaired Scientific Advisory Board Meeting for Cerapaedics Ltd	Chaired a clinical advisory group meeting for Cerapaedics Ltd on osteobiologics.	11/09/2020	11/09/2020
1	Alden, Dr Katrin	Specialty Doctor	Financial interests	Outside employment	I create an deliver training for Atrainability, a medical training company in my own time.	This was declared using the paper form at the tine I started the work and now transferred into esr.	03/08/2022	
1	Allen, Mrs. Kathryn Louise (Louise)	Pharmacist	Non-financial personal interests	Shareholdings and other ownership interests	Directorship of Davies Homes Ltd	Ongoing to date silent director of family building business no financial gain, non NHS	01/01/2010	17/11/2021
1	Allen-Ridge, Mr. Callum Charles	Senior Manager	Indirect interests	Outside employment	Bank Work for North Bristol NHS Trust	I am registered to work for North Bristol NHS Trust for both clinical bank work and also consultancy work around performance management and quality improvement.	25/06/2018	
1	Al-Rajoodi, Ms. Sheha Jameel Mohaisen	Chiropodist/Podiatrist	Non-financial professional interest	Clinical private practice	I work with Murray medical private practice. Currently still employed.		20/08/2019	14/10/2021
1	Anand, Dr Bawani	Consultant	Financial interests	Sponsored research	Astra Zeneca sponsored research in UHW . Performing tests out of hospital hours . Totally about 4-8 patients. Directorate and Consultant will receive renumeration for the study	It is a very small study .May last less than 1 year. Totally around 8 or less patients to be done 2 times 18 weeks apart	01/04/2022	31/03/2023
1	Ateleanu, Dr Bazil	Consultant	Financial interests	Clinical private practice	I have PP outside NHS in SpireHospital and Vale Clinic Cardiff and I intend to start in St. Joseph’s Hospital Newport.		06/03/2022	01/05/2027
1	Atkin, Dr Philip Alan	Consultant	Financial interests	Shareholdings and other ownership interests	I am a company director of Nuform Medical Aesthetics Ltd, a healthcare delivery company for aesthetic medicine, since Nov 2019 I am a complany director of Brynmill Ltd, a healthcare delivery		21/03/2022	21/03/2022
1	Atter, Mr. James David	Physiotherapist	Financial interests	Clinical private practice	I own my own private physiotherapy practice as a self employed practitioner. This involves running private clinics in Cyncoed Consulting Rooms and in iCare Clinics, Ely. I also under my		01/11/2021	
1	Attwell, Mrs. Julia Anne	Senior Manager	Financial interests	Outside employment	As a Non Executive Director with Linc Cymru Housing Association, I receive an annual payment.		01/03/2022	
1	Bailey, Mrs. Sarah Elizabeth	Dietitian Manager	Financial interests	Gifts	I wrote and article for the April 2022 edition of the Nutrition Digest magazine. £100 received for this. Money used to buy books for the dietetic department; not for personal use.		08/03/2022	08/03/2022
1	Baldwin, Mrs. Julie Ann (Ann)	Physiotherapist	Indirect interests	Clinical private practice	Husband works in private practice		01/05/2000	
1	Bales, Mr. Henry Edward Howard	Accountant	Non-financial personal interests	Outside employment	On a yearly basis I receive a contract to mark one set of examination papers for GCSE Mathematics with OCR Examination Board. The period that I have to mark these papers spans a number of	I have informed the manager of the department and I am aware of my responsibilities.	30/05/2022	
1	Ball, Mr. Philip Edward	Staff Nurse	Financial interests	Sponsored events	I am member of Janssen sponsored All Wales Nurse Forum and this may attract a payment depending upon my contribution in the sessions		29/03/2022	
1	Banner, Mr. Timothy Elliott	Pharmacist	Non-financial personal interests	Outside employment	Wife works for Lloyds Pharmacy as Pharmacist manager in Gorseinon, Swansea.		01/08/2007	

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

Level of Conflict	First Name	Surname	Position held in UHB	Directorate / Speciality	Interests to Declare (Yes/No)	Third Party Declaration eg Spouse/Partner (Yes/No)	UHB Address:	Confirmed read & understood Standards of Behaviour Framework Policy	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	Start - End Date	Financial / Other Benefits	b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB	Start - End Date	Financial / Other Benefits	c) A personal or departmental interest in any part of the pharmaceutical, healthcare industry, diagnostic or personalised health industry likely to be perceived as influencing decision making or on the provision of advice to members of the team	Start - End Date	Financial / Other Benefits	d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary	Start - End Date	Financial / Other Benefits	e) A position of authority in a charity or voluntary body in the field of health and social care	Start - End Date	Financial / Other Benefits	f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Start - End Date	Financial / Other Benefits	g) Employment/self employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Start - End Date	Financial / Other Benefits	h) I undertake to notify the UHB of any changes which may occur within four weeks from the date of this declaration and I understand that I can contact the Governance Office. Please return completed forms to cav.declarations@wales.nhs.uk	i) I confirm that the information accurately reflects my interests and that of my family and understand that I am responsible for ensuring I am included in the Register which is available for public inspection
Low	Ejiah	Attorney	Consultant Transplant and General Surgeon	Nephrology and Transplant	Yes	Yes	UHW	Yes	Medlap Ltd, E&G Senior Care Ltd Spouse: Medlap Ltd, E&G Senior Care Ltd	MedLap 20/01/2012; E&G SC ltd. 22/1/2016 MedLap 20/01/2012; E&G SC ltd. 22/1/2016		E&G Senior Care Ltd E&G Senior Care Ltd			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	FP - Spine Cardiff		Yes	Yes	Yes
Low	Alaina	Adams	Principal Pharmacist	Pharmacy	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Attended two meetings as a Specialist Pharmacist in consultancy role for Pharmaceutical Industry and Marketing company	07.09.20 - 10.09.20	Honorarium received	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Participated in a podcast for Cardiff University	11.11.20 - 13.11.20	Payment received	Yes	Yes
Low	Charlotte	Addy	Consultant	Cystic Fibrosis Unit	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Support for educational lectures/activities from GlaxoSmithKline	2022	No personal gain	Member of British Thoracic Society Board	2022	No personal gain	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Sanjeev	Agarwal	Consultant Orthopaedic Surgeon	Orthopaedics	Yes	No	LHL	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Institutional funding from Zimmer Biomet for funding of a knee fellow in orthopaedic surgery	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Kashin	Ahuja	Consultant	Trauma and Orthopaedics	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Fellowship posts funded by Depuy Synthes, Nuvasive and Globus Medical LTD	Jun 21- Ongoing	None	No	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes
Low	Rania	Aldridge	Clinical Psychologist / Clinical Lead of the Integrated Autism Service	Psychology and Psychological Therapies / Autism	Yes	No	Awen House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I do some private work in my capacity as a psychologist - autism assessments, sometimes interventions and court reports. I do not assess anyone who is known to the UHB professionally.	2012 - current	Financial	Yes
Low	Kathryn	Allen	Community Pharmacy Advisor	Pharmacy	Yes	No	Woodland House	Yes	Davies Homes Ltd Directorship of Davies Homes Ltd - a family building business unconnected with healthcare	2010 - current	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Policy and planning manager Company Chemists' Association	2015 - to date	Yes salaried 7.5 hours per week	Yes
Low	Louise	Allen	Pharmacist	Primary Care Prescribing Advisers	Yes	No	Woodland House	Yes		ongoing	Dividends ad hoc	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Callum-Charles	Allen-Ridge	Senior Manager	Innovation and Improvements Team	Yes	No	Woodland House	Yes	Director for Lean in Health Ltd	2020-ongoing	Dividends ad hoc	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	Bank work for North Bristol NHS Trust, clinical work and also consultancy around performance management and quality improvement.	2022-Ongoing	Financial	Yes
Low	Sneha	Alshawadi	Podiatrist	Podiatry	Yes	No	UHL	Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	I work 7 hours per week as a Podiatrist for Murray Medical.	2021-ongoing	Fees	Yes
Low	Raveen	Anand	Consultant	Neurophysiology	Yes	No	LHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Astra Zeneca sponsored research in UHW- performing tests out of hospital hours. 6 patients maximum.	2022		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
Low	Richard	Anderson	Consultant Cardiologist	Cardiothoracic	Yes	No	UHW	Yes	Shareholder of Richard Anthony Anderson Ltd	1.08.15 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Directorate will receive remuneration for the study	N/A	N/A	N/A	Committee member of the Wales Heart research Fund	01/01/2010 - ongoing	N/A	N/A	N/A	Yes
Low	Angela	Andrenacci	Consultant Transplant Surgeon	Nephrology and Transplant	Yes	No	UHW	Yes	N/A	N/A	N/A	Small number of shares in Pfizer	1.10.19 - ongoing	£500 shares as part of portfolio	Sanofi-Evances, Novartis	01/10/2013 - 01.10.2016	Delegate fees are reduced thanks to the sponsorship received	30k provided for departmental research	Sanofi-Evances, Novartis	01/10/2013 - 01.10.2015	Funding for an MD research project	Kidney Wales Trustee	01.02.2027 - ongoing	Board of Trustees and its HR	N/A	N/A	N/A	N/A	N/A	Yes
Low	Basil	Petrangru	Consultant	Anaesthetics	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice at Spire Hospital Cardiff		Fees per session	Yes	Yes
Low	Philip	Allen	Consultant in Oral Medicine	Dental	Yes	No	UHW	Yes	Dr Allen provide Oral and Dentistry to patients, treated by:- 1. Nufarm Medical/ Aesthetics Ltd (aesthetic medicine) 3. Spouse 2. Spouse and colleagues	2014 - current 2020 - current	expenses only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Kim	Allenson	Strategic Lead Occupational Therapist	Therapies / Occupational Therapy	Yes	No	LHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Vice Chair of Royal College of Occupational Therapists	2018 - 2021	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Julia	Attwell	Senior Manager	Innovation and Improvement Team	Yes	No	Woodland House	Yes	Non-Executive director Linc Cymru Housing Association	2022	Annual Payment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of the Board for Cardiff YMCA Housing Association	2022	Voluntary	N/A	N/A	N/A	N/A	Deputy Superintendent Registrar for Bridgend Borough Council	2022	Casuall hours contract	Yes
Low	Maguire	Baba	Consultant Paediatric Palliative Care	Child Health	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have an honorary cotract with Ty Hafan Children's Hospice as their consultant	21.06.16 - ongoing	8 hours per week	N/A	N/A	N/A	N/A	N/A	Yes
Low	Sue	Bailey	Lead Quality and Safety	QS&T	Yes	No	Woodland House	Yes	Director of dormant registered company	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Low	Sarah	Bailey	Senior Specialist Speech & Language Therapist	Neurosrsychiatry Service	Yes	No	Hafan y Coed	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I occasionally provide independent speech and language therapy assessment for case managers in brain injury litigation. The patients seen are always outside of the geographical and clinical remit of my cardiff and vale caseload.	current	Yes	Yes	Yes
Low	Phillip	Ball	Mental Health Nurse	CHAT	Yes	No	No	Yes	No	N/A	Nil	Nil	No	I have accepted an offer to join an All Wales Excel for Life Antimicrobial Stewardship Network. This forum is designed to help network best practice and will be useful for myself and other senior nurses to network and share our practice. There is one paid event scheduled for the 30th April 2021, but all other work is non paid	Feb 21 - Ongoing	Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Yes	Yes
Low	Timothy	Banner	Pharmacist	Pharmacy UHL	Yes	Yes	UHL	Yes	No	N/A	Nil	No	Apr-19	N/A	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	No	No	N/A	No	N/A	N/A	Yes
Low	Miranda	Barber	Consultant Clinical Psychologist	MHDOP	Yes	No	UHL	Yes	I am the Director of a Ltd company which has not traded for 18 months	2015 - current	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Ruth	Barratt-Naylor	Principal Practitioner Psychotherapy	Psychotherapy	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Private Practice		Cheques	N/A	Yes
Low	Robert	Bauld	Principle Clinical Engineer / Design & Development Team Leader / Health and Safety Coordinator	Artificial Limb and Appliance Service	Yes	No	Tredweid	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Rehabilitation Engineer Associate Lecturer	21/09/2020 - 31/08/21	Yes	Yes	Yes
Low	Sally	Bayley	Independent Member of the Board	Executives / Corporate	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member, Governance Board ACCELERATE (Life Sciences Hub)	2019 - ongoing		N/A	N/A	N/A	N/A	British Heart Foundation research-related work	1994 - ongoing		N/A	N/A	N/A	N/A	Cardiff University	2007 - ongoing	Salary	Yes	Yes
Low	Andrew	Beamish	ST8 General Surgery	General Surgery	Yes	No	UHW	Yes	Director and Trustee of Limited Company "AST Exams"	2014 - ongoing	Nil (Voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director and Trustee ofAssociation of Surgeons in Training - Currently applying for its Limited company "AST Exams" to become a charitable company	2014 - ongoing	Nil (voluntary)	N/A	N/A	N/A	N/A	N/A	Yes	yes
Low	Melissa	Beard	High Intensity Psychological Practitioner	Psychology & Psychological Therapies	Yes	No	Cardiff Royal Infirmary	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work on the bank of primary mental health	2017 - ongoing	Average £100 a month	Yes	Yes
Low	Robert (Bryan)	Beattie	Consultant Obs & Gynae	Fetal Medicine	Yes	No	UHW	Yes	Working Director of Wrekenton Services Ltd trading as Innermost Healthcare	15+ years - current	financial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Shareholder in Time for Medicine		N/A	N/A	Yes
Low	Lorna	Bennett	Director of Public Health	Corporate Executives	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honorary Contract with Public Health Wales for out-of hours on call.	2022-ongoing	Nil	Yes	Yes
Low	Claire	Beynon	Deputy Director of Public Health	Corporate Executives	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Employment with Cardiff University, Swansea University, Cardiff Metropolitan University and the Faculty of Public Health for teaching and research duties	2016-Ongoing	Payment for teaching duties	Yes	Yes
Low	Freedmon	Bhat	Consultant Gynaecologist	Gynaecology	Yes	No	UHW	Not Ticked	HHH Healthcare Ltd Spouse	May 2013 - ongoing May 2013 - ongoing	Director Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Vijayaparamahl	Biju	Consultant	Elderly Care Medicine	Yes	No	UHW	Not Ticked	Medic Training Limited - private work from publication of articles, attending ad - board	1.03.17 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Robert	Blashen	Medical Consultant	Consultant Radiologist	Yes	Yes	LHL	Yes	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Cardiff Medical Consulting Ltd Partner: North Cardiff Medical Centre (Partner) and Cardiff Medical Consultant Ltd			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Yes	Yes
Low	Charlotte	Blodgworth	Advanced Nurse Practitioner	Haematology	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of medical advisory group for Lymphoma Action Charity	2022	Nil	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Mike	Bourne	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	UKAS	Now 16 - ongoing	Nil	N/A	N/A	Yes
Low	Ian	Bowler	Consultant Anaesthetist	Anaesthetics	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chairman of MEDSERVE Wales, an Immediate Care Charity based in South Wales			Medical Advisor to the Myotonic Dystrophy Support Group			N/A	Private Practice with admitting rights at Spire Cardiff Hospital and Vale Hospital Hensol	N/A	N/A	Yes
Low	Matthew	Boyd-Anderson	Physiotherapy Technical Instructor	Therapies	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Paul	Brackenbille	Senior Projects & Deputy Directorate Manager	Dental/Ophthalmology	Yes	No	UHW	Yes	Active Director at Tre-Ode Court Management Ltd, Companies House Reference Number 08965309	1.10.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Eileen	Brandreth	Independent Member of the Board	Executive / Corporate	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Employee of Cardiff University	December 2008 ongoing		Yes	Yes
Low	Carwyn	Bridges	Physiotherapist	Specialty Medicine	Yes	No	LHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Limited Consultancy Chess Ltd	June 20 - Oct 20	Honorarium	Yes	Yes
Low	Francis	Brooks	Consultant	Trauma and Orthopaedics	Yes	No	UHW	Yes	Yes	Nov-21	Yes	Yes	Nov-21	Yes	No	N/A	N/A	Consultant for Sonyker	Nov 21- Ongoing	Salary	No	N/A	N/A	No	N/A	Clinical Advisor for EDO (Medical IT Company) Advisor for Doctor care Anywhere	Nov 21-Ongoing	Fees	Yes	Yes
Low	Rachael	Broome	Assistant Business Partner	Finance Business Team	Yes	Yes	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ongoing	N/A	N/A	N/A	Yes
Low	Kate (Catherine)	Bryant	Consultant Clinical Scientist	Ultrasound Services	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes - Clinical Private Practice as a Doppler at St Joseph's Hospital	Ongoing	Salary	Yes	Yes
Low	Anne	Burgess	Pharmacist Team Leader	Pharmacy	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	The Neonatal and Paediatric Pharmacists Group (NPPG) have corporate partners (pharmaceutical companies) who pay the organisation for benefits such as access to professionals for advisory meetings. I attend these as an NPPG executive committee member. Conference attendance fee for the EuPFI conference 2020 paid for by Provexa Ltd.	2018 - Ongoing Sep 20 - Sep 20 Conference fee paid	Sponsorship to NPPG	Annual attendance at Neonatal and Paediatric Pharmacists Group (NPPG) Conference - this is an event sponsored by multiple pharmaceutical companies.	Nov 19 Ongoing	Delegate fees are reduced thanks to the sponsorship received	Member of the Neonatal and Paediatric Pharmacists Group (NPPG) executive committee and their Information Officer	Nov 11 - ongoing	SLA in place with WMIC to fund this position which is 0.2 WTE per wk. Personal expenses paid for attending meeting.	N/A	N/A	N/A	Presented healthcare professional educational sessions on excipients in medicines for children at events sponsored by Dentkin Pharma Ltd and Provexa Ltd	July 20 - Nov 20	Honoraria received		Yes
Low	Tanya	Burton	Myeloma Clinical Nurse Specialist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	We use some of the pharma drugs in our health board	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Janssen/Takeda/Celgene Sanofi	2017 - Ongoing 2020 - Ongoing	One off payment	Yes	Yes
Low	Adam Joshua	Cann	Trainee Clinical Psychologist	Clinical Psychology	Yes			Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment as CBT therapist working with [illegible] Ltd	16/09/20 - ongoing	Yes	Yes	Yes
Low	Rekha	Chakraborty	Consultant	Senior Medical MHSOP	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private assessments through Clinical Partners outside my working hours	Ongoing	Fees	Yes	Yes
Low	James	Chapira	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics, Spinal	Yes	Yes	UHW	Yes	Director 1. Tanman Consultancy Ltd 2. Tanman Investments Ltd Spouse Director 1. Tanman Consultancy Ltd 2. Tanman Investments Ltd	2008 - ongoing 2015 - ongoing 2008 - ongoing 2015 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spinasil Ltd, Director	Dec-19	N/A	N/A	N/A	N/A	Practice privileges at Nuffield Vale Hospital and Spire Cardiff Hospital	2008		Yes	Yes
Low	Mohammed	Chowdhury	Consultant Dermatologist	Dermatology	Yes	No	UHW	Yes	Director of Dr MAU Chowdhury Ltd (private dermatology work)	2012 - ongoing	Dividends, no salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	President-Elect, British Association of Dermatologists, Executive Officer of Charitable organisation (unpaid role)	July 21 - July 22	Nil	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Adam	Chrobon	Consultant Pathologist	Cellular Pathology	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I report (consult) for external companies, this is: Histopathology, which is a specialised area of pathology. This is usually reporting of backlog cases sent from NHS Labs in England to a central hub for distribution.	Oct-2019 - Ongoing	Yes	Yes	Yes
Low	Yu-Tai Daniel (Daniel)	Chung	Consultant	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Independent Contractor at the Spire Hospital	2019 - Ongoing	Fees	Yes	Yes
Low	Gail	Clacken	Lead Clinical Nurse Specialist in MS	Neurosciences	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of UKMSINA Committee		Sponsorship for overnight	N/A	N/A	Yes
Low	Dennis Llewellyn	Corbin	Locum Consultant Radiologist	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Declan	Coleman	Clinical Scientist	Medical Physics	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Medical and scientific advisor to Intelligent Ultrasound (formally MediaThis (Simulations and artificial intelligence in ultrasound)	2010	Consultancy Fees	Yes	Yes
Low	Sandra	Coles	Senior Nurse	Workforce	Yes	No	UHL	Yes		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I do some practice ultrasound scans for a private hospital in Newport.	current	Honoraria	Yes	Yes
Low	Philip	Connor	Consultant	Paediatric Oncology	Yes	No	UHW	Yes	N/A	N/A	N/A	No	I have no conflicts of interest. There was a planned advisory board with a company called Sobi but this fell through. I sit on an advisory board for Chugai.	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	Additional agency work outside of working hours	March 2021 - present	Hourly salary	Yes	Yes
Low	Tara	Cook	Consultant	Critical Care	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	Yes
Low	Kerrie	Cooke	Physiotherapy	Outpatient Physiotherapy	Yes	Yes	UHW	Yes	No	N/A	Nil	No	N/A	N/A	No	N/A	N/A	No	N/A	Nil	No	My husband who is a physiotherapist within the service and I have a small private physio practice.	2019-Ongoing	Fees	Yes	Yes
Low	Stephen	Coombs	Podiatrist	Podiatry	Yes	No		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	Chair of Wales Branch of College of Podiatry	Nov-21	No	Private Podiatry work	2022 - Ongoing	Fees	Yes	Yes
Low	Julie	Cornish	Consultant Surgeon	General Surgery	Yes	No	UHW	Yes	Cornish Healthcare Ltd Partner: Sinff Ltd	01/04/2019 January 2020	No Salary	N/A	N/A	N/A	N/A	N/A	N/A	I am the Secretary for the Pelvic Floor Society (another professional association) and a Trustee for the MASC foundation (charity). Both receive industry funding for educational events from multiple industry partners. I have been paid honoraria by industry for participation in events which have been declared to CAAUHB and have been paid into Cornish Healthcare limited.	2018	None	Trustee and Exec Board Member of MASC Foundation	2018	N/A	N/A	N/A	N/A	I work in Spire Cardiff in a session which has been agreed as part of my job plan	Apr-18		Yes	Yes
Low	Richard	Cousins	Consultant in Immunology	Immunology	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	I have shares in AstraZeneca	ongoing	Dividends	Sponsorship for travel and attendance at educational meetings from Novartis and Gilfolis	Ongoing	Accommodation, travel and conference fees	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Low	Claire	Cousins	Consultant	Sexual Health	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Fast Track Cardiff and Vale (HIV Prevention Network). Volunteer with a charity hosted by Pride Cymru.		Nil	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Gillian	Creed	Consultant Anaesthetist	Anaesthetics	Yes	No	UHW	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	N/A	N/A	Responder member and treasurer of MEDSERVE Wales (Charity Number 1039020)	2016-Ongoing	No	N/A	none	Yes	Yes
Low	Alex	Crompton	Pharmacist	Medicine	Yes	No	UHW	Yes	No	N/A	Nil	No	N/A	N/A	I took part in an advisory board meeting for Thame (ulcerative colitis Summit) in December 2020 and recieved an honorarium of £200	One off	£250.00	No	N/A	N/A	No	N/A	N/A	N/A	No	No	N/A	N/A	Yes
Low	Aniberdra	Dalla	Consultant Urologist	Urology	Yes	No	UHW	Yes	Director of Urology Solutions Cardiff Ltd Spouse: Director of Urology Solutions Cardiff Ltd	01.02.18 - current 01.02.18 - current	Dividents ad hoc Dividents ad hoc	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Hospital	Sept 2001 - ongoing		Yes	Yes
Low	Judy	Daniels	Clinical Psychologist	Neurosrsychiatry Service	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice. I work as an associate practitioner through an organisation called Headview		Fee	Yes	Yes
Low	Gareth	Davies	Clinical Scientist	Merges	Yes	No		Yes	Company Director of Penstome Property - dormant for +3 years	2019 - Ongoing	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes

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

Low	Ikram	Osanes	Consultant Paediatric Gastroenterologist	Child Health	Yes	Yes	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	Wife has done consultancy work for which she has been paid within the last 7 years with Janssen, Takeda and Jazz		Yes	N/A	N/A	N/A	Chair of NICE NG1 (2015), Previous Chair of the ESPGHAN Endoscopy Working Group and member of JAG (2012-2015). I have been a NICE expert witness in appeals for Crohn's and Colitis. I lead an induction programme twice each year. Health Advisory Council of Coeliac UK since spring 2020 and Servelli Cross party Group on Coeliac Disease since spring of 2020. I am now on the consultant's committee of BMA Wales	2016	N/A	I raise money for and contribute to events (as a speaker) held by CCRA and Crohn's and Colitis UK. I am part of IBD Wales.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Robyn	Davies	Head of Innovation	Improvement and Implementation	Yes	No	Woodland House	Not Ticked	Chairman - Cultivvate Ltd	1.09.17	None	Chairman - Cultivvate Ltd (existing UHB customer)	1.09.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Visiting Professor - University of South Wles, Hon Innovation Fellow - Cardiff University	1.07.20 - 1.07.23 16.11.20 - 1.01.25	None	N/A	N/A	N/A	Yes	Yes
Low	Ikram	Osanes	Consultant Paediatric Gastroenterologist	Child Health	Yes	Yes	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have raised money for and contribute to events (as a speaker) held by CCRA and Crohn's and Colitis UK.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Paul	Davis	Consultant Paediatrician	Child Health	Yes	No	St David's Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Scientific Advisor to The Lullaby Trust							Yes
Low	Imogen	Davis	Practitioner Psychologist	Psychological Therapies	Yes	No	Links CMHT, CRI	Yes	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Private clinic at Cyncoed Consulting Rooms. Undertake private practice in relation to child safeguarding tasks (legal proceedings)	1. 1/4/ 2022 - Ongoing 2. Jan 2023-Ongoing	Fees per report	Yes	Yes
Low	Dov	Deitz	Consultant in Metabolic Medicine	Haematology/ Immunology / Metabolic Medicine	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	Honoria received for expert advice and speaker fees from Amgen, Sanofi, Actelx, Amryt, Kyowa Kirin, Novartis	2011 – ongoing	Financial	N/A	N/A	N/A	Trustee, HEART UK	2018	None	N/A	N/A	N/A	N/A	N/A	Private Practice- Metabolic Clinic Ltd	2011	Financial	Yes	Yes
Low	Ceris	Devereux	Public Health Dietitian	Nutrition and Dietetics	Yes		UHW	Yes	N/A	N/A	N/A	N/A	N/A	I have done work advising Quorn foods around diet for monetary payment, I have also worked with the NHS in conjunction with stjon producing diabetic advice for monetary payment for E-learning					N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have undertaken some activities as part of my private practice	Ongoing	N/A	Blank	Yes
Low	Catherine	Doman	Programme Lead for Integrating Health and Social Care	PCIC	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	16th October 2019 and 10/02/20	one off payment	N/A	N/A	N/A	N/A	Trustee of Llamau	June 2021 - Ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	yes
Low	Catherine	Doman	Director of Health and Social Services Integration	Health and Social Services	Yes	No	Strategic Planning	Yes	No	N/A	N/A	Nil	No	N/A	N/A							Trustee for Llamau (Homelessness Charity)	Jan 20 - ongoing	Nil	No	N/A	N/A	No	N/A	N/A	N/A	Yes	Yes
Low	Nicholas	Drage	Consultant in Dental and Maxillofacial Radiology	Dental	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Lecturing to dentists on all aspects of dental radiology	sessions	Lecturing- personal payment	Yes	Yes
Low	Mark	Drury-Smith	Consultant Cardiologist	Cardiothoracics and Medicine	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	13.07.20	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Jonte	Dunkers	Consultant Medicine	Specialised Medicine	Yes	Yes	UHL	Yes	N/A	N/A	N/A	N/A	N/A	CF service has previously received educational grant from Vertex	2015							pharmaceutical companies - Vertex, Merke, Chiesi, Insmed - intermittent	ongoing		N/A	N/A	N/A	Research Ethics Committee, member of organising committee of CF research events	ongoing	N/A	N/A	N/A	N/A	Yes	Yes
Low	Martin	Edwards	Consultant Paediatrician	Paediatrics	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am a trustee for the Advanced Life Support Group (ALSG)	N/A	N/A	I work 2.5 sessions for HEIW as a deputy director for neonatology care	Apr 21 - Ongoing	N/A	Yes	Yes
Low	Natalie	Elliot	National AHP lead for Dementia	Mental Health	Yes	Yes	Academic Centre UHL	Yes	No	N/A	N/A	N/A	No	N/A	N/A	N/A	N/A	No	N/A	N/A	Yes		2017-ongoing	Spouse Salary	No	Spouse: Executive Director of People & Places at Taff Housing.	N/A	N/A	Honorary Lecturing Session [outside of NHS Working Hours] for Cardiff University.	2017-ongoing	Paid and hourly rate	Yes	Yes
Low	Nabah	Elmusharaf	Consultant Haematologist	Haematology	Yes		UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Roche- Abbvie- AstraZenca	Fees for organising talks and to attend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Susan	Elsmore	Independent Member of the Board	Executive / Corporate	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cabinet Member for Social Care, Health & Wellbeing Cardiff Council / Health & Social Care Spokesperson WLGA / C&V Regional Partnership Board Chair	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	George	Enald	Consultant Neurosurgeon	Neuroscience	Yes	No	UHW	Yes	Director of my own PLC	Mar 20 - ongoing	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice: Spire Hosp and Sancta Maria Hosp	01/03/2020 - ongoing	Fees	Yes	Yes
Low	Libby	Erin	Consultant Clinical Psychologist	Child Psychology	Yes	No	Global Link	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work privately seeing families where children are struggling with their mental health.	2018 - ongoing	N/A	Yes	Yes
Low	Kayla	Evangelou	Consultant Cellular Pathology	Cellular Pathology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2018 - January 2021	Fees	Yes	Yes
Low	Caroline	Evans	Consultant Healthcare Scientist	Biochemistry	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsored Research: Applied for funding from Abbott for a Q1 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	N/A	Yes	Yes
Low	Caroline	Evans	Consultant Anaesthetist	Perioperative Care	Yes	No	UHW/UHL	Yes	N/A	N/A	N/A	N/A	N/A	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. ex. TET 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 privileges since 2011 2. Deputy Director for Secondary Care for Wales	1. Jan 11 - ongoing 2. 2022 - ongoing	1. Fees 2. 2 x sessions	Yes	Yes
Low	Kasen	Fabi	Radiographer	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	Jul 08 - Ongoing	Fees per session	Yes	Yes
Low	Fatrick	Feeding	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	received travelling expenses and a lecturing fee for a GE molecular imaging symposium	Aug-18	Lecturing fee and travel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake a small amount of private practice during my work at the UHB both in NM and via PETIC. I do not consider that these constitute a conflict of interest	Sept 2010 - ongoing	fee per patient basis	Yes	Yes
Low	Elaine	Flannery	Counsellor	MHSOP Psychology	Yes	No	CRI	Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	No	No	N/A	No	N/A	No	No	N/A	No	No	N/A	2 hours per week as a self employed counsellor.	2021-Ongoing	Yes	Yes	Yes
Low	Joseph	Flora	Genetic Counsellor	All Wales Medical Genomics Services	Yes	No	Institute of Medical Genetics, UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Employed by prenetics EMEA Ltd - zero hours contract (Maximum 8 hours per week averaged over a week period)	18.03.21 - Ongoing	hourly rate	Yes	Yes
Low	Chris	Fosker	Director of Corporate Governance	Corporate / Executive	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Company secretary for Safe Ventures Ltd	N/A	N/A	N/A	Yes
Low	Mark	Fowler	Consultant Orthopaedic Surgeon	Trauma & Orthopaedics	Yes	Yes	UHW	Yes	Cardiff Knee Surgery Ltd (private practice)	2010 - ongoing		Partner, Cardiff Knee Surgery Ltd (private practice)	2010 - ongoing	Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Aaron	Fowler	Head of Risk and Regulation	Corporate Governance	Yes	Yes	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	My wife is employed by NWSSP Legal and Risk, w/ks the health board contact for legal advice.	2019-ongoing	N/A	Yes	Yes
Low	Joanna	Fox	Consultant	Anaesthetics	Yes	Yes	UHW	Yes	One-over business Dr Jo Aesthetics	2022-ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Malcolm	Graing	Consultant	PICU	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1. Director of quality management HEIW 2. GMC Enhanced monitoring associate	2022	Ad hoc payments	Yes	Yes
Low	James	Galea	Consultant Neurosurgeon	Neurosciences	Yes	No	UHW	Yes	Neurosurgery Services Ltd (Not seeking to do business with UHB)	30.11.17 - ongoing	Nil	N/A	N/A	Clinical Research involving but not funded by pharmaceutical companies (IGOR Ab, Sweden)	2015 – ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Claire	Gandecha	Senior Pharmacist	AKTTC	Yes	Yes	UHL	Yes	Director Spouse / Partner - Director	12.09.17 - ongoing 12.09.17 - ongoing	Annual Dividend Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Simona	Gatto	Consultant in Haematology	Haematology	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Roche Advisory Board			Yes	Yes
Low	Sarah	Goldsmith	Consultant	Anaesthetics	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Andrew	Gorringe	Consultant in Haematology	Haemastology Laboratory	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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 in Cardiff including reporting occasional blood films and chairing their Blood Transfusion	June 18 - ongoing		Yes	Yes
Low	Vanessa	Goulding	Podiatrist	Podiatry	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honorary lecturer for Cardiff University. External lecturer for University of South East Norway - commitment for 1 x lecture per annum.		Costs only	Yes	Yes
Low	Sumit	Goyal	Consultant Surgeon	Surgery	Yes	No	UHW		Director of limited company Dr Goyal Ltd Spouse - secretary of company	Oct 2014 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Breast Centre Charity	2009 - ongoing		N/A	N/A	N/A	N/A	Yes	Yes
Low	Craig	Greenstock	Counterfraud Manager	Finance	Yes	Yes	Woodland House	Yes	No	Q5 - (November 2021)		N/A	Nil	Member of family works for another NHS Body	N/A	Nil	No	N/A	Nil	No	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		Jun-21	N/A	Yes	Yes
Low	Ifan	Griffin	Consultant Nephrology & Transplantation	Nephrology and Transplant	Yes	No	UHW	Yes	N/A	N/A	N/A	Becton Dickinson - (June 2021)	N/A	N/A	Advisory Board attendance - Roche, Novartis, Reinophin, Astra, Zeneca	17.08.20 - 16.11.20	Honoraria	N/A	N/A	N/A	General Secretary British Transplantation Society	01.03.18 - 31.03.21	None	N/A	N/A	N/A	N/A	N/A	N/A	Mar-22	N/A	Yes	Yes
Low	Helen	Griffiths	Occupational Therapist	Community Resource Team	Yes	No	Whitchurch Hospital	Yes	N/A	N/A	N/A	Billions Institute - (March 2022)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Work as occupational therapist for Stroke case management on ad hoc basis	Jan-20	zero hour contract	Yes	Yes
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Yes	Yes	UHW	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Cardiology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	CHI/Singapore - January 2020)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd My wife is a Director and Shareholder in Groves Cardiology Services Ltd	2021	Income and Dividends	Yes	Yes
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Yes	Yes	UHW	Yes	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Cardiology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	I anticipate usine this company for any oth	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd My wife is a Director and Shareholder in Groves Cardiology Services Ltd	June 96 - current	Income and Dividends	Yes	Yes
Low	Tristan	Groves	Lead Cardiology and Anticoagulation Pharmacist	Adult Cardiology	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	I work a number of weeks - outside my NH	N/A	N/A	N/A	N/A	N/A	N/A	Receiving honoraria for providing educational sessions from Pharmaceutical companies related to anticoagulation. Honoraria received from BMS/Pfizer alliance and Bayer. Sponsored attendance of educational meetings also supplied by the above companies	2016 - current	Honoraria and meeting travel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Laura	Gwyther	CART Clinical Nurse Specialist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N	To be clear, I receive no financial benefit fr	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have been asked along side all the other CART nurses across the UK to participate in a paid advisory board discussion hosted by Celgene. I would like to partake in the discussion to get more understanding of the new product and hear about other nurses experiences. This is a 1 day event on the 15th October 2020 from 1pm until 5pm. This is a one off participation as far as my knowledge serves.	15/10/2020	£140	Yes	Yes
Low	Richard	Hain	Consultant and Clinical Lead, Paediatric Palliative Care	Child Health (Community)	Yes		UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CAVHB Office space within Ty Hafan Children's Hospice	2018		Office space, coffee			Yes	Yes
Low	Sarah	Hale	Consultant Ophthalmologist	Ophthalmology	Yes	No	UHW	Yes	N/A	N/A	N/A	Nominated member of Cardiff Eye Surgeons LLP; Company that carries out ophthalmic work	2006 - current	Paid for any work carried out	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Khalid	Hamandi	Consultant Neurologist	Evidence Unit	Yes		UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secretary, International League Against Epilepsy British Chapter, Chair Epilepsy Action Cymru National Advisory Council.	2019 - present	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Kathrin	Hammer	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	No	No	N/A	Nil	No	No	N/A	Nil	No	No	N/A	nil	No	N/A	N/A	No	No	N/A	No	Fee for service at European screning centre Cardiff and Spire hospital Cardiff for radiology work	One session	One off payment	Yes	Yes
Low	Kathrin	Hammer	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	No	No	N/A	N/A	No	No	N/A	N/A	No	No	N/A	N/A	No	No	N/A	No	No	N/A	N/A	Clinical Private Practice	06.09.20 - Ongoing	Fees	Yes	Yes
Low	David	Hanna	Consultant Paediatrician	Emeresncy Medicine	Yes	Yes	UHW	Yes	N/A	N/A	N/A	My wife, Dr Alison Whyte is a partner in Clark Avenue Surgery, a GP Practice in Cwmbran, within the Aneurin Bevan UHB area. This practice does not currently do business or is it seeking to do business with Cardiff and Vale UHB.	2019		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Abigail	Harris	Executive Director of Strategic Planning	Strategic Planning	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 Tennage Cancer Trust.	Ongoing	No	I am an independet Board member of Social Care Wales.	Ongoing	No	Husband works for Competition and Markets Authority which on occasions rules in matters of fair competition in the NHS and healthcare.	Ongoing	Husband's salary	Yes	Yes
Low	Tara	Harrison	Consultant Radiologist	Radiology	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private patient scans at Cardiff Spire Hospital during non contracted time.	2022 - Ongoing	Fees	Yes	Yes
Low	Mary	Hart	Consultant Radiologist	Radiology: Medical Physics, Clinical Engineering	Yes	No	UHW	Yes	Director Hart-Jones Consultancy LTD	Apr-19	Salary	N/A	N/A	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment: Hart-Jones Consultancy LTD	Apr-19	Salary		
Low	Jamie	Hayes	Pharmacist	AKTTC	Yes	Yes	UHL	Yes	Director of JMH Collaborations	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Director of JMH Collaborations Ltd	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Honorary Senior Lecturer appointments with Cardiff University School of Medicine and School of Pharmacy and Pharmaceutical Sciences	2006 - ongoing	Honoraria	N/A	N/A	N/A	Elected Board member of the Royal Pharmaceutical Society and member of the Royal Pharmaceutical Society Assembly. Wife is Medical Director at Marie Curie, Cardiff and Vale Hospice, Penarth.	June 2016 - ongoing	Honoraria, expenses	N/A	N/A	N/A	N/A	Programme Leader for University of Buckingham MSc	2022-Ongoing	Ad hoc payments from Lecmic Ltd	Yes	Yes
Low	Caroline	Hayhurst	Consultant	Neurosurgery	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Neuroanatomy				Yes
Low	Rhys	Hewett	Consultant Gastroenterologist	Gastroenterology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsored by Fresnius Kabi to attend BAPEN conference Nov 2019.		Paid for conference, hotel and flights.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Julie	Hadfield	Consultant Clinical Psychologist /Associate Director	Critical Care	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National Director of Wellbeing Intensive Care Society	15/06/20 - Ongoing	No	secondment from NHS 0.4WTE at N	N/A	N/A	N/A	Occasional private practice	2005 Ongoing	ad/hoc salary	Yes	Yes
Low	Christopher	Hingston	Consultant Critical Care	Critical Care	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spouse: Director and Trustee of Lasch Childrens Charity	2014 - current	Nil	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Gillian	Hingston	Consultant & Honorary Senior Lecturer Paediatric Dentistry	Paediatric Dentistry	Yes	No	UHW	Yes	Director of LATCH cancer charity	2014 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee for LATCH - Children's Cancer Charity	2013 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Peter	Hockey	Consultant Histopathologist	Cellular Pathology	Yes	Yes	UHW	Yes	Director Director / Secretary	Dividend Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I perform post mortem examinations for HM Coroner and do some private histology reporting	Jan 21-Ongoing	payment per case	Yes	Yes
Low	Angela	Hodges	Physiotherapist	Radiv	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Work as a Physiotherapist for Cardiff City Ladies Football Club.	9/12/20 - ongoing	paid	Yes	Yes
Low	Paul	Hodgson	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice (company name PDH Ortho Ltd)	Feb 2013 - ongoing	payment per case	Yes	Yes
Low	Rebecca	Hoey	Training Manager	Genomics Strategy	Yes	No	AWMGS	Yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Yes	Yes
Low	Mathew	Hoskin	Locum Consultant Psychiatrist	Adult Psychiatry	Yes	No	Barry Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am the Chief Investigator for a phase 2 clinical trial sponsered by the Multidisciplinary Association for Psychedelic Studies (MAPS, USA), which will take place in partnership with Cardiff Uni and Cardiff and Vale UHB in 2021. I have received training funded by MAPS.	03/03/2022	n/a	n/a	I have done part time agency locum consultant work for Powys Health board. Finished in July 2020. No more planned as I'm no longer part-time.			Yes	Yes
Low	Tony	Howell	Macmillan AHP Cancer Lead	Therapies	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private dietetic practice	2008 - ongoing	Salary	Yes	Yes
Low	David	Howells	Consultant	MHSOP	Yes	No	South East Cardiff team	Yes	No	N/A	N/A	N/A	N/A	N/A	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 - CIAO work Schedule 2 Visits - Mental Health Act Monitoring Work - Trustee for Charity 3BCEC Private Mental Health Clinical Work at Cyncoed Consulting Rooms, Cardiff	Jan 21 – Ongoing	Yes	Yes	Yes

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

Low	Richard	Hughes	Consultant Anaesthetist	Peri-Operative Care	Yes	No	UHW	Yes	Director of R H Health Ltd (to manage private medical anaesthetic activities undertaken outside my NHS contract)	08/01/2013	Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Lauren	Humphreys	Sonographer	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	29.06.2022		Yes	Yes
Low	Nia	Humphry	Consultant	General Surgery	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University 0.1. WTE		Salary	Yes	Yes
Low	Jenny	Hunt	Psychology Manager	Child Psychology	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	My partner (Rob Kidd) is the professional lead for psychology and psychological therapies in the UHB	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Sarah	Hunt	Consultant Anaesthetist	Anaesthetics and Critical Care	Yes	No	UHW	Yes	Vale Anesthetics Ltd	2014 - ongoing	I do not draw a salary or dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd I undertake private practice in Spire Hospital. They	2014 - ongoing	I do not draw a salary or dividends	Yes	Yes
Low	Nicola-Xan	Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for European Respiraotry Conference attendence fees by Boehringer Ingelheim	7-9/10/20	Financial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Louise	Ingleton	Avanced Paediatric Clinical Nurse Specialist	Community Child Health Deurodevelopmental	Yes	No	St David's Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of UK Nurse Advisory Board-ADHD sponsored by Takeda Pharmaceuticals	March 20 - ongoing	honoria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Wendy	Ingram	Consultant Haematologist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.Novartis Advisory Board Meeting 2. Takeda sponsored educational event - invited speaker. 3. Swedish Orphan Biovitrium advisory board meeting 4. Takeda sponsored attendnave at 2 x virtual meetings.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Bethan	Ingram Holden	Senior Nurse	Haematology	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Awardeed Florence Nightingale Foundation Scholarship (£9K) from Teenage Cancer Trust (Approved by Chief Nurse)	2021 - to be completed by end 2022	No personal gain	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Sharon	Irving	Senior Nurse ENT	ENT	Yes	No	UHW	Yes	No	N/A	N/A	No	N/A	N/A	A position with HIW as a nurse peer reviewer.	2019-Present	No	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes
Low	Carly	Jackson	Clinical Psychologist	Child Health	Yes	No	St David's Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Psychologist with Sport Wales (employed by Sport Wales) and Clinical Psychologist for Mindful Mindset (Self-Employed)	Sports Wales (1.09.19) both ongoing	Sports Wales Salary	Yes	Yes
Low	Charles	Janczewski	UHB Chair	Executives / Corporate	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Swansea University - Chair of Governance Board for Health & Wellbeing Academy	May 2018 - ongoing	Unpaid	N/A	N/A	N/A	Yes	Yes
Low	Benjamin (Ben)	Jelley	Consultant Gerentologist	Clinical Gerentology	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Treasurer of the Welsh Stroke Conference Organising Committee	2020 - Ongoing	Nil	Associate Editor for the Age and Ageing Journal		Unpaid	Contract with Cardiff University for 1 session per week to deliver an MSc in Clinical Geriatrics	N/K	Fees	Yes	Yes
Low	Fiona	Jenkins	Executive Director of Therapies and Health Science	Executive	Yes	No	UHW	Yes	Interim Executive Director Therapies and Health Science, Cwm Taf Morgannwg UHB	Nov 20 - tbc	Shared role with C&V UHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Lynda	Jenkins	Nursing Informatics Lead	Corporate Nursing	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake hospital inspections in other health boards/ private health care in Wales on invitation from health inspectorate Wales. These are infrequent.			N/A	N/A	N	Yes	Yes
Low	Meriel	Jenney	Medical Director	Executive	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Chief Investigator for an international clinical trial funded by Bayer	Oct 21 - Dec 21	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Michaela	John	Programme Manager	Genomics Strategy	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee for a charity (The Margaret Bell School)	2022	No	N/A	N/A	N/A	Yes	Yes
Low	Adam	Jones	Consultant Dental Surgeon	Dental	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Merck Sharp & Dohme Ltd. funded travel / hotel and course expenses for training on 'PD-L1 testing (22C3) Professional Expert Course Head and Neck - Advanced Training'.	13.01.21 - 14.01.21	Course, travel and hotel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Ceri Hopcyn	Jones	Consultant Haematologist (BMT & CAR T)	Consultant Haematologist	Yes	No	UHW	Yes	I received sponsorship to attend various conferences including European Haematology Asssociation General meeting (EHA) 2019 and American Society of Hematolgy (ASH) 2019 from Abbvie, and EHA 2020, British Society of Haematology Annual General Meeting 2020 and ASH 2020 from Kite Gilead and Novartis	May 2019 - ongoing	Travel and registration costs only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Lisa	Jones	Clinical Psychology	Neuropsychology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work as a self employed clinical neuropsychologist	2014 - ongoing	salary	Yes	Yes
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	Yes	Yes		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for Re-Live (Registered Charity Number: 1162546) Spouse is a Board Member with the charity 'Wish Upon a Star'.(Registered Charity Number 1168140).	01/07/2015 01/07/2015	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Menna	Jones	Clinical Lead	Mental Health	Yes	No	Global Link	Yes	Director of Vegan International Ltd	24.12.19 - ongoing	none	Self employed as complementary therapist	2018 - ongoing	sessional payments		N/A	N/A	N/A	N/A	N/A	Director of British Eating Disorders Society	10.01.18 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Sharon	Jones	Consultant Rheumatologist	Specialised Medicine	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Educational funding from Lily for EULAR conference (virtual) in June 2021			Have been an advisor to NASS - National Ankylosing Spondylitis Society and received an award in 2018		N/A	N/A	N/A	N/A	Private rheumatology practice at Spire funded (self employment) since 2001	N/A	N/A	Yes	Yes
Low	Stephen	Jones	Consultant	T&O	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at the Nuffield Cardiff and Vale Hospital - performed outside NHS timetable	2022 - Ongoing	N/A	Yes	Yes
Low	Nia	Jones	Podiatrist	Therapies	Yes	No	CRI	Yes	No	N/A	No	No	N/A	N/A	No	N/A	N/A	Receives honoraria for speaking at wound care conferences	May 2019- Ongoing	Honoraria	No	N/A	N/A	No	N/A	N/A	Employed by Toetal Footcare Private Clinic.	May 2019 - Onwards	Fees	Yes	Yes
Low	Anurag	Joshi	Consultant	Cellular Pathology	Yes	No	UHW	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	I report on cases referred to AWLP from Spire Hospital Cardiff when these are allocated to me.	Sep 21-Ongoing	Yes	Yes	Yes
Low	Naushad Ali	Junglee	Consultant in Acute Medicine and Nephrology	Acute Medicine	Yes	No	UHL	Yes	NAJ Clinical Services PLC. A PLC set up by me for the purposes of private medical practice	2018 - current	private practice earnings	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Nephrologist at Spire Hospital Cardiff	2017 - current	Private Practice earnings are paid	Yes	Yes
Low	Sridhar	Kamath	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have private practising privileges at Spire cardiff hospital, Nuffield hospital cardiff and St Josephs hospital Newport.			Yes	Yes
Low	Arul	Kandan	Service Group Manager	T&O	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Physiotherapy in my own time	2022 - ongoing	Fees	Yes	Yes
Low	William Jonathan	Kell	Consultant Haematologist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional requests from Pharmaceutical companies to give education (non-promotional) talks, or to sit on paid advisory boards	2002 - ongoing	Less than £2k	Treasure of UK MDS forum	2010 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Emma	Kempshall	Consultant Haematologist	Haematology / BMT	Yes	Yes	UHW	Yes	Director Gloucestershire Knee Surgery Ltd Spouse: Director Gloucestershire Knee Surgery Ltd	August - ongoing August - ongoing	No No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Alexander	Kennedy	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Yes	No		Yes	Director South East Wales Hang Gliding and Paragliding Club Ltd	16.03.17 - ongoing	No benefits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Mohid	Khan	Consultant Gastroenterologist	Gastroenterology	Yes	No	UHW	Yes	Dr Mohid Khan Ltd	16.04.19	None	N/A	N/A	N/A	AAA	9.03.20	Speaker Fee	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Robert	Kidd	Consultant Psychologist	Mental Health	Yes	Yes	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Partner is a Consultant Psychologist within Child Health at the Health Board.	Current	Salary	N/A	N/A	N/A	N/A	N/A	N/A	Declarant is a member of the All Wales Approval Panel for Approved Clinicians in Wales, which sits within BCUHB and carries out its functions on behalf of the other LHBs. Declarant is also an external examiner at Birmingham University & an honorary lecturer at Cardiff University & an honorary (consultant) assistant professor to the school of medicine at nottingham university .	Current	Salary	Declarant occasionally undertakes direct (private) instructions for Crown Court reports, but does not make recommendations for hospital bed disposals	Ongoing	Fees	Yes	Yes
Low	Caroline	Kirwan	Counsellor	Medical Genetics	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Intermittent private genetic counselling workvia Innermost Healthcare	2022	Fees	Yes	Yes
Low	Anna	Kuczynska	Clinical Board Director	PCIC	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	GP partner, Highlight Park Medical Practice , Lakin Drive, Barry CF628GP		Yes	Yes	Yes
Low	Howard	Kynaston	Consultant Urologist	Medicine	Yes	No	UHW	ESR	Co Director of Bay Tree Wine Company - retiring from NHS 28.02.21 Spouse also co Director	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Mary	Lawrence	Associate Specialist in Psychiatry	Mental Health	Yes	No	Hamadryad CMHT	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private work in the form of reports for solicitors, DVLA, CPS, CICB, Child Services, Benefits Appeals, Immigration Applications, Occupational Health, Police etc. plus Mental Health Act Assessments. These are conducted in my own time (if undertaken during my normal working hours time slipping utilised with equivalent amount of NHS work undertaken in my own time)	Ongoing		Yes	Yes
Low	Mari	Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University MSc in clinical pharmacy. Provide 2 hour teaching session every 12 or 24 months. Annual leave taken, therefore undertaken during my own time.	March 11 - present	Hourly rate for delivering presentation	Yes	Yes
Low	Fong	Leong	Consultant	Cardiothoracic	Yes	No	UHW	Yes	Rhythmus Cordis Ltd	Jun 19 - Ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private work at Spire Hosp Cardiff	Ongoing	Fees	Yes	Yes
Low	Robert	Letchford	Consultant Physiotherapist	Physiotherapy	Yes	No	CRI	Yes	POBREN Wellbeing PLC	2019 - Ongoing	Dividends	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes
Low	Aled	Lewis	Consultant	Nephrology and Transplant	Yes	Yes	UHW	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	My wife is a joint owner/director in a private physiotherapy company specialising in exercise/rehabilitation for Parkinson's disease. I have no direct interests in the company.	Jun 21-Ongoing	none	Yes	Yes
Low	Christopher	Lewis	Interim Executive Director of Finance	Finance	Yes	Yes	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	President of Wales Branch of the Healthcare Financial Management Association(HFMA). HFMA is a registered charity.	Oct 09 - Preesent	None anticipated	My wife is Samantha Lewis, Assistant/Deputy Director of Finance, Swansea Bay University Health Board	2011 - Present		N/A	N/A	N/A	Yes	Yes
Low	Kenneth	Lim	Consultant Obs & Gynae	Obs & Gynae	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of South Wales Gynae Cancer Fund - registered chairity	2009 - ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Peter	Lindsay	Locum Consultant	Obs & Gynae	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Treasurer - South Wales Gynaecological Cancer Fund	1997 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Kate	Littler	Principal Clincal Psychologist	Haematology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	01/07/2020 - Ongoing	Salary	Yes	Yes
Low	Andrea	Liu	Consultant Neuroradiologist	Radiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4Ways Healthcare and Spire Cardiff	2012 and April 2010		Yes	Yes
Low	Andy	Lodwick	Lead Clinician Psychological Therapy Hub	Psychology	Yes	Yes	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Andy Lodwick	2014 - ongoing	Self employed as a sole trader as Dr Neil Kitchiner. Personal website cbt cardiff attracts individuals seeking Private out-pt psychological therapy.	Yes	Yes
Low	Ne-on	Loh	Consultant Paediatrician	Child Health	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultant Paeditricin in Royal United Hospital Bath	February 2010 -	2PA	Yes	Yes
Low	Rachel	Long		Directorate Manager	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Magistrate on Cardiff Bench	N/K	Expenses only	Yes	Yes
Low	Julie	Loxton	Clinical Lead Nurse	Vale Locality Office / Daytime Servi	Yes	No	Barry Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	I offer locum shifts to general practice as self employed. This does not conflict with my C&V role	March 22 - Ongoing	Salary	Yes	Yes
Low	Alice	Loyal	Clinical Psychologist	Psych EMI Community	Yes	No	N/K	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	I am company secretary for my husband's design engineering company. I hold a 7% share in the company. This does not conflict with my duties in C&V UHB.	Nov 21-Ongoing	Dividends	Yes	Yes
Low	Jill	Lubienski	Family Therapist	SHED	Yes	No	Global Link	Yes	N/A	N/A	N//A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have a private psychotherapy practice based at my home in Cardiff. I do not see clients privately where they could be seen in the SHED team. I am also a self employed Associate for Partnership Projects UK (www.partnershipprojectsuk.co.uk) providing NVR parenting therapy, and training to practitioners and therapists but again this work does not cross over with my SHED employment.	13/10/20 - ongoing	Yes I have some income from my self employed work.	Yes	Yes
Low	Helen	Ludlow	Macmillan Senior Nurse Band 8a	Medicine	Yes	No	UHW	Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	I have spoken at 3 non-promotional webcasts for Janssen, a pharmaceutical company that provides one of our Biologic drugs. 1 meeting was how IBD Nurses coped during COVID, and tips to keeps services running smoothly and then 2 (both the same presentation) on a case study of an IBD pt and also again keeping IBD services running during COVID	3 sessions	total amount received as honorarium: £1105. I am registered as also self-employed for my outside speaking engagements and tax has been set aside for these payments and my books are up to date and available for scrutiny if required	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Yes	Yes
Low	Jane	Maddison	Paediatric Physiotherapy	Acute Child Health	Yes	No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of Chartered Society of Physiotherapy Welsh Board	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Roger	Maggs	Laboratory Manager	Dental	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Managing Director of a company for private work Wife - Director of same company	01/04/2015 - current 01/04/2015	salary	Yes	Yes
Low	Claire	Main	Nurse Manager	Clinical Board	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Executive member of Association of Nephrology Nurses UK. I receive no renumeration for this.	29.05.2018 - ongoing	No	N/A	N/A	N/A	Yes	Yes
Low	Aleksander	Marin	Consultant Radiologist	Radiology	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Medica Teleradiology Speciallity Advisor in Thoracic Radiology, Spire Hospital Cardiff Reporting Radiologist	20.06.16	Monthly p0ayable fees for service	Yes	Yes
Low	Carys	Marshall	Principal Clinical Psychologist	Clinical Health & Neuropsychology	Yes	No	Global Link	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment - private practice	Mar-21	Ad hoc	Yes	Yes
Low	Syed	Masud	Counsultant in Emergency Medicine & Pre-Hospital Emergency Medicine	Emergency Medicine	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	I am the director of a personnal company - COPMED Ltd. Small company specialising in teaching specialist medical skills to special Forces, military and police.	2020	Occasional salary for courses	N/A	N/A	N/A	N/A	N/A	N/A	I sit on multiple Police Clinical Governance Panels for TVP/Hampshire and SWP and Gwent - all are voluntary - NON PAID		Voluntary - non paid	Volunteer Special Constable for SWP		Volunteer	Advisor to company called Team Fusion Ltd - specilaist protection for high end clients and courses		Salary for advise given	Yes	Yes
Low	Joanne	May	Locum Consultant Paediatric Rheumatologist	Child Health	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Medical advisor to treat to target panel for systemic JI	Nov 2020 - Nov 2021	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	The department is supported by Versus Arthritis family workers. We have a project (currently on hold) with ballet cymru and the Arts Council for Wales to provide patient support.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Kenneth	May	Consultant Cellular Pathology	Cellular Pathology and Mortuary Service, Laboratory Medicine	Yes	No	UHW	Yes	STTC Limited	Jul-19		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Histopathology reporting for backlogs Ltd				Yes
Low	Haydn	Mayo	Assistant Clinical Board Director, PCIC	Community Director	Yes	No	Woodland House	Yes	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	N/A	N/A	N/A	Forget Me Not Chorus Charity Trustee			Penarth Civic Society Member / Chair - Friends of Victoria Square sub group			N/A	N/A	N/A	Yes	Yes
Low	Neil	McCann	Consultant Anaesthetist	Anaesthetics	Yes		UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship by Medtronic UK to attend a day meeting in Leeds	4.12.19 - 5.12.19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Mike	McCarthy	Consultant	Trauma & Orthopaedics	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad Hoc educational contract with Globus Medical. I teach on 2 x courses per year.			Yes	Yes
Low	Annette	McLean	Dietetic Lead Mental Health	Dietetics	Yes		UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc private dietetic work: Orbis education, plus dietetic consultation/training ad hoc on request, eg: cardiff uni/somek/knights-absorb.	2005 - ongoing		Yes	Yes
Low	Jan	Melichar	Consultant Psychiatrist	Addictions	Yes	No	CRI	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultancy & training for all UK pharmaceutical companies in this area	1995 - ongoing	Honoraria	Consultancy at third sector organisation (DHI) in Bath and Bristol	2011 - ongoing	Honoraria	Consultancy to LearnitOnline - online health education and training	2016 - ongoing	Honoraria	Self employed in private practice primarily Spire	2011 - ongoing	Fees	Yes	Yes
Low	Angela	Miser	Associate Specialist, Paediatric Haematology / Oncology	Acute Child Health	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Chief Medical Officer, Lixte Biotechnology Holdings, Inc., East Setauket, New York 11733, USA	2020 - Present	Salary	N/A	N/A	N/A	**1.** Chairman of Board, Christian Salvation Service, Taipei, Taiwan (USA Office), **2.** Chairman of Board, Desi Geestman Foundation (supports children with cancer), Los Angeles, USA	20+	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Biju	Mohamed	Consultant	Gerentology	Yes	No	UHW	Yes	Co-Director Medic Training Ltd	2017	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical expert NICE diagnostic pathway for PKG	Jan 2022 - Feb 2023	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	[illegible]	Moideen	Consultant Spinal Surgeon	Trauma and Orthopaedics	Yes	Yes	UHL	Yes	Director Private Practice Spouse: Director Private Practice	02.2022 02.2020	Salary Salary	N/A	N/A	N/A	1. Attended 2 x Training Programmes sponsored by Globus Medical. 2. Attended a training course sponsored by Stryker.	2022	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Hospital Cardiff	2020 - Ongoing	Fee	Yes	Yes
Low	Siobhan	Moore	Clinical Psychologists	Neurosciences	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	One off training session for a drug company (Biogen where I was paid during this financial year	Apr-20	Yes	N/A	N/A	N/A	Yes	Yes
Low	Matthew	Morgan	Consultant in ICU	Critical Care	Yes	Yes	UHW		Matt PG Morgan Ltd, Director - Author/Writing Business for a book publishing about ICU Spouse - Matt PG Morgan Ltd, Director - Author/Writing Business	01/11/2017 - present 01/11/2017 - present	Dividends Dividends and salary	N/A	N/A	N/A										I have donated £5000 to the 2 Wish Upon a Star charity and £200 to the C&V Health Charity.	2020		Writer for BMJ and BMJ Learning	2005 - present	Salary	Yes	Yes
Low	Paul	Morgan	Consultant Critical Care	Critical Care	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	Lead volunteer, the UK Sepsis Trust	2013		Lecturer for Doctors Academy	Apr-19		Yes	Yes
Low	Rhiannon Meleri	Morgan	Consultant in Cellular Pathology	Cellular Pathology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board Member of Manon Jones Foundation - not yet established as a charity	01.01.20	None	Coronial post mortem work for South Wales Central Coroner's Office	2004	£96 per individual PM	Yes	Yes
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Yes	Yes	UHW	Yes	Dan Morris Ltd Spouse: Director	2003 - present	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sambury Trust, Vale 4 Africa Keeler Trust (Trustee)	Ongoing	Nil	N/A	N/A	N/A	Work at Spire & Nuffield Paid via DM Ltd			Yes	Yes
Low	Ian	Morris	Consultant	Neonatal	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2 sessions per week as programme director for neonatal MSc Cardiff University	Ongoing	Salary	Yes	Yes

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

Low	Jeffrey	Morris	Head of Electronic Assitive Technology Service for Wales	ALAS	Yes	No	Rookwood Hospital	Not Ticked	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Organising Committee and Scientific Committee member of the European Seating Symposium (ESS), based in Ireland.	Jun-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Sara	Moseley	Independent Member of the Board	Executives / Corporate	Yes	No	Woodland House	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director, Mind Cymru	01.11 - 04/ 21	Salary	Head of GMC Wales	04/21 - current	Salary	N/A	N/A	N/A	Yes	Yes
Low	Richard	Motley	Consultant Dermatologist	Dermatology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake Private Practice at the Spire Cardiff Hospital and in The Welsh Institute of Dermatology	1994 - ongoing		Yes	Yes
Low	Sian	Moynihan	Consultant Paediatrician	Child Health	Yes	No	St David's Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am welfare Officer (Safegarding Officer) which is voluntary and unpaid for the Maindy Youth Cycling club- Im on the committee supporting decision making for the club that involves child welfare. It is recognised by British Cycling Authority and Welsh Cycling Authority and done necessary Safeguarding training. I do not believe there is any conflict of interest as this is done in outside work hours.		None	N/A	N/A	N/A	Yes	Yes
Low	Peter	Mullaney	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	Yes	2019		Yes	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Pippa	Mundy	Consultant Clinical Psychologist	Child Health	Yes		Global Link	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Orbis Education & Care	2014	Payment for clinical services	Independent practice as psychologist	2014	Payment for clinical services	Yes	Yes
Low	Alexandra	Murray	Consultant Medical Genetics	Genetics	Yes	No	UHW	ESR	N/A	N/A	N/A	N/A	N/A	N/A	Paid a fee per patient to counsel them about private genetic test results purchased via Inntermost Healthcare	6.02.2017 - ongoing	Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am paid a month fee to provide a consultancy service to the National Pathology Manager about genetic tests	1.11.2017 - ongoing	monthly fee	Yes	Yes
Low	Ravindra	Nannapaneni	Consultant	Neurosurgery	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Cardiff and St Joseph's Hospital, Newport	Jul 21 - Ongoing	Yes	Yes	Yes
Low	Jones	Nia	Podiatrist	Podiatry	Yes	No	UHL	Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Private Podiatry Work	Oct 2021-Ongoing	Fees	Yes	Yes
Low	Peter	O'Callaghan	Medical Consultant	Cardiothoracic	Yes	No	UHW	Not Ticked	Dr Peter O'Callaghan Ltd	2012 - ongoing	Private practice income	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	George	Oliver	Physiotherapist	Physiotherapy	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I provide voluntary first aid cover for Ty Celyn U9 football team	2022 - Ongoing	N/A	Wife works as a journalist for BBC Wales - may occasionally cover a healthcare story.	Ongoing	Nil	N/A	N/A	N/A	Yes	Yes
Low	Balarao	Oruganti	Consultant in Psychiatry	Psychiatry	Yes	No	UHL	Not Ticked	Director of limited company but cannot see any conflict as not doing or seeking any business with UHB Spouse - Director of a limited company but cannot see any conflict as not seeking or doing any business with UHB			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Works for HIW and Judicial Appointment Committee for MHRT on ad hoc basis			Yes	Yes
Low	Craig	Parry	Consultant Radiologist	Radiology	Yes	No	UHW	Yes	Craig Parry Diagnositics Ltd Co	Jul-17		Craig Parry Diagnostics Ltd Co	Jul-17	Salary	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice - Spire Hospital Cardiff		Salary	Yes	Yes
Low	James	Peaker	Clinical Scientist	Cellular Pathology	Yes	No		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Approached by a market research company of behalf of an undisclosed pharm. Company to complete a questionnaire on my thoughts around biomarkers within UGI adenocarcinomas	2022	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Low	Frauke	Pelz	Associate Specialist in Clinical Genetics	All Wales Medical Genomics Service	Yes	Yes	UHW	Not Ticked	Director of limited company	Since May 2016 - ongoing	Dividends	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I hold a very small private psychotherapy practice, limited to very few monthly hours, well outside my job planned hours in NHS post			Yes	Yes
Low	Thomas	Pembroke	Consultant Gastroenterologist	Gastroenterology	Yes	No	UHW		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University Employee			Yes	Yes
Low	Richard	Penketh	Consultant Obs & Gynae	Obs & Gynae	Yes	Yes	UHW	Not Ticked	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	N/A	N/A	N/A	N/A	N/A	N/A	Trustee Welsh Institue for Women's Health Trustee Welsh Institue for Women's Health			N/A	N/A	N/A	Private practice at Spire all the income goes into RPSF Ltd			Yes	Yes
Low	Ceri	Phillips	Independent Member of the Board	Board	Yes	No	Woodland House	Yes	No	N/A	No	No	N/A	No	No	N/A	N/A	No	N/A	N/A	No	N/A	No	Emeritus Professor at Swansea University and Honarary Professor at Cardiff University.	Sep 21-Ongoing	N/A	No	N/A	N/A	Yes	Yes
Low	Gwenda	Phillips	Clinical Psychologist	Psychology Therapies	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director in Carers Trust South East Wales	2018 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Katie	Pink	Respiratory Consultant	Medicine	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma management (Astra Zeneca)		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Katie	Pink	Respiratory Consultant	Medicine	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma management (Astra Zeneca)		Speaker Fees / Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Laura	Price	Assistant Psychologist	Neuroscience	Yes		Rookwood Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private healthcare work within ithe community	9/09/20 - ongoing	paid hourly	Yes	Yes
Low	Ann Marie	Procter	Consultant in Medical Genetics & Clinical Board Director	AWMGS	Yes	No	UHL	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Kaleidoscope Addictions Charity	2018	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Michael	Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engin	Yes	No	Medicentre	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member of the catholic Medical Association Club	15/04/2018 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Rebekah	Pryce	Consultant Endocrinologist	Paediatric Endocrinology	Yes	No	UHW	Yes	No	N/A	N/A	No	N/A	Nil	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Public Health Wales Clinical Lead for Congenital Hypothyroidism. Paid 6 sessions per year.	Jun 21-Ongoing	Yes	Yes	Yes
Low	Clare	Quinn	Consultant Clinical Psychologist	Psychology and Psychological The	Yes	No	UHL	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	Feb 22 - Ongoing	Fees	Yes	Yes
Low	Jessica	Quirke	Consultant Clinical Neuropsychologist	Neuroscience	Yes	No	Rookwood Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	2008	Salary	Yes	Yes
Low	Ella	Rafferty	Consultant Clinical Psychologist	Welsh Gender Service	Yes	No	St David's Hospital	Yes	Director of Raffery Psychology Ltd (Dormant Company)	Oct 13 - Ongoing	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed private practice	2011 - ongoing		Yes	Yes
Low	Rajeswari	Ramaraj	Consultant	Gastroenterology	Yes	No	UHW	Yes	Director of own company	N/K	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Registered to work for a private endoscopy company and a private virual consulting company.	2022 - ongoing	Fees	Yes	Yes
Low	Suzanne	Rankin	Chief Executive	Corporate Executives	Yes	No	UHW	Yes	Director of Welsh Wound Innovation Centre	1.04.2022 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Lay Member (NHS) Cardiff University Council	28.04.2022 - 27.04.2025	None	N/A	N/A	N/A	Yes	Yes
Low	John	Rees	Consultant Radiologist	Radiology	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Hospital - one afternoon per week.	2022	Fee	Yes	Yes
Low	Suzanne	Rees	Lead Nurse CD&T	CD&T	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Contract with HIW	2022	Salary	Yes	Yes
Low	Aled	Roberts	Clinical Board Director	Medical Consultant	Yes	Yes	UHW	Yes	Co-Director SAGE Roberts PLC Co-Director SAGE Roberts PLC	2018 - ongoing 2018 - ongoing	dividend only "	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Gareth	Roberts	Consultant	T&O	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	2022-Ongoing	Fees	Yes	Yes
Low	Stuart Ashley	Roberts	Consultant Radiologist	Radiology	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Whilst not a Trustee of the Intubation Box Charitable Trust, I was involved developing this protective device for COVID-19 staff protection. Charity Ref ZD07662	21.04.20 - ongoing	Nil	Private Practice at Spire	1997 - Present	Fee per case payment	Yes	Yes
Low	Zoe	Roberts	Consultant	EU Medical Rota	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Reviewer HIW	2022	Expenses	Yes	Yes
Low	Debbie	Roberts	Health Visitor	Flying Start	Yes	No	Eastmoors Road		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Volunteer with Breastfeeding Network and Volunteer on the National Breastfeeding helpline	2004 - ongoing	Reduced study costs	N/A	N/A	/A	Yes	Yes
Low	Angus	Robertson	Consultant in Trauma and Orthopaedics	Trauma and Orthopaedics	Yes	No	UHW	ESR	N/A	N/A	N/A	Managing Partner Cardiff Sports 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
Low	Natalie	Robertson	Principal Physiotherapist in Mental Health	Physiotherapy	Yes	Yes	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Husband is Director of Operations for CD&T - Matthew Temby	01/12/2014 - Ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	Yes	Yes
Low	Darren	Robinson	Registered Nurse	Addictions	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trusteeship with Recovery Cymru	Jan-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Graham	Roblin	Consultant	Surgery	Yes	Yes	UHW	ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Private Practice	2022-Ongoing	Fees per session	Yes	Yes
Low	Matthew	Rodd	Senior Clinical Perfusion Scientist	Perfusion	Yes	No	UHW	ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Second Employment with Assured Perfusion Services	2022 - Ongoing	Salary	Yes	Yes
Low	Sheelagh	Rogers	Dental Consultant	Orthodontics	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Specialist Practitioner; Cathedral Orthodontics; Cathedral Road; Cardiff	Oct 20 - Ongoing	Fees	Yes	Yes
Low	Patricia	Romero	Community Food Worker	Capital Estates and Facilities	Yes	No	Community	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Private Practice	Ongoing	Salary	Yes	Yes
Low	Clare	Rowntree	Consulant Haematologist	Haematology	Yes	No	UHW	Not Ticked	N/A		N/A	N/A	N/A	N/A	Members of previous advisory Boards for Novartis and Amgen in past 3 years		Yes	N/A	N/A	N/A	Advisory role to Leukaemia Care		No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Rachel	Rushforth	Senior Nurse Education, Quality, Safety and Patient Experience	Mental Health	Yes	No	Hafan Y Coed	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Associate Lecturer at the Open University	Jan 19 - Ongoing	Salary	Yes	Yes
Low	Joanna	Rutkowska-Wheel	Specialist Occupational Therapist	neurology	Yes	No	UHW	Yes	No	N/A	N/A	No	N/A	N/A	I received an honoraria for presenting on a MS ACADEMY: Fatigue in MS webinar sponsorde by Novartis.	22.11.21	22.11.21	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	Yes	Yes
Low	Ramsey	Sabit	Consultant Physician in General and Respiratory Medicine	Medicine	Yes	No	UHL	Yes	Director of Ramsey Sabit Ltd. This is a PLC for earnings from private practice Spouse is a fellow share holder and director for "Ramsey Sabit ltd"	23.05.18 - ongoing	share dividends in 2019 but not 2020	N/A	N/A	N/A	I have received honoraria from Pharm Companies (GSK, AstraZeneca, Cheiesi) to present at educational meetings.	N/A	N/A	Support for educational lectures/activities from Glead/Chiesi	2022	No personal benefit	N/A	N/A	Nil	N/A	N/A	N/A	Outpatient private practice at Spire Hospital and Nuffield hospital	Aug 2014 - ongoing	Private Practice earnings are paid	Yes	Yes
Low	Seetal	Sall	POCT Lead	Laboratory Medcine	Yes	No	Ty Glas, Llanishen	Yes	Yes	Jan 20 - Dec 20	None	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Caroline	Scherf	Consultant	Sexual Health	Yes	No	SE Cardiff Locality	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Gideon Richter sposored attendnace at 2022 European Society of Contraception Meeting in Ghent	May-22	approx £700	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Annete	Schlaudrdaff	Consultant SRH	DoSH	Yes	No	CRI	Yes	N/A	N/A	N/A	N/A	N/A	N/A	DoSH ha supplied fro for pharmaceutical funding for training and Waiting list reduction clinics from both Bayer plc and MSD succesfully. One such application that was apporved was filed by myself.			N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Stefan	Schwarz	Consultant Radiologist	CD&T	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Practising privileges at SPIRE Hospital Cardiff, I also hold a honorary position at the University of Nottingham as a 'Clinical Associate Professor' since May 2016 for which I receive honoraria.	Current	Honoraria	Yes	Yes
Low	Jane	Scourfield	Speciality Doctor	CAMHS	No	Yes		Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director APPERTA Foundation Charity	2019 - ongoing	No	No	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Prabhu	Sekaran	Consultant Paediatrician Surgeon	Child Health	Yes	Yes	UHW	Not Ticked	Director - Novel Surgery	2019 - current	nil	N/A	N/A	N/A	Spouse shares in GlaxoSmithKine			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertaken private practrice in the Spire, Cardiff	N/A	N/A	Yes	Yes
Low	Sagar	Shah	Specialist in Acute and Special care dentistry	Max Fax Surgery	Yes	Yes	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work 1 day per week (7.5 hours) per week at NHS Business Services Authority	2021	Salary	Yes	Yes
Low	Nimish	Shah	GP MHSOP	MHSOP	Yes	No	UHL	Yes	Director Dr Nimish Shah Ltd	2016 - ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Swaroop	Shanbhag	Consultant Spinal Rehabilitation	Neurosciences	Yes	No	UHW	Not Ticked	Abergavenny Hand Surgery Ltd - Director Partner - Vasedev Shanbhag	Mar-17	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Aarti	Sharma	Consultant	Obs & Gynae	Yes	No	UHW	Yes	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spire Hospital	Feb-18	Payment for seeing patients	Yes	Yes
Low	Jacqueline	Sharp	Physio Manager		No	Yes		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Husband works for private physion practice (Go Physiotherapy) in Cowbridge Health Centre.		Husband's salary.	Yes	Yes
Low	Andrew	Sharp	Consultant Cardiologist	Cardiology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Consultant: Boston Scientific, Medtronic, Philips, Recor Medical, Penumbra	1.07.20 - ongoing	Speaker's and/or consultancy compensation for time	Research funding, Boston Scientific	1.10.20 - 2025	Executive committee recompense for time running study	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Timothy	Sheppard	Locum Consultant O&G	Obs & Gynae	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Discussion and offer of employment in BPAS (not yet accepted, pending job planning)	2020	Sessional	203 Field Hospital, Army Reserve	1998 - Ongoing	Sessional / Daily Rate	Yes	Yes
Low	Hamsaraj	Shetty	Consultant Physician	Medicine Stroke	Yes	No	UHW	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have received honoraria for GP lectures sponsored by Bayer on 7th October, 2020 and 28th January 2021) & from Portola/Alexion Pharmaceuticals for being a member of Delphi panel	6.10.20 - Ongoi	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Somashekara	Shivashankar	Consultant Psychiatrist	Adult Mental Health	Yes	No	CRI	Yes	Director of a Limited company but have no actual or perceived conflict with the Health Board Spouse is also a Director of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019		Part ownership of a limited company but have no actual or perceived conflict with the Health Board Spouse is also a part owner of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Yes	Yes
Low	Anju	Sinha	Consultant Obs & Gynae	Obs & Gynae	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Cardiff Hospital	Ongoing	consultant fees charged	Yes	Yes
Low	Philip	Smith	Consultant Neurologist	Neuroscience	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Co-Editor of BMJ journal, Practical Neurology (2011–present)	2011 - present	Honorarium	1. Chair of NICE Guidelines Panel on Heart Valve Disease 2. Member of NICE Guidelines Panel on Epilepsy	2019 - 2021	Nil	Member of GMC Tests of Competence Panel	2018 - present	ad hoc payment for specific tasks	Yes	Yes
Low	Alex	Speakman	PN Pharmacist	Pharmacy	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Offer of sponsorship to ESPEN nutrition conference from B.Braun, travel and conference fees, this was declined.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Sarah	Spencer	Deputy Head of Midwifery	Obs & Gynae	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	Huntleigh Healthcare	2-14 - ongoing	£1,000	Yes	Yes
Low	Pushplata	Srivastava	Speciality Doctor	Dermatology	Yes	Yes	UHW	Yes	Cutis Consulting Ltd	Mar 19 - Ongoing	Dividends	Cutis Consulting Ltd	Mar 19 - Ongoing	Dividends	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Clinical Lecturer Cardiff University 1 day per week	Apr 18 - Ongoing	Sal;ary	Yes	Yes
Low	Mark	Stacey	Consultant Anaesthetist	Anaesthetics	Yes	No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board member of the Association of Anaesthetics	Oct 20 - Oct 24	Nil	N/A	N/A	N/A	I run a course called Medtrim - I occasionally run private courses	2017 - current	Yes	Yes	Yes
Low	Michael	Stechman	Consultant Surgeon	General Surgery	Yes	Yes	UHW	Yes	Director of KVMS Medical, Private Medical Practice Company Director of KVMS Medical, Private Medical Practice Company	June 2019 - present June 2019 - present	Dividends Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of the British Association of Endocrine and Thyroid Surgeons	October 2018 - Present	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Michael	Stephens	Consultant Nephrologist	National Organ Retreival Service	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of two charities - Kidney Wales and Believe Organ Donation	NK	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Emyr	Stephens	Prescribing Advisor	Pharmacy	Yes	No	Woodland House	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I attended a Health Service Journal (HSJ) award dinner in London in Feb '20, as a project that I (and other C&V colleagues) was involved with was shortlisted for an award. This was in the category of 'Partnership working with the Industry', and so the company (Lilly) paid for the dinner, accomodation	27.02.20 - 28.02.20	Attendance at awards event, accomodation and travel costs	N/A	N/A	N/A	I have taken part in an Advisory Board for various products over the last 10 years or so. These were all for 1 day only.	Various	Honoraria	N/A	N/A	N/A	Yes	Yes
Low	Lawrence	Sunder Raj	Consultant Gastroenterologist	Gastroenterology	Yes	Yes	UHW	Yes	Yes Spouse Yes	6.01.19 - 18.02.20 18.02.20	Directors salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Cardiff Bay Hospital	N/A	N/A	Yes	Yes
Low	Gillian	Swift	Consultant Gastroenterologist	Gastroenterology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have worked 2 days for Remedy Healthcare providing endoscopy services as part of weekend insourcing at UHL/UHW as plans to reduce waiting lists.			Yes	Yes
Low	Indu	Thakur	Consultant Paediatric Oncologist	Child Health	Yes	No	UHW	ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I was given a sponsorship place on a Haematology update conference by Novartis amounting to registration and stay costs of £268.20		Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Abraham David	Theron	Consultant Anaesthetist, CD Perioperative Care	Anaesthetics	Yes	No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	As Chair of the Royal College of Anaesthetist Welsh Advisory Board I am a co-opted member of college council. I am also Vice Chair of the Academy of Medical Royal Colleges of Wales.	N/A	N/A	Executive Member of the Welsh Medical Committee. Part od the clinical reference group of the National Clinical Framework.	N/A	N/A	I have co-edited the Oxford Handbook of Obstetric Anaesthetsia for Oxford University Press. Royalties for this book is to be donated to SAFE Africa.	N/A	N/A	Yes	Yes
Low	Lena	Thia	Consultant in Paediatric Respiratory Medicine	Child Health	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honorarium for speaking to nurses on asthma sponsored by AstraZeneca. Honorarium for speaking at two webinars sponsored by Vertex	13.02.20 - 1.10.20	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Benny	Thomas	Consultant Neurophysiologist	Neuroscience	Yes	No		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private Practice	2002 - Present	Reimbursement of fees	Yes	Yes
Low	Christopher	Thomas	Consultant Physician	Clinical Gerontology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Previous sponsorship to attend international conferences and honoraria for teaching from pharmaceutical agencies (BIAL, GSK, Abbvie, Britannia) on various occasions between 2009 and 2019. I also sat on expert advisory panel for GSK for one day in approx 2012.	2009 - 2019	Honori & Sponsorship	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	David Hywel	Thomas	Consultant Histopathologist	Histopathology	Yes	No	UHW	Yes	Co-director of company to provide autopsy service for HM Coroner My wife is a co-director of the company	March 20 - ongoing March 20 - ongoing	payment from HM Coroner per autopsy salary from company	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Gareth	Thomas	Consultant in Gastroenterology	Gastroenterology	Yes	No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Underake 1 session private work per week in uncontracted time	2001 - current		Yes	Yes
Low	Mary Annette	Thomas	Director Wegas	Wegas	Yes	No	Llanishen	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Becton Dickinson - European Advisory Board member for Point of Care. Provided Advice and attended meetings. Invited Speaker at Siemens Healthineers meeting in Bangkok in 2019 and Brussels Oct 2018. Invited speaker at Nova Biomedical User Group meetings in Manchester and London November 2018.	Aug 18 - current	Received travel expenses to attend meeting in London 2018, Aberdeen in 2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes

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

Low	Matthew	Thomas	Consultant Restorative Dentistry	Dental	Yes		No	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	West Coast Dental Care - Self employed private practice	ongoing		Yes	Yes
Low	Nerys	Thomas	Radiographer	Radiology	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PHW Ultrasound Advisor. 10 sessions per annum paid to radiology dept. No personal financial gain		none	Yes	Yes
Low	Alwen	Thomas	Independent Member of the Board	Executive / Corporate	Yes		No	Woodland House	Yes	N/A	N/A	N/A	N/A	Owner of consultancy business	01.03.19 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Glas Cymru Cyf (Welsh Water) Co-opted Board Director of Cardiff & Vale Credit Union	01.10.13 - present 15.05.20 - present	Voluntary Voluntary	Senior Lecturer - University of South Wales	04.05.20 - ongoing		Yes	Yes
Low	Rhian	Thomas-Turner	Clinical Research Facility Manager	Leeds Clinical Research	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Office holder at MHRA - Paediatric Medicines Expert Committee	Ongoing	Expenses	Yes	Yes
Low	Andrew	Thorpinson	Psychologist	Mini Psychology Training	Yes		No		Yes	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	No	N/A	Nil	Trustee for the charity Changing Faces, also member of research board for The Vitiligo Society. Occasional spokesperson for The British Psychological Society, The British Skin Foundation, The British Association of Dermatologists. All are unpaid occasional activities	Oct 20 - Ongoing	Nil	No	N/A	Nil	N/A	N/A	Occasional clinical psychology private practice (registered with HIMIC as a sole trader) - medico-legal reports, invited talks/teachings, occasional psychological therapy	Oct 20 - Ongoing	Yes	Yes
Low	Ryan	Trickett	Consultant	T&O	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice - Vale Hand Surgery Ltd	2012-Ongoing	Few	Yes	Yes
Low	Ryan	Trickett	Consultant Head Surgeon	T&O	Yes	Yes	UHL			Dragon Locums		salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spouse: Member BMA, RCGP	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	David	Tuthill	Consultant Paediatrician	Child Health	Yes		No	UHW	Yes	Director Cardiff Paediatrics Partner: Director Cardiff Paediatrics	ongoing ongoing	Dividends	N/A	N/A	N/A	I am chair of the Paediatric formulary committee of the BNF. I have advised the company A Imsume on Pafloxta.	2021	Fee paid	Organiser of the South Wales Paediatric Allergy Update Course - biannually over the last 10 years. This meeting is sponsored by a variety of pharmaceutical companies	2012 - Ongoing	N/A	I am a botard member of Medicines for Children	2006-Onwards	Nil	Cub Scout Leader	2008-Onwards	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Jonathon	Underwood	Consultant Physician	Infectious Diseases	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Intermittent	Honoraria	On the executive committee and a trustee of the British HIV Association	2022 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	John	Urwin	Independent Member of the Board	Executives / Corporate	Yes		No	Woodland House	Yes	NED, Swansea Building Society Iqmaxx Ltd (Subsidiary of Cadwyn Housing) Cardiff Business Club Ltd	1.11.17 - ongoing 1.1.20 - ongoing 1.1.20 - ongoing	Salary No salary No salary	John Urwin Ltd	1.6.16 - 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, Cambrai Cuiffaldiaeol Ltd (Will step down shortly)	1.1.20 - ongoing 1.1.20 - ongoing	No salary No Salary	N/A	N/A	N/A	Yes	Yes
Low	Stephen	Ustun	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice at Spire Hospitals	Mar 22 - Ongoing	Fees	Yes	Yes
Low	Judith	Van der Voort	Consultant Paediatrician	Paeds Nephrology	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Support and consultancy to Chiesi (Phase 4 study) and Vifor (Iron) regarding access to the Welsh medication group for inclusion of the medication to NHS Wales.	2022	£1700 in total	Yes	Yes
Low	Akpot	Varghese	Consultant Clinical Geneticist	ABMGG	Yes	Yes	UHW	Yes	One of the directors of a ltd company - AppleMedics Ltd. Not linked to NHS or Cardiff & Vale UHB	01.01.2011 - ongoing Spouse - 11.01.21	Both have shares	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Andrew	Vidgen	Consultant Psychologist	Mental Health	Yes		No	Whitchurch Hospital	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	private medico-legal work. Approximately 1.5 sessions / month outside normal working hours. Undertaken in Gwent area	Apr-17		Yes	Yes
Low	Andrew	Vidgen	Consultant Clinical Psychologist	Applied Psychology	Yes		No		Yes	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private medico-legal work. Approx 1.5 sessions mper month. Undertaken in Gwent area.	2022 - Ongoing	Fees	Yes	Yes
Low	Karen	Visser	Professional Unit Lead for Speech & Language	Community Child Health	Yes		No	Riverside Health Centre	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Community Music Wales	N/A	N/A	N/A	Yes
Low	Justin	Van Oppell	Consultant Cardiac Surgeon	Cardiac Services	Yes		No	UHW	Yes	Director - U & C Von Uppell Ltd	Nan 02	Private Practice	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Amar	Vrijhrd	Consultant Paeds Gastroenterology	Paediatric Gastroenterology	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Secretary for Private Practice	November - ongoing November - ongoing	Salary Salary	Yes	Yes
Low	Fiona	Walker	Head of Prescribing	Cardiff North and West Locality	Yes		No	Woodland House	2021	N/A	N/A	N/A	N/A	N/A	N/A	I am a NICE Medicines and Prescribing Associate. This is a role that does not attract a salary or any payment. I am standing down from this role at the end of 2020.		Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Ruth	Walker	Executive Nurse Director	Executive	Yes		No	Woodland House	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member of the Nursing and Midwifery Council	2016 - ongoing	salary	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Mark	Wardle	Consultant Neurologist	Neurology	Yes		No	UHW	Yes	ELDRIX	21.05.14 - ongoing	Company Director-Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Jonathon	Watts	Senior Manager	Strategic Planning	Yes		No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Committee member of Whitchurch Hockey Club which has an interest in purchasing the land that CAVUHB are disposing of on the Whitchurch Hospital site	2022	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Peter	Welch	Senior Hospital General Manager Llandough/Barry	Executives / Corporate	Yes	Yes	UHL		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Magistrate - Cardiff Bench	1989 - ongoing	N/A	N/A	N/A	N/A	Wife - Optician for Roberts Opticians Whitchurch Road, Cardiff Son has own web design business	1985 - ongoing 2014 - ongoing		Yes	Yes
Low	Richard	White	Consultant Radiologist	Radiology	Yes		No	UHW	Yes	Director of White Imaging Services Ltd	2022-Ongoing	Dividends	As per (a)	As per (a)	As per (a)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultant Radiologist with 4 Ways Healthcare Ltd	2020-Ongoing	Fees	Yes	Yes
Low	Simon	White	Consultant Orthopaedic Surgeon	Trauma and Orthopaedics	Yes		No	UHW	Yes	Director, Simon P White Ltd	2008 - Present	Nil	N/A	N/A	N/A	Educational contract with Zimmer Biomet	2018 - present	Annual lease	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Kathrin	Whalehouse	Consultant Neurosurgeon	Neurosurgery	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Council Member for British Neurological Surgeons	N/A	N/A	N/A	Yes	Yes
Rebecca	Whelan	Whelan	Consultant Physician	EU Medical Boss	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2022 - Ongoing	Fees	Yes	Yes
Jo	Whitlock	Whitlock	Head of Quality and Safety Improvement	Parent Safety and Quality Improvement	Yes		No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2016 - ongoing	Modify pro bono	Yes	Yes
Mr	Wilson	Wilson	Consultant Vascular Surgeon	General Surgery	No		Yes	UHW	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2020 - ongoing	N/A	N/A	Yes	Yes
Lauren	Whittington	Clinical Psychologist	CAMHS	Yes		No	St David's Hospital	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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
Catrine	Wilson	Deputy Director of Commissioning	Commissioning	Yes		No	Woodland House	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Part-time lecturer University of South Wales	2021 - Ongoing	hourly rate	Yes	Yes
Lowri	Wilkins	Associate Editor Pharmacist	Therapeutics & Toxicology	Yes		No	UHL	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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
Ian	Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital	Yes		No	St David's Hospital	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Tutoring with the Open University - Nursing	01/10/2020	Salary	Yes	Yes
Low	Matthew Gareth (Matt)	Williams	Nurse Manager	OOH Primary Care	Yes		No		Yes	Director and Safeguarding Officer of Pencoed Athletic Boys and Girls Football Club (a PLC)	2020 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional pitch side medical cover for Cardiff City Football Club - employed by Lubex Medical	2020 - Ongoing	Fees	Yes	Yes
Low	Paul	Williams	Principal Clinical Scientist	Therapies and Health Science	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	25.10.20 - 31.10.20	One off payment	Yes	Yes
Low	Claire	Wilson	Consultant Clinical Psychologist	Neuropsychology	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am a partner at Positive Neuro-Rehab. I work as a Consultant Clinical Neuropsychologist with people who present with neurological conditions either privately or as part of a medico-legal claim. I conduct medico-legal assessments for the courts. I do not take on any patients where there is a conflict of interests (e.g. on my NHS waiting list, a previous patient, or someone who might be referred to me, or are pursuing a claim against the UHB.	Sep 21 - Ongoing	Yes	Yes
Low	Katerina	Wilcock	Consultant Physician	Medicine	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes. I received travel grants and honoraria for talks from the following companies: Nagp, Boehringer-Ingelheim, Novo-Nordisk	Nov 19 - Ongoing	Travel grants/honoraria for talks/lectures	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Low	Zoon	Wong	Specialty Doctor in Paediatric Cardiology	Child Health	Yes		No	Children Hospital for wales	Yes	No	N/A	N/A	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Employed by Independent General Practice Cardiff on a 0.2 WTE basis that I do for 8 hours per week. An Children Heart Screening Day on behalf of the Welsh charity organisaion Welsh Hearts	Oct 2017 - ongoing Bot haven't done a session since October 2019	Fees	Yes	Yes
Low	Andrew	Wood	Consultant	Radiology	Yes		Yes	UHW	Yes	N/A	N/A	N/A	N/A	Wife has a private garden design business (Eileen Garden Landscapes) currently working on the 'Orchard' project at Llandough	2008	Ongoing	N/A	N/A	N/A	N/A	Occasional Lecturing Honoraria	Last date 2016	Fees	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Treasurer - Heart Research Fund Wales	2000 - Ongoing	N/A	N/A	N/A	Private Medico-Legal Cases	Current	Fees	Yes	Yes
Low	Karen	Wright	Clinical Endoscopist	Gastroenterology	Yes		No	UHL	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Agency work in off duty time for an insourcing company.	2020 - Ongoing	payments	Yes	Yes
Low	Marcellus	Wulff	Consultant Anaesthesia	Perioperative Care / Anaesthetics	Yes		No	UHL	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Research Cooperation (History of Technology) Charger Company, Ludwick, Germany & Wood - Library Museum, Schaumburg, IL., USA	2021/2022 - ongoing	No	Occasional sponsorship of conference and travel expenses	2021 - ongoing	nil secret	N/A	N/A	N/A	N/A	Welsh Medical Committee (Member)	2018 - 2021	No	N/A	N/A	N/A	Yes	Yes
Low	Alison	Cardiologist	Cardiologist	Yes		No	UHW	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical private practice - Spire Hosp	2022 - sessions	Fees	Yes	Yes
Low	Yvette	Zelmer	Consultant Anaesthetist	Anaesthetics	Yes		Yes	UHW	Yes	Brockwier Clinic Ltd	Apr-18	Nil	Brockwier Clinic Ltd	Apr-18	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes

Report Title:	Internal Audit Recommendation Tracker Report				Agenda Item no.	7.5
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	08.11.2022
			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 shared at the September Committee Meeting set out the progress made against recommendations from 2019/20, 2020/21, 2021/22 and 2022/23.

At the September Committee Meeting it was agreed that procedure for Internal and External Tracking Report updates would be varied (See minute: AAC 5/7/22 018) so that the Tracker is now reported at alternating Committee meetings, as opposed to every meeting.

The rationale for this change was to provide those with responsibility for actioning audit recommendations with additional time to implement required changes, inform updates and close out recommendations. The additional time between meetings will also provide the Risk and Regulation team with the ability to meet with colleagues, internally and from Internal Audit, to provide support and guidance to ensure that recommendations are proactively managed. This support will enable the identification of superseded entries (as a result of subsequent Follow Up and/or external reviews) and the identification of other aged recommendations that can legitimately be regarded as complete.

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

115 outstanding Internal Audit recommendations were shared with the Committee in September, 25 of which were recorded as complete. Of the remaining 90 entries there were 16 remaining High Priority Recommendations which can be summarised as follows:

Audit Year	Audit Title	Number of Outstanding High Priority Recommendations
2019-20	PCIC Adults CHC Adults Follow-up - Final	1
2019-20	Management of Health Board Policies and Procedures	1
2021-22	Clinical Audit	4
2021-22	Five Steps to Safer Surgery	2

2021-22	Theatre Utilisation (Surgery CB)	1
2021-22	IT Service Management (ITIL)	3
2021-22	Network & Information Systems (NIS) Directive	1
2021-22	Nurse Bank (Temporary Staffing Department) - Final - LIMITED	2
2021-22	ChemoCare IT System - Final	1

The full detail of these entries, with updates for the November Committee Meeting, is attached as Appendix 1 for reference purposes.

A further High Priority entry for the year 2022/23 has also been made in relation to Stock Management - Neuromodulation Services (Specialist Services CB). This recommendation was added to the Tracker following September's Committee Meeting with the following additional reports:

- Monitoring and Reporting of Staff Sickness Absence (3 recommendations);
- IMTP Development Processes (3 recommendations)
- Stock Management - Neuromodulation Stock – Specialist Services Clinical Board (5 recommendations)
- Waste Management (8 recommendations)

A follow up report on Ultrasound Governance was also shared at the September Committee meeting but did not include recommendations that required addition to the Tracker.

As of 25th October 2022, the Tracker records 104 recommendations, 17 of which are High Priority, 59 are Medium Priority and 28 are low priority. These recommendations will continue to be monitored and managed offline with a further update shared at the February 2023 Committee Meeting.

Since the September Committee meeting a concerted effort has been, and will continue to be made, to work specifically with Recommendation Owners for High Priority recommendations for the years 2019/20, 2020/21 and 2021/22 to ensure that these entries are either, fully updated so that the Committee receives assurance that the recommendations will be actioned, or, removed from the Tracker because they have been completed or superseded by subsequent events and reviews.

To assist with this process the Risk and Regulation team have met with and will continue to work with Internal Audit Colleagues to identify any recommendations that may be capable of closure (with Committee Approval), due to being; superseded, identified as complete via other reviews, or otherwise suitable for closure due to impending reviews that will more accurately address aged recommendations.

Following more direct dialogue with aged High Priority Recommendation Owners, five aged High Priority Recommendations have been reported as complete. This has also prompted a review of linked aged recommendations and a further 14 aged (medium and low priority) entries being recorded as complete.

It is hoped that the additional time spent focusing on these entries prior to the February Committee meeting will enable the Tracker to be suitably refreshed and updated prior to year-end.

In the interim the Committee's attention is drawn to the following reports:

- Network & Information Systems (NIS) Directive – Final
- Performance Reporting (Data Quality)
- ChemoCare IT System - Final

The Director of Digital Health and Intelligence ("the DDHI") is the nominated Lead for each of the above Reports, which account for 31% of outstanding aged High Priority Recommendations.

The DDHI shared verbal updates in relation to the ChemoCare IT System Report and IT Service Management generally at the September Committee Meeting. As the recommendations linked to these reports remain outstanding and are linked by their reliance on digital solutions, the Committee are invited to consider whether it would be appropriate for the DDHI to provide further assurance to the Committee in relation to progress made against these recommendations at the February 2023 Committee Meeting.

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 work underway and plans in place to proactively monitor aged High Priority Internal Audit Recommendations in accordance with the revised Workplan timetable for Internal Audit Recommendation Tracker Report; and

(b) **Consider** whether a further Progress Report should be shared by the Director of Digital Health at the February 2023 Committee meeting.

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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	x

Impact Assessment:

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

Risk: Yes/No

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

Safety: Yes/No

N/A

Mohamed Siyah 03/11/2022 16:33:19

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

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

Mohamed,Sarah
03/11/2022 16:33:19

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for September 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	31.04.2020	PCIC Adults CHC Adults Follow-up	R2/3	High	**Original Recommendation:** A timescale should be set to ensure the Head of Service Agreement is agreed promptly.	The Director of Nursing has written to the leads for both local authorities to understand the timescales for the update of the Heads of Service Agreement, there has been no response. There is however a jointly commissioned working group, attended by the Health Board, which have been tasked with updating the agreement. This has a proposed finish date of April 2018, however, this date has not been formally communicated.	Chief Operating Officer	Director of Nursing PCIC	C	**Updated Management Response:** There has been significant progress with community stakeholders including Third sector providers, their legal representatives and Cardiff and Vale Local Authorities in developing an agreed contract process which will then lead to the updating of the Heads of service agreement. These discussions have been overseen by Regional Commissioning Board which has representatives from C&V UHB (PCIC and the Planning team) and both LA's. **UPDATE 12/8 • The Joint Contract was finalised and signed off in 2020** **• The new contract and service specification was fully implemented by October 2021 by both LA's albeit at slightly different times and is now fully implemented across the UHB footprint in alignment with the two LA timescales** **• The main overarching contract has been issued to all residential providers** **• There will be a review of implementation of the new contract in 2022 and the partnership team are working with the statutory partners to develop a quality outcomes based agreed joint contract monitoring process** **• Any proposed amendments to the contract are discussed and signed off by the Regional Commissioning Board of which I am a member on.**
2019-20	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.	A plan will be put in place to review all out of date policies and to contact document owners to update their policies. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Director of Corporate Governance	Head of Corporate Governance	PC	This piece of work is partially complete. An initial review of the Health Board's current Policies Register (which details all of the policies and other written controlled documents held by the Corporate Governance Dept) has been undertaken by the Corporate Governance Directorate. A tracker has been produced which identifies all policies/other written controlled documents held on the Policies Register with corresponding Review Dates. All of those policies/other written controlled documents with an outstanding Review date having been coded "Red". A copy of current policies tracker has been sent to the Executive Directors for their individual review. Initial meetings with each individual Executive Director have been arranged to take place over the next few weeks so that each Executive Lead can feed back on how he/she intends to:- (i) identify which policies/other written controlled documents which fall to the respective Executive's Directorate require an urgent view together with proposed timescales relating to the same, (ii) identify which policies/written controlled documents may no longer be relevant/obsolete and/or have been superseded by new documentation, (iii) carry out a thorough cleanse of the documents to ensure correct terminology, fall to the most appropriate Exec Lead etc, (iv) determine which policies/other written contolled documents should be published on the Health Board's external website and/or Intranet site. As each Executive Lead undertakes his/her review of the tracker, the centrally held Policies Register will be updated accordingly. Given the scale of this piece of work, it is anticipated that the Executive reviews will be carried out in bite sized chunks with those policies/other written control documents which relate to patient safety taking priority. As such, it is unlikely that the action required to complete this recommendation will be fully completed until end of January 2023.
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.	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)	Executive Medical Director	Head of Patient Safety and Quality Assurance and Associate Medical Director	PC	8/8/22 A clinical audit strategy is under development and will be presented at the September CEC for ratification.
2021-22	31.01.2022	Clinical Audit	R2/9	High	The Health Board should develop a Clinical Audit Policy and subsequent Procedure, which will require formal approval, to provide a mandate to direct staff on a consistent basis. The policy and procedures should be developed in keeping with HQIP guidance, so that national and local clinical audits are carried out consistently and comply with current information governance legislation and guidance.	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)	Executive Medical Director	Head of Patient Safety and Quality Assurance and Associate Medical Director	PC	8/8/22 AMaT (Audit Monitoring and Tracking) has been procured and will be implemented in C&W clinical board from the 12.9.22. Engagements events are ongoing with clinical boards regarding governance around clinical audit and a Clinical Audit Policy under development and will be presented at September CEC for ratification. A Clinical Effectiveness Lead that will lead on this work has been appointed and will start on the 30/8/22.
2021-22	31.03.2022	Clinical Audit	R3/9	High	Management should continue as planned, to present the proposal for the future organisational structures to support Quality, Safety and Experience to management executive, to ensure identified resource issues are mitigated. Specifically, that the Health Board are able to: • Monitor the progress or completion of action plans / improvements in response to National Clinical Audits; • Monitor and support the development of Quality and Safety priority audits (Tier 2); and • Monitor the progress, completion and reporting of clinical audits and action plans that have identified the need for improvement.	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 systemand the team to progress this work. This action is dependent on the timing and level of investment.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	8/8/22 Clinical Effectiveness Lead starting in post 29/8/22, AMaT Officer in post. Engagements events are ongoing with clinical boards regarding governance around clinical audit and a Clinical Audit Policy and strategy is in draft which will be presented at September CEC for ratification. The Clinical Effectiveness Team is working with clinical boards regarding prioritising of Tier 2 audits and a guide has been developed and shared with the clinical boards.
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.	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.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	8/8/22 Clinical Effectiveness Lead will start in post 30/8/22 AMaT officer in post. Superuser training on AMaT for the Clinical Audit team has commenced. Training in C&W clinical board will commence 12/9/22. The AMaT system has the functionality to monitor and track the quality assurance process from project to action plans and re -audit.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for September 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.03.2022	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.	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.	Executive Medical Director	IT Service Manager and Interim Lead Nurse	C	Internal Audit Follow Up Report, reported at the November 2022 Committee meeting reports this recommendation as complete.
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.	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. 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. 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. 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 non compliance culture associated with the '5 Steps to Safer Surgery	Executive Medical Director	IT Service Manager Interim Lead Nurse Director of Nursing & Clinical Director	C	Internal Audit Follow Up Report, reported at the November 2022 Committee meeting reports this recommendation as complete.
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.	The Peri-Operative Care Directorate will continue to write a procedure titled 'Operating Theatre Scheduling, Cancellation and Utilisation. This will be a standard operating procedure which explains the process of how theatre lists should be utilised, who should attend the scheduling and utilisation meetings and how the meetings will be run. This policy will be approved by the Peri-Operative Care directorate Governance forum and will also be sent to all stakeholders that use the Peri-Operative Care service and attend the scheduling and utilisation meetings. We have contracted with a company to support developing this policy. "Foureyes Ltd" are working with us until end of March and the focus will be on utilisation and efficiency. The Directorate will also write a Health Board policy which states the rules around the booking process of theatre lists and how performance and utilisation will be monitored and adhered to. This policy will need to be approved by the Peri Operative care Directorate and Surgery Clinical Board but will also need executive approval by the Board. These two policies will incorporate the recommendations: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; Clarity of roles and responsibilities, including but not limited to the distinction between Peri-operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). These policies/procedures will be available on the Health Board's intranet pages. The Policy and procedure will be found under the policies section within the	Chief Operating Officer	General Manager Peri-operative Care	C	**Update 11/08/2022 - This has been completed**. The SCB will continue to work with "Foureyes insight Ltd" until the end of June 2022 and the main focus will be on utilisation and efficiency. **Update 11/08/2022 - This programme has ended successfully.** **Update 11/08/2022 - This has been completed.** **- Update 11/08/2022 - This has been completed**.These policies/procedures will be available on the Health Board's intranet pages. **Update 11/08/2022 this is to be actioned.** The Policy and procedure will be found under the policies section within the PeriOperative Care Directorate web site. All old policies relating to theatre scheduling, utilisation and systems and processes in relation to these will be removed from Cardiff and Vale UHB intranet pages. **Update 11/08/2022 - This is to be actioned** Update 13/10/22 - Perioperative Care are in the process of transferring and uploading all information currently displayed on the intranet pages onto the SharePoint system. This will be completed during November 2022 and a final close out date of 01/12/2022 agreed by the Perioperative Care Educational Team. All documents relating to theatre scheduling and effective utilisation will be included in this upload.
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.	1.1a In conjunction with a new ITIL compliant Service Desk software solution (Ivanti Service Manager – ISM). The current limited IT support resources will be restructured to provide a skeleton framework of an ITIL service desk structure. A business case is currently under review to increase staffing within the Service Desk, to allow for separation of key tasks and address single points of knowledge. 1.1b The new Service Desk (ISM) implementation will provide a digital front door which will include incident and problem management as well as service requests, change and asset management. There will be a User Portal on all User devices. 1.1c Staff ITIL training has already started in Jan 2022. 10x members of the IT Support/Service Desk team have successfully passed the ITIL v4 Foundation course and exam to gain their accreditation. An additional 6x team members have attended the Advanced ITIL CDS course (March 2022).	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.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for September 2022: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	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.	2.1a CAVUHB have employed the services of a dedicated Ivanti ITSM Implementation Expert. As part of the deployment Standard Operating Procedure documents have been created. A standalone and dedicated automation server has been setup, this server will provide workflow with approval steps which will provide automation for numerous tasks including; New Starters, Leavers and Movers. Access Requests and general tasks. 2.1b The ISM implementation also contains an FAQ and Staff Help portal which will continue to be developed and expanded as part of the product use.	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.	3.1a Automated for call category, call type and priority fields has been implemented as standard. Exceptions can be made, although require additional approval within the Service Desk management structure. 3.1b Free Text fields for call category, call type and priority fields have been removed. 3.1c Call category, call type and priority fields are all mandatory when creating incidents and service requests.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	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	n/a	Network & Information Systems (NIS) Directive	R2/4	High	Management should ensure that the CAF is reviewed and accurately completed to include assessed status and justifications for each IGP and objective.	This was an oversight on one of the questions that has now been amended.	Director of Digital & Health Intelligence	Head of Information Governance and Cyber Security	C	Reported as complete within Management response.
2021-22	31/01/2023	Nurse Bank (Temporary Staffing Department)	R2/8	High	The Assistant Director of Workforce Resourcing is to review the current structure of the Temporary Staffing Department, giving consideration to the resilience issues highlighted in this review, to ensure the Nurse Bank is operating effectively.	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.	Executive Director of People and Culture	Sandra Coles, Senior Nurse, Temproary Staffing & Stratgic Nursing Workforce	PC	Revised structure agreed to include changing the Professional Lead role to also become the deputy role. This is cost neutral and will be implemented when the current post holder retires in January 2023. Changes to other parts of the structure are also being proposed and will be implemented by the end of 2022.
2021-22	31/03/2023	Nurse Bank (Temporary Staffing Department)	R7/8	High	The Temporary Staffing Department is to maximise all available agency options via framework agreements, to ensure a greater fill rate, to support the safer operation of wards.	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.	Executive Director of People and Culture	Sandra Coles, Senior Nurse, Temproary Staffing & Stratgic Nursing Workforce	NA	This action is part of the TSD's action plan and will be implemented by the end of March 23 due to other actions needing priority.
2021-22	30/09/2022	ChemoCare IT System	R2/8	High	2.1 Windows servers should be upgraded to versions for which support is available; 2.2 SQL Server 2008 R2 should also be replaced with new versions for which support is available; 2.3 Database authentication should be moved to Windows authentication; 2.4 User passwords should be encrypted within the database; 2.5 The core user account should have the dba role removed and a more appropriate user access role defined; and 2.6 Database management tasks should be defined and regularly undertaken, this should include review and clear out of the error table.	2.1 As part of the chemocare upgrade to version 6 Windows servers OSrs have been replaced with a version which is supported i.e Windows 2016 2.2 As part of the Chemocare upgrade to version 6, SQL Server 2008R2 has been replaced with a version which is supported. i.e. SQL Server 2019. 2.3 Discussion with the supplier and service will take place post upgrade to understand if this is doable. 2.4 Not required if using Windows Authentication (as suggested in 2.3). 2.5 Discussion required with the service and supplier. 2.6 Discussion required with the service and supplier.	Director of Digital & Health Intelligence	Gareth Richards (Server Manager) Gareth Richards (Server Manager) Kerry Crompton, David Trigg / CIS Kerry Crompton, David Trigg / CIS Kerry Crompton, David Trigg / CIS	NA	
2022-23	31.10.2022	Stock Management - Neuromodulation Services (Specialist CB)	R5/5	High	To address the missing stock the Directorate need to undertake the following: - Note the outcome of the July 2022 stock count; - If the variance remains, to investigate and attempt to locate the missing stock; - Depending on the outcome, implement suitable controls to ensure that this issue does not re-occur; and - Engage with central finance over the value of the missing stock. * *The implementation of the previous recommendations made within this report will strengthen the control environment.*	Following the July stock take there is still missing stock. Attempts are ongoing to find the missing stock with stores, theatres, directorate and the product supplier. The final variance with the potential missing stock will take two to three months to work through the system, due to timely receipting/delivery of products. Finance colleagues are sighted on volume of missing stock. The directorate and finance colleagues have a monthly finance meeting scheduled to review the neuromodulation stock variance in detail in order to finalise the position. The SOP sets out the processes and systems in place to track all stock from ordering to implantation/return to supplier.	Managing Director for Non-Acute Services	Directorate Manager - Neurosciences	NA	

Report Title:	Audit Wales Recommendation Tracking Report				Agenda Item no.	7.6	
Meeting:	Audit and Assurance Committee	Public	x		Meeting Date:	08.11.2022	
		Private					
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

Main Report
Background and current situation:

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

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

The Tracker shared at the September 2022 Committee Meeting set out the progress made against 24 Audit Wales recommendations brought forward from the Audit and Assurance Committee in July which were all recorded as partially complete.

At the September Committee Meeting it was agreed that procedure for Internal and External Tracking Report updates would be varied (See minute: AAC 5/7/22 018) so that the Tracker is now reported at alternating Committee meetings, as opposed to every meeting.

The rationale for this change was to provide those with responsibility for actioning audit recommendations with additional time to implement required changes, inform updates and close out recommendations. The additional time between meetings will also provide the Risk and Regulation team with the ability to meet with colleagues, internally and from Audit Wales, to provide support and guidance to ensure that recommendations are proactively managed. This support will enable the identification of superseded entries (as a result of subsequent Follow Up and/or external reviews) and the identification of other aged recommendations that can legitimately be regarded as complete.

Since the September Committee the Risk and Regulation team have met with Audit Wales (28/09/2022) to discuss outstanding recommendations and options to support their proactive management moving forward. Similar meetings have been scheduled following Committee meetings in January 2023 and beyond following the submission of updated Tracker entries.

It is hoped that the development of an enhanced dialogue with Audit Wales in this manner, alongside the existing dialogue with Internal Audit, will enable the Risk and Regulation team to identify areas where additional assurance is required in relation to outstanding recommendations within this arena and also within Internal Audit.

Following the September Committee Meeting a further 11 recommendations were added to the tracker and can be attributed to the following Audit Reports:

Audit Report	Number of Recommendations
Audit of Accounts' Addendum Report	8
Estates Follow Up Review	3

The Tracker now records 35 Audit Wales recommendations which are all partially complete. 14 of these recommendations are overdue and have been targeted for additional scrutiny in advance of the January 2022 Committee meeting.

A review of all outstanding recommendations will also be undertaken with executive and operational leads for each recommendation since in advance of the January 2022 Committee meeting

Recommendation:

The Committee are requested to:

(a) Note and receive assurance from the ongoing work which continues in relation to the completion of Audit Wales recommendations.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment:

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

Risk: Yes/No

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

Safety: Yes/No

N/A

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No

N/A

Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

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

Report Title:	Assurance Mapping Phase 2 Update			Agenda Item no.	7.7
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	08.11.2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

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

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

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

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

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

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

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

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

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

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

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

Following the September Audit and Assurance Committee work has been undertaken to action the above recommendations. In particular the following progress has been made:

1) A revised Three Lines of Defence Model has been prepared and shared with Internal Audit Colleagues for comment. That model incorporates elements of best practice highlighted within the Advisory Review so that it aligns with examples of external risk, governance and assurance models. Specifically, the updated model re-aligns functions within the Lines of Defence to ensure that the more accurately reflect recognised best practice.

   Once agreed with Internal Audit, the revised Model will be embedded within the Health Board's Risk Management Policies and Procedures and Assurance Strategy and shared with the Audit and Assurance Committee and Board for Approval.

2) A revised version of the Health Board's Template Assurance Map has also been prepared and shared with Internal Audit Colleagues for comment. The revised map has been designed so that it specifically maps Assurance Levels in relation to risks that are reported within the Corporate Risk Register. Once agreed with Internal Audit, the revised Assurance Map will be embedded within the Strategy and shared with the Audit and Assurance Committee Board for Approval.

   It is hoped that monitoring the level of Assurance that can be provided against those risks held within the Corporate Risk Register will enable more targeted action to be taken to proactively manage these risks and identify opportunities to control the same.

   Once this approach is fully embedded it is proposed that supplemental Assurance Maps will be populated and reviewed within specific corporate and clinical areas. These maps will identify what levels of assurance can be provided to the Board in areas where high scoring risks are frequently held for prolonged period of time and will enable more targeted reviews and support to be undertaken/provided by Internal Audit and other colleagues.

3) The below action plan has been prepared and shared with Internal Audit

Action:	To be actioned by:	Completion Date:
To agree revised Three Lines of Defence Model and Assurance Map with Internal Audit.	Head of Risk and Regulation and Internal Audit	November 2022
To fully populate an updated Assurance Map in relation to those risks included within the Corporate Risk Register at the November 2022	Head of Risk and Regulation	December 2022

To share an updated Assurance Strategy and Risk Management and Board Assurance Framework Strategy with the Audit and Assurance Committee and Board for approval. To share a copy of the fully populated Corporate Risk Register Assurance Map with the Audit and Assurance Committee and Board for approval and/or comments.	Director of Corporate Governance Head of Risk and Regulation	January/ February 2023
Commencement of Phase 2 of Advisory Audit Work	Internal Audit	February 2023

Recommendation:

The Committee is requested to:

- **NOTE** the progress made against the Advisory Recommendations made by Internal Audit;
- **APPROVE** the proposed action plan detailed at point 3 above;
- **AGREE** that a further Assurance Strategy update, to include an updated Assurance Strategy and Risk Management and Board Assurance Framework Strategy for approval, be shared at the February 2023 Audit and Assurance Committee Meeting.

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

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

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

Prevention		Long term		Integration	x	Collaboration	x	Involvement	x

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

Risk: Yes

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

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

Report Title:	Regulatory Compliance Tracking Report			Agenda Item no.	7.8
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	08.11.2022
		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.

This report also 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.

At the September Committee Meeting it was agreed that procedure for Internal and External Tracking Report updates would be varied (See minute: AAC 5/7/22 018) so that the Tracker is now reported at alternating Committee meetings, as opposed to every meeting.

The rationale for this change was to provide those with responsibility for actioning audit recommendations with additional time to implement required changes, inform updates and close out recommendations. The additional time between meetings will also provide the Risk and Regulation team with the ability to meet with colleagues, internally and from Internal Audit, to provide support and guidance to ensure that recommendations are proactively managed. This support will enable the identification of superseded entries (as a result of subsequent Follow Up and/or external reviews) and the identification of other aged recommendations that can legitimately be regarded as complete.

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

Whilst an updated version of the Tracker is not shared on this occasion (as agreed at the September Committee meeting) the following update is provided to advise the Committee of the regulatory reports and associated recommendations that have taken place since September:

External Regulator	Report Area	Number of Recommendations	Responsible Executive Officer
Health Inspectorate Wales	Emergency Unit and Assessment Unit – UHW	16	Executive Nurse Director
Health Inspectorate Wales	Diagnostic Imaging at University Hospital of Wales – Improvement plan update	9	Executive Nurse Director

Health Inspectorate Wales	Cardiothoracic Surgery Ward, Ward 6, University Hospital Llandough	21	Executive Nurse Director
Community Health Council	Island Ward, Childrens Hospital for Wales	4	Executive Nurse Director
Community Health Council	Lakeside Unit, UHW	3	Executive Nurse Director
Community Health Council	Ward East 4, UHL	7	Executive Nurse Director
Community Health Council	Midwife Led Unit, UHW	5	Executive Nurse Director

A full update in relation to these entries and those previously shared with the Committee will be provided at the January 2023 Committee meeting.

It should also be noted that Health Inspectorate Wales have recently undertaken an inspection at the Nuclear Medicine Department at UHL to monitor compliance with the Ionising Radiation (Medical Exposure) Regulations and measurement against the Health and Care Standards. Whilst a final report is awaited, initial feedback has been positive. It is anticipated that a final report and any recommendations will be issued prior to year end.

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 and Quality teams respectively.

Since the September 2022 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

- WHC/2022/003 - Adult continence products
- WHC/2022/004 - Paediatric continence containment products
- WHC2022/011 - Patient Testing Framework – Updated guidance
- WHC/2022/026 – Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning
- WHC/2022/027 - Polio Catchup 2022

As of the 27.10.2022 the Health Board's WHC tracker was fully up to date and each WHC detailed on the Welsh Government website had been allocated to an Executive Lead to monitor and action.

Patient Safety Solutions: Alerts and Notices

PSN's are monitored and managed by the Patient Safety and Quality (PSQ) Team who maintains a tracker of all PSN's that are received and ensure that each PSN is shared with relevant clinical and corporate directorates for action. The PSQ Team also regularly chase 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 PSQ Team notify the relevant Welsh Government delivery Unit and copies of all such notifications and completed compliance forms are logged by the PSQ Team 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			

Compliance with Patient Safety Solutions: Alerts and Notices can also be tracked at the following NHS Wales Delivery Unit website: https://du.nhs.wales/patient-safety-wales/patient-safety-solutions-compliance/ (this link will need to be copied and pasted into your internet browser for access).

As of the 10.10.2022 the Health Board is reported to be compliant with all 63 Patient Safety Notices which date back to the 31.07.2014.

The Health Board is currently Non-Compliant with the following two Patient Safety Alerts:

PSA Number:	Title of Safety Solution:	Compliance Date:	PSQ Team update:
PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm	30.11.2017	An All Wales Training Solution is awaited to enable compliance with this alert across Wales.
PSA012	Deterioration due to rapid offload of pleural effusion fluid from chest drains	01.07.2021	A Pleural Effusion pathway has been developed and approved by the Medicine Clinical Board Quality and Safety Group. This will be adopted more widely across the Health Board in the coming months to demonstrate compliance with this Alert.

Assurance can be taken from the ongoing monitoring and management of External Regulatory Reports and Recommendations. A further update will be shared with the Committee in January 2023, by which point it is hoped significant progress will be noted against aged and incomplete recommendations.

Recommendation:

The Committee are requested to:

(a) To note the updates shared and the continuing development and review 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:

Report Title:	Procurement Compliance Report				Agenda Item no.	7.9	
Meeting:	Audit Committee		Public	X	Meeting Date:	8 November 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 (5)

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
IT Equipment refurbishment	£6,645.00	N/A	One off	Executives – D&HI	No Procurement involvement in engaging requirement	Ongoing
Agency Staff	£18,674.34	N/A	12 months	Executives – D&HI	No Procurement involvement in engaging agency staff	Resolved – Agency no longer in post
Agency Staff	£6,261.75	N/A	3 months	Capital Planning, Estates and Facilities	No Procurement involvement in engaging agency staff	Resolved – Contract now in place
Cubric Scan Charges	£6,600.00	N/A	2 weeks	Specialist	No Procurement involvement in engaging with University for services	Ongoing – SLA being put in place
Provision of Ophthalmology Services	£16,560.00	N/A	2 months	Surgery	Service engaged Consultant without STA being submitted and approved	Ongoing – Procurement awaiting STA from Surgery to progress with approval for future provision

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

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

Other Non-Compliant Activity (Nil Return)

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

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

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

Report of Single Tender/Quotations Actions

Retrospective – (1)

The report outlines all SQA/STA (1) requests during the period the 1st August 2022 to 30th September 2022.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
Specialist	Stemsoft	Maintenance of Bone Marrow Transplantation Database	£1,759.75	Sole Supplier of Goods or Services

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

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (16) requests during the period the 1st August 2022 to 30th September 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	Proposed Supplier	Name of Project	Total Value of Contract Excl VAT	Type
C,D&T	Source LDPath	Outsourcing of Cell Path Microtomy Samples	£49,260.00	Sole Supplier of Goods or Services
Specialist	University of Plymouth	ACCP Training Course	£16,080.00	Sole Supplier of Goods or Services
Executives	Hilton Heathrow (Terminal 4)	WEQAS Conference 2022	£27,870.80	Sole Supplier of Goods or Services
Surgery	Mercian Surgical Supply Co Ltd	Maintenance of Drills for SSSU, Main Theatres & CHFW	£47,385.00	Capability with existing equipment or service
Surgery	Trisoft Healthcare	TheatreMan Service and Maintenance	£42,665.38	Sole Supplier of Goods or Services

Specialist	University of Southampton	Tuition Fee	£8,250.00	Sole Supplier of Goods or Services
C,D&T	Mason Science	HPLC Service Contract	£37,125.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Knox and Wells	Lease of car park for Woodlands House	£75,200.00	Sole Supplier of Goods or Services
Surgery	HealthEdge	Sterile Services Traceability System Service Contract	£82,339.44	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Multitone	Maintenance of Internal Pager Bleeper System 2178	£78,648.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Cardiff Council	Gritting Provision for UHW	£8,290.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	The Vale of Glamorgan Council	Gritting Provision for UHL	£6,227.50	Sole Supplier of Goods or Services
Public Health Local Team	Synbiotix	Audit Tool for Welsh Health Hack	£20,000.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Protec Fire Detection Plc	Maintenance and Remedial Costs of Fire Alarms - UHW	£419,706.50	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	The Vale of Glamorgan Council	HSS Hire Services Group Ltd	£29,779.20	Capability with existing equipment or service
C,D&T	Vision	Image Cube Mobile Service Contract	£10,200.00	Sole Supplier of Goods or Services

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	1	1
Clinical, Diagnostics and Therapies	6	0	1	1	0	0
Executives	14	8	3	1	4	0
Medicine	3	0	0	1	0	0
Mental Health	0	0	0	2	0	0
PCIC	1	0	0	0	0	0
Specialist	6	0	0	0	1	0
Surgery and Dental	4	0	1	2	1	0
TOTALS	**44**	**17**	**6**	**10**	**7**	**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	8	0
Clinical, Diagnostics and Therapies	28	4	14	1	9	2
Executives	20	4	9	3	13	0
Medicine	6	3	6	1	3	0
Mental Health	3	0	1	0	0	0
PCIC	8	2	2	0	5	2
Public Health Commissioning Team	0	0	1	0	1	0
Specialist Services	7	1	6	2	7	1
Surgery Services and Dental	9	3	5	1	5	0
Grand Total	**87**	**18**	**52**	**11**	**56**	**8**

Recommendation:

The Committee are requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.
Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:
As outlined in the above section
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
03/11/2022 16:33:19

Report Title:	Counter Fraud Progress Report			Agenda Item no.	7.10
Meeting:	Audit and Assurance Committee	Public	X	Meeting Date:	08/11/2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	X
Lead Executive:	Catherine Phillips - Executive Director of Finance				
Report Author (Title):	Gareth Lavington – Head of Counter Fraud				

Main Report
Background and current situation:

This report builds on the interim Counter Fraud progress report verbally presented at Audit Committee on 6th September 2022. This report provides an update of all the work undertaken by the CF team at CAVUHB on behalf of CAVUHB between the dates 12/08/2022 – 19/10/2022 (submission date of papers)

The report 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.
Other activity

Recommendation:

The Committee is requested to:

a) **Note** the content of the report.

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Financial loss impacting upon patient care. Risk of reputational impact as a secondary result.
Safety: No
Financial: Yes
Possible financial loss as a result of fraud which will lead to impact upon patient care
Workforce: Yes
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes
Use Statutory legislation to conduct investigations
Reputational: Yes
Negative publicity resulting in negative publicity that undermines public confidence
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
03/11/2022 16:33:19

NHS WALES
Cardiff and Vale University Health Board

Counter Fraud Progress Report
12/08/2022-19/10/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Cardiff and Vale Health Board from the 12th August 2022 to 19th October 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 22th October 2022, 201 days of Counter Fraud work have been completed against the agreed 500 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness, investigating referrals in relation to fraud and financial crime, and the recruitment of a new team member.

This report builds upon previous progress reports delivered to Audit Committee during the financial year 2022-2023.

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

TYPE	Days P1	Days P2	Days P3	Days P4	Days P5	Days P6
Proactive	15	14	35			
Reactive	70	42	25			
TOTAL	85	56	60			

2. Progress

Staffing

There continues to be a temporary reduction in staffing resource during the third quarter of this financial year. Recruitment of a new team member is underway. The advert for the Band 6 Local Counter Fraud Specialist vacancy went live on 25th September 2022 and closed on 17th October 2022. A total of fifteen (15) applications were submitted, of which six (6) candidates have been shortlisted for interview. The interview date is scheduled for 10th November 2022. It is anticipated therefore, that the team will be at full capacity by the beginning of Quarter 4 (1st January 2023).

Activity

Infrastructure/Annual Plan

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

a. The maintenance of a comprehensive activity database which is already assisting in maintaining a detailed and accurate record of work undertaken.
b. Review of the Counter Fraud Bribery and Corruption Policy – the CAVUHB Counter Fraud Bribery and Corruption Policy is in date but requires review and updating by December 2022. This review is now underway and it is anticipated that an amended policy will be finalised by the end of Quarter 3.
c. Counter Fraud digital presence – Fully functional, modern, Counter Fraud Intranet site continues (Link to the site for reference : Counter Fraud - Home (sharepoint.com)) https://nhswales365.sharepoint.com/sites/CAV_Counter%20Fraud%20&%20Internal%20Audit

d. Counter Fraud e-Learning arrangements – the situation with regard to this remains the same as previously reported. Development of Counter Fraud education page on the All Wales 'Learning @ Wales Platform' is now built, but awaits the new All Wales eLearning package to be finalised and distributed by the Counter Fraud Service Wales. When complete this will be available to all Cardiff and Vale University Health Board staff as a, Counter Fraud, education, learning and awareness tool. It will be signposted internally within the organisation in order that staff can access at the click of a button.

Fraud Prevention Notices and IBURN notices

(These notices are issued nationally by the NHS Counter Fraud Authority and require action by Local Counter Fraud Teams)

During this reporting period there have been no fraud prevention notices or intelligence bulletins issued by the NHS Counter Fraud Authority.

Local Alerts/Bulletins

During this reporting period there has been no requirement to issue any local alerts or bulletins.

Awareness Sessions

During this reporting period two department specific fraud awareness sessions have been delivered; one to CAVUHB Capital Estates and Facilities team; one to the community Dental teams.

Newsletters

During the reporting period no newsletters have been produced. This decision was made on the basis of reserving the newsletter for International Fraud Awareness week in November.

Referrals/Enquiries

During this reporting period the Counter Fraud team have received ten (10) referrals via the online reporting tool. Four (4) of these referrals have been informally resolved with six (6) having been promoted to formal investigation.

The four (4) informally resolved enquiries not promoted to formal investigation were as follows:

1. Locum Dr suspected of fraud due to high volume of shifts for two HB's. Investigation carried out with Swansea Bay UHB. All shifts found to be legitimate. **No offences disclosed. No further action required.**
2. Concerns over letters being received by staff from Accounts Payable department believed to be a scam. Investigation showed that it was a genuine letter but the 'assistance' phone line promoted not being staffed caused concern and confusion. New system implemented – **No fraud issues identified.**
3. Scam email – **Advice provided reported to Cyber security team and Action Fraud.**
4. GP reporting patient obtaining Gabapentin and selling it – **advice given re the continuation of prescribing the drug. Police informed and investigating.**

Investigations

A summary of investigations carried out by the team since the beginning of this financial year is provided at **Appendix 1**. The cases highlighted in red relate to new investigations commenced within this reporting period.

As can be seen from the table during this reporting period:

Six (6) new investigations have been started; and four (4) have been closed.

There are therefore, seven (7) investigations open at the time of reporting.

Other

A meeting was held with members of the NHS Counter Fraud Authority compliance team on 13th October 2022. This meeting was held to discuss the organisations compliance with the Cabinet Office requirement concerning Fraud Risk management. Various issues were raised and as a result a clear strategy has now been adopted by the Cardiff and Vale UHB Counter Fraud Team. This has led to the development of an internal fraud risk assessment form that will be used from this point on when reporting fraud risk. (See Appendix 2) It is understood that all NHS organisations in Wales will be adopting the use of the Datix Risk Module for recording risk at some point in 2023. When this goes live fraud risks will also be recorded in this way. Until that time, and in line with the organisational Risk Management Policy all fraud risks will now be forwarded for recording and management on local risk registers and they will be owned by the relevant department.

Appendix 1

	Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
1	First - WARO/20/00050	Prescription Fraud	Carried Over - 28/05/2020	08/06/2022	Criminal Conviction obtained at Cardiff Crown Court. Defendant found guilty of Fraud by false representation and Fraud by Abuse of position. Suspended sentence. No compensation awarded. Financial loss to the organisation of £1734.37- non-recoverable.
2	INV/21/00124	Overpayment of Salary and Working hours	Carried Over - 09/07/2021		
3	INV/21/00262	Overpayment of Salary	Carried Over - 30/09/2021	24/05/2022	No fraud identified, employee had not spent the money and a voluntary agreement made to repay the money. Money repaid - £5,371.52
4	INV/21/00386	Prescription Fraud/ Living Abroad	Carried Over - 30/11/2021	20/05/2022	False report good intent. After investigation, subject found to be receiving private treatment in Singapore. No issues identified.
5	INV/22/00037	Overpayment of Salary	Carried Over - 11/01/2022	02/08/2022	No fraud identifies, voluntary agreement made to repay money. Money to be repaid - £6,223.17
6	INV/22/00038	Overpayment of Salary	Carried Over - 11/01/2022	24/05/2022	Closed as finance had previously referred to debt collection.
7	INV/22/00416	Overpayment of Salary	Carried Over - 24/03/2022	19/04/2022	No offences identified. Employee had been in contact with health board and in process of repaying the overpaid funds.
8	INV/22/00417	Overpayment of Salary	Carried Over - 24/03/2022	24/05/2022	No fraud identified, voluntary agreement to repay the money. Money repaid - £798.17
9	INV/22/00418	Overpayment of Salary	Carried Over - 24/03/2022	19/04/2022	No offences identified. Employee had been in contact with health board and in process of repaying the overpaid funds.
10	INV/22/00489	Working whilst Sick	04/04/2022	18/08/2022	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
11	INV/22/00555	Working whilst on sick leave	28/04/2022		
12	INV/22/00556	Overpayment of Salary	28/04/2022	23/09/2022	Employee resigned prior to disciplinary process. Issues over termination form made criminal proceedings not possible.
13	INV/22/00590	Prescription Fraud	13/05/2022	24/05/2022	Investigation identified no concerns regarding current or historic prescription issues.
14	INV/22/00599	Overpayment of Salary	30/05/2022	05/07/2022	Transferred to CSF Wales
15	INV/22/00710	False Sickness	21/06/2022	21/06/2022	No offences identified. Employee had doctors sick note stating "not fit for work" the allegation made was that they were collecting children from school.
16	INV/22/00730	False On- Call Claims	24/06/2022		

	Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
17	INV/22/01087	Overpayment of Salary	15/08/2022		
18	INV/22/01231	False address for prescriptions	06/09/2022	16/09/2022	No offence identified, initial report stated subject had not lived in locality for a number of years, investigation showed they moved from the area in June 2022
19	INV/22/01255	Working on Sick Leave	09/09/2022	14/10/2022	After investigation no evidence of working elsewhere, potentially malicious report.
20	INV/22/01270	Timesheet fraud	12/09/2022		
21	INV/22/01460	Working elsewhere on Sick Leave	11/10/2022		
22	INV/22/01521	False Overtime Claims	20/10/2022		

Appendix 2

FRAUD RISK ASSESSMENT FORM

Risk Owning Department:		**Location of Risk:**	
Risk Owning Directorate:		**Date Form Completed:**	

Risk Title

Description of Risk:
Describe identified fraud risk using the Actor, Action, Outcome format as below. ***Actor****: Who commits the fraud (may be a single individual or one or more individuals);* ***Action****: What the fraudulent action is;* ***Outcome:*** *What is the resulting impact or consequence(s). This will be mainly financial, but consider whether other aspects are relevant such as: reputational; loss in service; social; physical harm; environmental; national security.* ***E.G.*** *Individuals (the Actor) may apply for a post at a health body using forged or false qualification certificates (the Action). The actor is successful in their application and following an interview is offered the post. The actor commences work at the health body.*

Assessment of control measures in place:
Step 1*: identify control-measures that have a role to play in mitigating the risk in question.* ***Step 2:*** *Consider the nature of each control-measure - is it Directive (e.g. Guidance); Deterrent (designed to put people off of fraud); Preventative (designed to stop fraudulent claims being processed); Detective (detecting fraud/error after payment); Corrective (actions to make post-payment corrections).* ***Step 3****: Describe what each control-measure actually does to mitigate the risk and how it operates - not just the name of the control. Also describe what the identified control-measure doesn't do in relation to mitigating the risk.*
Risk score <u>with</u> current control measures in place and no action or remedy (Use Risk Scores Rationale template at bottom of form)
Likelihood ( ) x Consequence ( ) =

Gaps in Assurance/Control:

Recommendations to risk rating:

Is there a requirement to escalate:
Put here any supporting information to justify whether the risk can be managed locally or whether it needs to be escalated

Considering all of the information you have on the controls and assurances how would you rate the risk if all the actions are completed (Target Risk Score):							
Consequence		**X**	**Likelihood**		**=**	**Target Risk Score**	

Proposed Actions to be undertaken by Counter Fraud Team *(Counter Fraud Department to complete)*
Include here any proposed actions that are to be carried out by Counter Fraud Team. E.g. Arrange and conduct awareness sessions to staff, provide support materials to relevant cohorts of staff

Signature of Assessor	
Date of Assessment	
Risk Owner	
Signature of Head of Counter Fraud	
Date of Submission	

Proposed Actions to be undertaken within the Risk Domain *(Risk owner to complete)*
Please provide details of proposed actions (including timescale) to be introduced to reduce the risk. If no actions are to be taken then provide justification for this decision.
Has this Risk been added to the Local Risk Register:
Please state whether the risk outlined in this report has been added to the local risk register as is required by the organisational Risk Management Policy, and on what date. If this risk has not been added to the register then please provide justification for this decision.

Risk Owner Signature:	Date:

Risk Scoring Rationale

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

	1-3	Low risk
	4-6	Moderate risk
	8-12	High risk
	15-25	Extreme risk

Guide to completion and process

1. *Risk Assessor to complete template and forward to Head of Counter Fraud.*
2. *Head of Counter fraud to review and return to assessor signed off or with remedial action required.*
3. *When complete, Risk Assessor to forward to relevant stakeholders including Risk Owner.*
4. *Risk Owner and/or delegated representative to review report, record risk on local risk register, and outline any actions to be undertaken to address any weaknesses/risk identified.*
5. *Risk owner to return completed form, and copy of entry on local risk register to Head of Counter Fraud (Gareth.lavington2@wales.nhs.uk)*

Report Title:	Decarbonisation – Audit Wales 5 Calls For Action			Agenda Item no.	7.11
Meeting:	Audit Committee	Public	X	Meeting Date:	08/11/2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Abigail Harris, Executive Director of Strategic Planning				
Report Author (Title):	Calum Shaw, Environmental Sustainability Project/Planning Manager				

Main Report
Background and current situation:

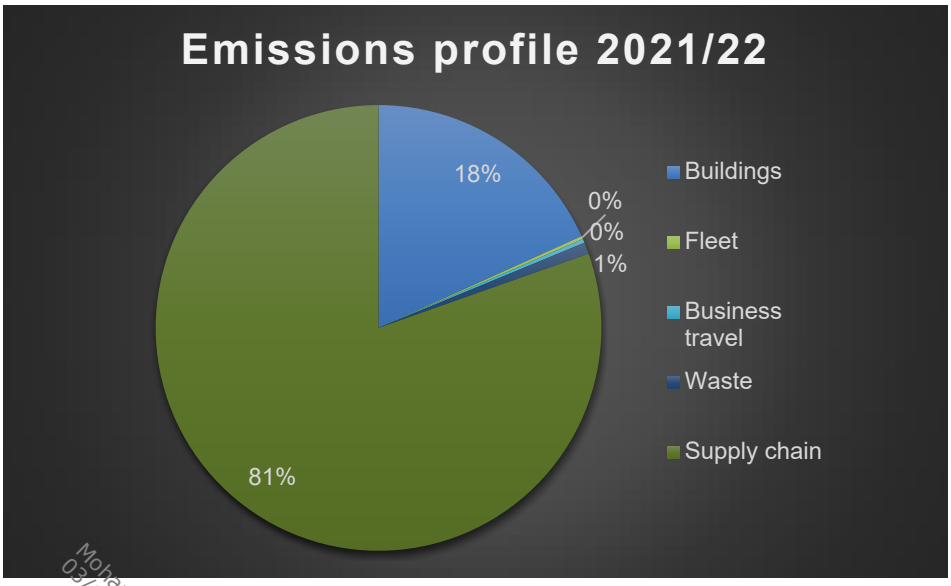
According to the WHO in October 2021, "Climate change is the biggest single threat facing humanity". In 2022, there have been extreme weather events in the UK and globally, there have been almost 50 flood warnings and alerts in large parts of Wales due to storm Franklin. More than a third of Pakistan under water due to heavy rain, official declarations of drought throughout the UK this summer and wildfires blazing in the Arctic. In January 2020, our Board made a commitment to respond urgently and declared a climate emergency.

In July 2022, Audit Wales published the Public Sector Readiness for Net Zero Carbon by 2030.https://www.audit.wales/publication/public-sector-readiness-net-zero-carbon-2030. This report called for an increase in pace of activity amid clear uncertainty about whether it is possible to achieve an ambition for net zero emissions by 2030 for the Welsh Public Sector. NHS Wales has a target for a 16% and 34% reduction in emissions against a 2018/19 baseline by 2025 and 2030 respectively.

Audit Wales say that all organisations are to "ramp up" activities, increase collaboration and put decarbonisation at the heart of day-to-day activities. They have set out 5 calls to action:

1. Strengthen your leadership and demonstrate your collective responsibility through effective collaboration;
2. Clarify your strategic direction and increase your pace of implementation;
3. Get to grips with the finances you need;
4. Know your skills gaps and increase your capacity; and
5. Improve data quality and monitoring to support your decision making.

Cardiff and Vale University Health Board's (CVUHB) emissions in 2021/22 were 202,149 tonnes CO2e. This is made up of the following proportions. Note that data quality requires refining and is not directly comparable with 2018/19 data.



Sector	Emissions (tonnes CO2e)
Buildings	36,871
Fleet	458
Business travel	589
Waste	1,690
Supply chain	162,541
Total	**202,149**

CVUHB's current sustainability action plan (the second action plan) runs until March 2023 and will be updated in the coming IMTP cycle. Some progress is highlighted in the body of this paper below and a long form report on progress against actions up to 31/8/22 attached. A lot has been achieved in the past year and awareness is embedded deeper into the organisation. However, when stepping back and putting into context the 2025 and 2030 targets of a 16% and 34% reduction in emissions, a number of red flag findings have been concluded:

- The current financial landscape doesn't allow the NHS to reach Net Zero.
- The NHS supply chain business model is largely based upon single use/disposal.
- The existing method for calculating supply chain emissions is flawed.
- Sustainability is not embedded throughout decision making (operational, clinical, corporate).
- COVID-19 recovery focusses on increasing the amount of clinical activity to address the backlog.
- Sustainable healthcare is not a mature discipline.
- Unless dedicated resource or time is provided to already stretched and overburdened staff, sustainability will continue to be seen as an add-on to existing work and priorities.

This report asks the Audit Committee to:

- **Note the action CVUHB have taken regarding decarbonisation set against the calls for action**
- **Note that a new decarbonisation action plan is in the early stages of development which will form part of the next IMTP**
- **Note that there is no line of sight to the 2025 or 20230 targets and that radical action is needed to embed sustainability as a core responsibility and ensure delivery of the action plan**

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

Taking each of Audit Wales actions in turn, a short summary of the progress made so far is highlighted along with early views of the sorts of actions that could be required to be included in the next plan.

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

- In October 2022, C&VUHB agreed a clear governance structure for the Decarbonisation programme.
- Each Executive Director has a decarbonisation objective for 22/23.
- Part time clinical and therapies leadership positions have been put in place with nursing expected to follow in November 2022.
- A full-time environmental sustainability project manager was recruited in May 2022.

However,

- As an immature field, it cannot be said that decarbonisation is being driven naturally within the organisation. Therefore, consideration for the next action plan could include each part of the organisation could be set carbon savings targets after a suitable baseline position has been measured. This would help generate more ownership.
- Further work could be done on decision making where all decisions could be made with decarbonisation in mind, notwithstanding patient need being primary.

2. Clarify your strategic direction and increase your pace of implementation;

- Our second action plan has seen activity in the Health Board increase as evidenced in the attached report.
- The Our Future Hospitals Programme Business Case identifies decarbonisation as a central theme, which the requirements for carbon zero to be build into the clinical model and infrastructure.

However, the direction of the organisation has not been focused on Decarbonisation up until this point.

- The IMTP and strategy refresh should identify climate adaption and mitigation to help embed action within the UHB.
- Although Health Boards each need to hit a 16% reduction in emissions by 2025, a target could be set organisation wide for 31/3/24.
- Investigating how the 'spread and scale' approach could be applied to carbon reduction.
- We need procurement to challenge all single-use procurement.

3. Get to grips with the finances you need;

- To date, CVUHB have been drawing down where any grant monies are available from Welsh Government. These include the Re:Fit programme which has been aiding Estates to make small incremental improvements to the energy efficiency our buildings. In the past year, electricity generated from renewable sources on site increased from zero to 297,920 kwh. We have also received funding to resource the clinical leadership team. This needs to be made recurrent.

However,

- A fully costed assessment to hit the 2025 and 2030 targets has not been completed. There has not been funding available to undertake this work in a viable way, where feasibility investments would need to be paid for from existing and over-committed budgets. WG's response to the Audit Wales report was that the investment required to achieve targets should come from existing expenditure. In **para 29**, it highlights that "Public bodies recognised that significant investment in decarbonisation will be required, particularly for upfront infrastructure costs. But they were uncertain about where the funding for this investment would come from. The Welsh Government is

providing funding to public bodies in various ways, but it has said it cannot fund everything. Public bodies will therefore need to think carefully about how they can use their existing funding in different ways, explore potential additional funding opportunities and consider how they might share costs with partner organisations."

- The largest proportion of emissions within CVUHB is from procurement. The cost of low(er) carbon products is generally more expensive, particularly for the initial investment (for reusable).

4. Know your skills gaps and increase your capacity

- CVUHB has relied on 'enthusiasts' to make progress on decarbonisation so far, who try to spread amongst their peers. This has served us well so far. To make further progress, part time leadership roles have been set up in clinical, therapies and nursing.
- CVUHB has funded a Sustainability and Decarbonisation Manager and a Comms Manager (who left in June 2022 and for whom a replacement has been recruited with an expected start of January 2023).

However,

- There is not clarity what sustainable healthcare is amongst our colleagues, despite much communications activity over the past year.
- The role of HEIW will need to be clarified and calls made to the Royal Colleges on their policies to help understand the approaches, behaviours and techniques that could be adopted in CVUHB. The time of people will need to be allocated to undertake this research.

5. Improve data quality and monitoring to improve decision making

On request CVUHB reported to WG on the emissions for f/y 21/22. These were calculated at 202,149 tonnes of CO2e. A baseline measure was taken for 2018/19 (against which the 2025 target of a 16% reduction was deduced) at 160,000 tonnes. This highlights a significant increase in emissions, however, the calculation methods used were different, which does not allow for a consistent comparison. Also the quality of the data that created this calculation was mixed. This has been raised with Welsh Government as there is a need for consistent data and calculation methods to be used by all Health Boards. Welsh Government recognise the issue and are investigating. Swansea Bay and Cwm Taf Morgannwg raised similar concerns. CVUHB have undertaken an exercise to calculate as best as possible its historic emissions using a single consistent method from the best information available (EFPMS). Excluding supply chain data, this shows a 1% decrease in emissions from 18/19 to 21/22.

- In the coming year, attempts could be made to understand the breakdown of emissions by our organisational structure to be able to set baselines and locally owned targets.
- Furthermore, studies could be undertaken to understand the impact that radical changes could have, such as district nurses being given electric cars as opposed to using their own, creating emissions and claiming business mileage. Although there may be tax and practical implications to implementing such initiatives, it is not known whether there could be benefit and plans put in place.

Recommendation:

In summary, CVUHB are on the right pathway for tackling decarbonisation but need to heed the advice of Audit Wales and significantly upscale the actions, investment and impact throughout the health board on all fronts. A new action plan will be created this autumn with the aim of attaining deeper ownership and action from within the health board.

The Audit Committee is requested to:

- **Note the action CVUHB have taken regarding decarbonisation set against the calls for action so far**
- **Note that a new decarbonisation action plan is in the early stages of development which will form part of the next IMTP**
- **Note that there is no line of sight to the 2025 target of a 16% reduction in carbon emissions and that radical action is needed**

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	x

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

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

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

Risk: ~~Yes~~/No

Safety: ~~Yes~~/No

Financial: Yes/~~No~~

There is a risk that the financial impact of meeting NHS Wales decarbonisation targets cannot be met through current methods of funding. The mitigation is to better understand the scale of the requirement in a prudent way as per the recommendation from Audit Wales mentioned in this paper.

Workforce: Yes/~~No~~

There is a risk that given the need to make progress against NHS Wales targets, our workforce doesn't understand how the need to decarbonise impacts their day to day work. There is also a risk that under the current operational pressures, colleagues will focus their attention on the day job and not take on board additional asks. The mitigation is to undertake further sensitive culture change activity and also understand how the representative bodies (such as Royal Colleges) are responding and rolling out initiatives.

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

There is a risk that as a public body, not showing leadership on decarbonisation will cause reputational damage amongst our colleagues, Welsh Government, public sector bodies and our population. The mitigation is to demonstrate results and share these successes through internal and external channels.

Socio Economic: ~~Yes~~/No

Equality and Health: Yes/~~No~~

There is a risk that not adapting to the impacts of a changing climate, the health of the most vulnerable in society could decrease. The mitigation is to consider widespread adoption of adaption strategies.

Decarbonisation: Yes/~~No~~

There is a risk that NHS Wales carbon saving targets of 16% by 2025 and 34% by 2030 are not met. The mitigation is to increase and accelerate participation and ownership of decarbonisation across the UHB through an updated Sustainability Action Plan.

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Report Title:	Report on the Draft Annual Accounts of the Cardiff and Vale University Health Board's Funds Held on Trust 2021/22			Agenda Item no.	7.12
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	8th November 2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Assistant Director of Finance				

Main Report
Background and current situation:

Cardiff and Vale Health Charity ("the Health Charity") is the official charity and working/trading name of Cardiff and Vale University Health Board General Purposes Charitable Fund, Charity Registration Number 1056544.

Cardiff and Vale University Health Board holds Charitable Funds as sole corporate trustee and the board members of the Health Board are jointly responsible for the management of those charitable funds. The management of Charitable Funds is a delegated responsibility from the Board of Trustee to the Charitable Funds Committee.

The Finance Department of Cardiff and Vale University Health Board provides financial administration for the Health Charity. The day to day administration of funds and operational management of the Health Charity is undertaken by a team of staff based at Woodland House. The Draft Annual Accounts are provided to the Charitable Funds and Audit and Assurance Committees for endorsement on an annual basis.

The draft accounts cover the activities of the Health Charity for the period 1st April 2021 - 31st March 2022. As the Draft Annual Accounts are still being audited by Audit Wales, they are therefore, still subject to change.

The Final Audited Accounts, ISA260 report and Letter of Representation will be taken to the Board of Trustee at its January 2023 meeting for formal approval.

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

The Audit and Assurance Committee is asked to receive and consider for endorsement the Health Charity Draft Accounts 2021/22 and the draft response provided to the audit enquiries to those charged with governance and management.

These documents are included as follows:

- Cardiff and Vale Health Charity Draft Annual Accounts;
- The response given to the audit enquiries to those charged with governance and management;

Assurance can be provided on the accuracy of the Draft Annual Accounts and associated documents by:

- The response given to the audit enquiries to those charged with governance and management which have been endorsed by the Chair, Interim Chief Executive, Chair of the Charitable Funds Committee, Chair of the Audit and Assurance Committee, Director of Governance and Director of Finance

- On completion of the audit of the financial statements, further assurance will be given on the annual accounts by the work that will be completed by Audit Wales in determining whether the Health Charity's Annual Report and Accounts give a true and fair view.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The Draft Annual Accounts of the Charity has been prepared in accordance with recommended practice. These will be subject for external review by Audit Wales. Should any misstatements or errors be identified during the course of the audit these will be noted in the ISA 260 audit report.

The key points to note are:

- Donations and legacies decreased by £0.5m in 2021/22 to £1.3m. The Health Charity received higher donations in 2020/21 as a result of a number of generous donations during the pandemic.
- The Health Charity investments saw growth of £0.5m in 2021/22 reflecting the continuation of post Covid gains.
- The value of the Health Charity reduced slightly by £0.1m in 2021/22 to £9.0m.

- **Recommendation:**

The Audit and Assurance Committee is asked to:-

- REVIEW Draft Annual Accounts;
- NOTE the reported financial performance contained within the Draft Annual Accounts;
- NOTE the response of the audit enquiries to management and those charged with governance;
- Subject to any further amendments SUPPORT and ENDORSE the Draft Annual Accounts.

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

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

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

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

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

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CARDIFF & VALE HEALTH CHARITY ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2022

Foreword

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

Statutory Background

The Cardiff & Vale University Local Health Board is the corporate trustee of the charity under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

Main Purpose of the Funds Held on Trust

The main purpose of the charity is to apply income for any charitable purposes relating to the National Health Service wholly or mainly for the services provided by the Cardiff & Vale University Local Health Board.

Cardiff and Vale University Local Health Board Charities Accounts 2021/22

Statement of Financial Activities for the year ended 31st March 2022

	Note	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2021-22 £000
Incoming resources from generated funds:					
Donations and Legacies	3	1,172	128	0	**1,300**
Other trading activities	4	0	286	0	**286**
Investments Income	5	123	50	1	**174**
Total incoming resources		**1,295**	**464**	**1**	**1,760**
Expenditure on :					
Raising funds	6	371	85	0	**456**
Charitable activities	7	1,655	301	25	**1,981**
Total expenditure		**2,026**	**386**	**25**	**2,437**
Net gains / (losses) on investments	13	448	0	3	451
Net income / (expenditure)		-283	78	-21	-226
		5	-5		
Transfer between funds				0	0
Net movement in funds		-278	73	-21	-226
Gains / (losses) on revaluation of fixed assets	12	0	0	67	67
Reconciliation of Funds		-278	73	46	-159
Total Funds brought forward as at 1 April 2021	19	4,958	1,711	2,478	9,147
Total Funds carried forward as at 31 March 2022		**4,680**	**1,784**	**2,524**	**8,988**

The notes on page * to * form part of these accounts

Cardiff and Vale University Local Health Board Charities Accounts 2020/21

Statement of Financial Activities for the year ended 31st March 2021

	Note	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2020-21 £000
Incoming resources from generated funds:					
Donations and Legacies	3	1,708	76	1	**1,785**
Other trading activities	4	1	266	0	**267**
Investments Income	5	103	43	1	**147**
Total incoming resources		**1,812**	**385**	**2**	**2,199**
Expenditure on :					
Raising funds	6	292	83	0	**375**
Charitable activities	7	1,512	475	22	**2,009**
Total expenditure		**1,804**	**558**	**22**	**2,384**
Net gains / (losses) on investments	13	864	0	5	869
Net income / (expenditure)		872	-173	-15	684
Transfer between funds		-17	17	0	0
Net movement in funds		855	-156	-15	684
Gains / (losses) on revaluation of fixed assets	12	0	0	-19	-19
Reconciliation of Funds		855	-156	-34	665
Total Funds brought forward as at 1 April 2020	19	4,103	1,867	2,512	8,482
Total Funds carried forward as at 31 March 2021		**4,958**	**1,711**	**2,478**	**9,147**

The notes on page * to * form part of these accounts

Cardiff and Vale University Local Health Board Charities Accounts 2021/22

Balance Sheet as at 31 March 2022

	Note	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 31 March 2022 £000	Total 31 March 2021 £000
Fixed assets:						
Tangible Assets	12	0	0	2,479	**2,479**	2,436
Investments	13	4,820	1,705	44	**6,569**	6,368
Total fixed assets		**4,820**	**1,705**	**2,523**	**9,048**	**8,804**
Current assets:						
Debtors	14	103	42	0	145	130
Cash and cash equivalents	15	149	57	1	**207**	514
Total current assets		**252**	**99**	**1**	**352**	**644**
Liabilities:						
Creditors: Amounts falling due within one year	16	392	20	0	**412**	301
Net current assets / (liabilities)		**-140**	**79**	**1**	**-60**	**343**
Total net assets/ (liabilities)		**4,680**	**1,784**	**2,524**	**8,988**	**9,147**
The funds of the charity:						
Endowment Funds	19	0	0	45	45	42
Revaluation Reserve	19	0	0	2,479	2,479	2,436
Restricted income funds	19	0	1,784	0	1,784	1,711
Unrestricted income funds	19	4,680	0	0	4,680	4,958
Total funds		**4,680**	**1,784**	**2,524**	**8,988**	**9,147**

Director of Finance

Mrs Catherine Phillips

Date……

Statement of Cash Flows for the year ending 31 March 2022

	Note	Total Funds 2021-22 £000	Total Funds 2020-21 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	17	-731	-847
Cash flows from investing activities:			
Dividend, interest and rents from investments	5	174	147
Movement in Investment Cash	13	-11	68
Proceeds from the sale of investments		1,923	1,062
Purchase of investments	13	-1,662	-1,130
Net cash provided by (used in) investing activities		**424**	**146**
Change in cash and cash equivalents in the reporting period		-307	-701
Cash and cash equivalents at the beginning of the reporting period	15	514	1,215
Cash and cash equivalents at the end of the reporting period	15	**207**	514

The notes on page to form part of these accounts

The notes on page * to ** form part of these accounts

NOTES TO THE ACCOUNTS

1. Accounting policies

a) Basis of Preparation

The financial statements have been prepared under the historic cost convention, with the exception of tangible fixed assets and investments which have been included at a valuation.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom And Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a “true and fair” view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a “true and fair view”. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended practice effective from 1 April 2005 which has since been withdrawn.

The Trustees consider that there are no material uncertainties about the Charity’s ability to continue as a going concern. In future years, the key risks to the Charity are a fall in income from donations or a fall in investment income but the Trustees have arrangements in place to mitigate those risks (see the Investment Risk Management and Reserves Policy sections of the annual report for more information).

The Charity meets the definition of a public benefit entity under FRS

b) Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the trustees have the discretion to spend the capital

(expendable) and those where there is no discretion to expend the capital (permanent endowment).

Those funds which are neither endowment nor restricted income fund, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the trustees' discretion, including the general fund which represents the charity's reserves.

c) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exits as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet.

d) Income resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income generation are met.

e) Income resources from endowment funds

The incoming resources received from the invested endowment fund are wholly restricted**.**

f) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably. Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant

- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant

- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised but a contingent liability is disclosed.

g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs are apportioned on an average fund balance basis.

h) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds represent fundraising costs together with investment

management fees. Fundraising costs include expenses for fundraising activities and a fee paid to a related party, the Health Board, under a fundraising agreement. The fee is used to pay the salaries and overhead costs of the Health Board's fundraising office.

i) Charitable Activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

j) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount**.**

k) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90 day notice interest bearing savings accounts.

l) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.
Amounts which are owed in more than a year are shown as long term creditors.

m) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later).
Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

n) Fixed Assets

Investments are stated at market value at balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Tangible fixed assets are valued at current cost as follows:

i) The land and buildings in respect of Rookwood Hospital was revalued as at 1st April 2017, and the revaluation reflected the restriction to hospital use only. Where appropriate between valuations an appropriate index, supplied from the Welsh Government, is applied to revalue the asset.
ii) Assets in the course of construction are valued at current cost.
iii) Capitalisation threshold is £5,000

iv) Movements in revaluation are recorded in the revaluation reserve on the balance sheet

Professional valuations are carried out by the District Valuer Service every five years, which (as the commercial arm of the Valuation Office Agency) is part of HMRC. The valuations are carried out in accordance with Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Welsh Government and HM Treasury. Movements in revaluations are recognised in the Revaluation Reserve.

Depreciation

i) Depreciation is charged on each main class of tangible asset as follows: land and assets in the course of construction are not depreciated. Buildings, installations and fittings are depreciated on their revalued amount over the assessed remaining life of the asset as advised by the professional valuers;

ii) Impairments, where incurred in the year, are separately identified in note 13 and charged to the funds of the charity where caused by price fluctuations and to the Statement of Financial Activities for the year when the impairment was recognised**.**

iii) The estimated remaining life of the assets are split between engineering (15 years) and structure (45 years).

Donated Assets are capitalised at their valuation on full replacement cost basis on receipt and are revalued and depreciated as described above.

2. Related party transactions

Cardiff and Vale University Local Health Board is the Corporate Trustee of the Charity.

The related party transactions and balances involving the Corporate Trustee, trustee board members and senior staff are set out below.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not benefit personally from such decisions. Each trustee board member and senior officer have provided signed declarations in respect of themselves and their close family.

The Local Health Board has close links with Cardiff University which includes the sharing of staff as well as sharing accommodation on the University Hospital of Wales Site.

The table below relates to the related party financial transactions for financial year 2021/22.

Related Party	Income related party 2021/22 £000	Expenditure related party 2021/22 £000	Amounts owed to related party 2021/22 £000	Amounts due from related party 2021/22 £000
Cardiff Council	0	23	8	0
Welsh Government	0	0	0	0
University of South Wales	0	8	0	2
Cardiff and Vale Health Board	0	876	209	23
Cardiff University	0	24	0	0

The table below includes the names of the individual board members and the relationship with the related party.

Board Member	Related Party Relationship
Gary Baxter	Professor of Pharmacology at Cardiff University
Ceri Phillips	Professor at Cardiff University
Rhian Thomas	Senior Lecturer at University of South Wales
Susan Elsmore	Cabinet member for Social Care Health and Wellbeing for Cardiff Council

The table below relates to the related party financial transactions for financial year 2020/21.

Related Party	Income related party 2020/21 £000	Expenditure related party 2020/21 £000	Amounts owed to related party 2020/21 £000	Amounts due from related party 2020/21 £000
Cardiff Council	0	1	0	0
Welsh Government	0	1	0	0
University of South Wales	0	2	0	0
Cardiff and Vale Health Board	0	1,586	72	23
Cardiff University	0	42	1	0

3.Income from donations and legacies

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2021-22 £000	Total 2020/21 £000
Donations	1,032	113	0	**1,145**	1,638
Legacies	119	15	0	**134**	147
	1,151	**128**	**0**	**1,279**	**1,785**

4.Other trading activities

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2021-22 £000	Total 2020/21 £000
Staff lottery	0	278	0	**278**	263
Other trading	21	8	0	**29**	4
	21	**286**	**0**	**307**	**267**

5.Gross investment income

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2021-22 £000	Total 2020/21 £000
Fixed asset equity and similar investments.	123	50	1	**174**	147
Short Term Investments	0	0	0	**0**	0
Deposits and cash on deposit					
	123	**50**	**1**	**174**	**147**

6. Anaysis of expenditure on raising funds

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2021-22 £000	Total 2020/21 £000
Fundraising office	356	0	0	**356**	276
Fundraising events	0	79	0	**79**	76
Investment management fees	15	6	0	**21**	23
	371	**85**	**0**	**456**	**375**

7. Analysis of charitable activity

	Activities taken £000	Support costs £000	Total 2021-22 £000	Total 2020-21 £000
Patient education and welfare	1,483	76	1,560	1,792
Staff education and welfare	306	38	344	154
Research	18	1	19	37
Other	26	8	34	4
Depreciation	0	0	24	21
	1,833	**123**	**1,981**	**2,009**

Cardiff and Vale University Local Health Board Charities Accounts 2021/22

8. Grants

The charity does not make grants to individuals or the Health Board.
The charity does operate a Charitable Funds Bids Panel which approves grants to the Third Sector on an annual basis.
During 2021/22 £0.033m was approved by the Charitable Funds Committee.
During 2020/21 the Charity approved a sum of £0.050m to the Third Sector.

The table below provides the details of the grant payments.

Organisation	2021/22 £000	2020/21 £000
GLAMORGAN VOLUNTARY SERVICES	33	50
Total	**33**	**50**

9. Allocation of support costs

	Raising funds £000	Charitable activities £000	Total 2021-22 £000	Total 2020-21 £000
Governance	0	0	**0**	0
Audit Wales	0	20	**20**	20
Internal Audit	0	9	**9**	10
Investment Management Fees	21	0	**21**	24
Total governance	**21**	**29**	**50**	**54**
Finance and administration		94	**94**	94
	21	**123**	**144**	**148**

The finance and administration is to a related party (Cardiff and Vale University Health Board) and this related to staff costs.

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total Funds 2021-22 £000
Raising funds	15	6	0	**21**
Charitable activities	88	35	0	**123**
	103	**41**	**0**	**144**

10. Trustees' remuneration, benefits and expenses

The charity does not make any payments for remuneration nor to reimburse expenses to the charity trustees for their work undertaken as trustee.

11. Auditor's remuneration

The external auditor's remuneration of £20,700 (2020/21:£25,000) relates to the audit of the statutory annual report and accounts only.

12. Tangible fixed assets

	Freehold Land and Buildings 2021/22 £000	Freehold Land and Buildings 2020/21 £000
Cost or valuation		
Opening Balance	2,517	2,536
Additions	0	0
Revaluations	67	-19
Disposals	0	0
Impairments	0	0
Closing Balance	**2,584**	**2,517**
Accumulated depreciation		
Opening Balance	81	60
Disposals	0	0
Revaluations	0	0
Impairments	0	0
Charge for year	24	21
Closing Balance	**105**	**81**
Opening NBV	**2,436**	**2,476**
Closing NBV	**2,479**	**2,436**

Rookwood Hospital is the only Tangible Fixed Asset recognised in "Freehold Land and Buildings"

13.Fixed asset investments

Movement in fixed assets investments

	Investments Listed on Stock Exchange £000	Cash Held in Investment Portfolio £000	Total 2021-22 £000	Total 2020-21 £000
Market value brought forward	6,103	265	**6,368**	5,499
Add: additions to investments at cost	1,662		**1,662**	1,130
Less disposals at carrying value	(1,861)		**(1,861)**	(872)
Add any gain / (loss) on revaluation		389	**389**	679
Movement of cash held as part of the investment portfolio		11	**11**	(68)
Market value as at 31st March 2022	**5,904**	**665**	**6,569**	**6,368**

The gain on revaluation relates to the unrealised gain, however the overall gain of £0.451m, as shown in the Statement of Financial Activities is calculated by also adjusting for realised Gains of £0.062m. (2019/20 £0.190m). The movement of cash held as part of the investment portfolio includes a withdrawal of £250,000 from the investment portfolio.

As at 31st March 2022 the following investment was the largest percentage weighting (9.4%) holding considered material: UBS ETF MSCI USA Socially Responsible ETF.

The Charity's investment are handled by investment advisors appointed by the Charity, using the appropriate Health Board purchasing contract process. The Charity operates an investment policy that provides for a high degree of diversification of holdings within investment asset classes. A large proportion of investments are made with companies listed on a UK stock exchange or incorporated in the UK. The majority of expenditure is financed from donations and legacies and therefore the Charity is not exposed to significant liquidity risk. The Investment Management Company attends the Charitable Funds Committee twice a year to discuss all aspects of investment performance and the factors influencing the perform

14. Analysis of current debtors

Debtors under 1 year	Total 31 March 2022 £000	Total 31 March 2021 £000
Other debtors	2	10
Long-term prepayments	24	19
Short-term prepayments (one year)	23	12
Accrued Income	96	89
	145	**130**
Total debtors	**145**	**130**

15. Cash at bank and in hand

	31 March 2022 £000	31 March 2021 £000
Cash in hand	207	514
	207	**514**

16. Analysis of liabilities

	Total 31 March 2022 £000	Total 31 March 2021 £000
Creditors under 1 year		
Other creditors	389	244
Accruals	23	57
	412	**301**
Total creditors	**412**	**301**

17. Reconciliation of net income / expenditure to net cash flow from operating activities

	Total 2021-22 £000	Total 2020-21 £000
Net income / (expenditure) (per Statement of Financial Activities)	(226)	684
Adjustment for:		
Depreciation charges	24	21
(Gains) / losses on investments	(451)	(869)
Dividends, interest and rents from investments	(174)	(146)
(Increase) / decrease in debtors	(15)	27
Increase / (decrease) in creditors	111	(564)
Net cash provided by (used in) operating activities	**(731)**	**(847)**

18. Role of volunteers

Cardiff and Vale Health Charity continue to be extremely grateful to all the volunteers who support fundraising with so much energy, passion, and skill. The Charity could not achieve all their objectives without the on-going commitment of the volunteers to make such a difference to patients and staff.

The Charity aims to work more closely with Health Board volunteers in order to develop more specific Charity Champion roles, including supporting our runners at the Cardiff Half Marathon and supervising the charity collection tins. In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

19. Analysis of Funds

a. Analysis of endowment funds

	Balance 1 April 2021 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2022 £000
Catherine Jenkins	42	1	(1)		3	45
	42	**1**	**(1)**	**0**	**3**	**45**

b. Analysis of restricted material fund movements

		Balance 1 April 2021 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2022 £000
9447	**Cystic Fibrosis Better Life Appeal Fund**	389	25	(38)			376
9479	**Phillips Legacy - Asthma Research**	208	6	(5)			209
9149	**Breastcare Unit - General Purpose**	147	96	(60)			183
9478	**May Legacy - Asthma Research**	138	4	(5)			137
9582	**Murphy Legacy (Morfa Day Unit - General Purpose)**	90	3	(14)			79
9639	**Childrens Telemetry Appeal (General Purpose)**	94	3	(2)			95
9689	**Gould Legacy (Haematology)**	91	2	(2)			91
9690	**Gould Legacy (Bone Marrow Unit)**	91	2	(2)			91
9463	**Chidgey Legacy**	91	3	(3)			91
9678	**Staff Lottery**	68	281	(206)			143
	Other	304	39	(49)	(5)		289
		1,711	**464**	**(386)**	**(5)**	**0**	**1,784**

c. Analysis of unrestricted and material designated fund movements

		Balance 1 April 2021 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2022 £000
	Unrestricted Funds						
9809	Unrestricted Non Delegated	687		-712	5	448	428
		687		-712	5	448	428
	Designated Funds						
9649	Bale Covid Donation	442	10	-189			263
9644	Hughes Legacy (Cardiology)	305	22	-35			292
9600	UHW Nurses	291	26	-15			302
9524	Leukaemia & Lymphona	144	5	-12			137
9153	Geriatric Research (UHW)	135	4	-12			127
9494	Biggs Legacy Cardiac Research	103	3	-3			103
9712	ULHB Arts Programme	3	135	-13			125
9704	Food Sense Wales	122	407	-387			142
9659	Morgan Legacy Cardiac Research	101	3	-2			102
	Other	2,625	680	-646			2,659
		4,271	1,295	-1,314	0		4,252
	Total	**4,958**	**1,295**	**-2,026**	**5**	**448**	**4,680**

d. Revaluation Reserve

	Balance 1 April 2021 £000	Income £000	Expenditure (Depreciation) £000	Transfers £000	Gains and losses £000	Balance 31 March 2022 £000
Rookwood	2,436		-24		67	2,479
	2,436	**0**	**-24**	**0**	**67**	**2,479**

Cardiff and Vale University Local Health Board Charities Accounts 2021/22

Additional Notes

20. Commitments

	2021/22
	£000
The funds have the following commitments:	
Charitable projects	
Total	**573**

Name of commitment	**£000**
Third Sector Grant Scheme (CFC 22/06/012) 1 year	36
Neurological Gardens (BT 20/07/013) (1-3 Years)	145
Neurological Gardens Maintenance Cost(BT 20/07/013) (1-3 Years)	94
Staff Recognition Awards (CFC 18/052) (4 Years)	20
Disposal of Rookwood (CTM 19/06/009) (1-4Years)	155
UHB Transport Solutions (CT/19/03/007) (1-3 years)	70
Forget Me Not Chorus (CFC 22/03/010) (1 Year)	13
Welsh Transplant Team (CFC 21/12/011) (1-5 years)	40
	573

21. Donated Assets

During the year the Charity purchased assets to the value of £0.061m. These are included in the Charity's Statement of Financial Activities and are classified as Donated Assets in the LHB Financial Statements.

22. Post Balance Sheet Events

The financial statements are required to reflect the conditions applying at the end of the financial year. Therefore no adjustments are made for any changes in fair value of investments between 31 March 2022 and the date the financial statements are approved. The fair value of the investments held by the Charity at 31st Match 2022 has changed in the intervening period as follows:

	31 March 2022	** January 2023
	£000	£000
Investment	6,569	

Cardiff and Vale University Local Health Board Charities Accounts 20221/22

As Financial Trustee of the funds held on trust I am responsible for:

. the maintenance of financial records appropriate to the activities of the fund (s).

. the establishment and monitoring of a system of internal control.

. the establishment of arrangements for the prevention of fraud and corruption.

. The preparation of annual financial statements which give a true and fair view of the funds held on trust and the results of their operations.

……2023 …….. On behalf of Financial Trustee

Cardiff and Vale University Local Health Board Charities Accounts 2021/22

STATEMENT OF TRUSTEE RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The trustee is required to prepare financial statements for each financial year which give a true and fair view of the charity's financial activities during the year and of its financial position at the end of the year. In preparing financial statements giving a true and fair view, the trustee should follow best practice and:

- Select suitable accounting policies and then apply them consistently;
- Make judgements and estimates that are reasonable and prudent;
- State whether applicable accounting standards and statements of recommended practices have been followed, subject to any departures disclosed and explained in the financial statements; and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the charity and which enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) regulations and the provisions of the trust deed. The trustee is responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustee confirms that they have complied with the above requirements in preparing the accounts.

By order of the trustee

Signed:

Trustee……..Dated ……2023

The independent auditor's report of the Auditor General for Wales to the Trustee of Cardiff and Vale University Local Health Board Charity

Report on the audit of the financial statements

Opinion

I have audited the financial statements of Cardiff and Vale University Local Health Board Charity for the year ended 31 March 2021 under the Charities Act 2011. These comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows and related notes, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2020 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Emphasis of Matter

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the charity's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Report on other requirements

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee is responsible for the other information in the annual report and accounts. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies, I consider the implications for my report.

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report;
- sufficient accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit.

Responsibilities

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee responsibilities set out on page 38, the trustee is responsible for preparing the financial statements in accordance with the Charities Act 2011, for being satisfied that they give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Adrian Crompton
Auditor General for Wales
** January 2023

24 Cathedral Road
Cardiff
CF11 9LJ

Report Title:	ClinIcal Audit			Agenda Item no.	7.13
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	8 November 2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Executive Medical Director and Executive Nurse Director				
Report Author (Title):	Assistant Director of Quality and Patient Safety				

Main Report
Background and current situation:

The Healthcare Quality Improvement Partnership (HQIP) defines clinical audit as a "quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

Clinical Audit forms an integral part of the Health Board's processes for improvement and assurance. Cardiff and Vale UHB clinical audit process operates on a tiered system:

• Tier 1 – Mandatory national clinical audits – set out in the National Clinical Audit and Outcomes Review Programme (NCAORP).
• Tier 2 – All other national audits and local audits undertaken to address patient safety and quality agenda.
• Tier 3 – Local clinical audits undertaken for other reasons such as revalidation and CPD purposes.

Each year Welsh Government publish an Annual NCAORP that confirms the national audits that health boards in Wales are expected to participate in. The 2022/23 programme is included in appendix 1.

In October 2021 the Health Board Clinical Audit processes were subject to internal audit and were awarded **limited assurance**.

The audit identified that

- there was adequate overall leadership of clinical audit within the Health Board however as a result of under resourcing of the audit team audit training was not being delivered
- the Health Board was missing key documents to direct, mandate and ensure constancy of clinical audit approach
- The Clinical audit team and the Clinical Boards were not provided with the adequate tools to effectively enable them to monitor clinical audit outcomes and the improvements taken.

An Improvement plan was developed (appendix 2) and remains in progress with a number of milestones already achieved.

<u>Clinical Effectiveness Group</u>
A Clinical Effectiveness Committee was established in 2021 to monitor the implementation of the NCAORP, to provide strategic direction with respect to clinical audit, to provide oversight of the results of national clinical audits inclining action plans developed to address requisite improvements.

The Clinical Effectiveness Committee provides assurance to the C&VUHB Quality Safety and Experience Committee.

<u>Clinical Audit Policy and Strategy</u>

A clinal audit policy and strategy have been developed to define the rationale for clinical audit and to provide a framework to support a prudent clinical audit programme designed to provide assurance and to drive improvement around quality and safety priorities. The purpose of the policy is to ensure:

- Participation in all national clinical audits and outcome review programme, national confidential enquiries and inquiries, and national service reviews relevant to the services provided
- All clinical audit activity within the UHB, or conducted in partnership with external bodies, is registered both locally and nationally as appropriate, and conforms to nationally agreed best practice standards (see HQIP's guide, Best practice in clinical audit)
- The annual programme of clinical audit activity meets Board Assurance Framework objectives, and includes all of the clinical audits necessary to meet the requirements of regulators and commissioners
- Records of reviews of the annual programme of clinical audit, individual clinical audit projects, as well as the results of national clinical audits, national confidential enquiries and inquiries, and national service reviews, are maintained.
- To support the development of Clinical Board Clinical Audit plans aligned to key Clinical Board Quality and Patient Safety risks and priorities
- To engage health professional to engage in meaningful audit as part of their ongoing development

Both documents will be presented at the Clinical Effectiveness Committee as part of the consultation process prior to ratification.

Clinical Audit Quality Management System

The Health Board procured AMaT, a clinical audit quality management tool, in May 2022. The digital platform will support a systematic approach to audit proposal and approval, oversight and reporting of results and the development and monitoring of associated improvement plans.

The Clinical Audit Team are delivering AMaT training to clinical Boards to support the use of the system. It is anticipated that all Clinical Boards will have been trained by December 2022 and will be using the system to register their local audits.

Clinical Audit Team

The Patient Safety and Patient Experience teams developed a joint business case in 2022 and the clinal audit team received additional funding as part of the business case appointing to a new Clinical Effectiveness Lead, increasing the clinical audit facilitator establishment by 1.0 WTE band 5 and procurement of the AMaT system. In addition, the Health Board secured a Health Technology Wales grant to support the fixed term appointment of a project manager to deliver the roll out of AMaT.

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

The Health Board clinical audit processes were awarded limited assurance in October 2021. A number of milestones have already been met including

- The procurement of a digital clinical audit quality management system
- The development of a draft clinical audit policy and strategy
- Securing additional resource for the clinal audit team
- The embedding of the Clinical Effectiveness Committee

Recommendation:
The Committee is requested to:- a) **NOTE** the assurance provided by the progress made against the Internal audit recommendations.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: /No
Safety: Clinical Audit has an important function in proving assurance of the quality and safety of services and driving improvements
Financial: /No
Workforce: No
Legal:/No
Reputational: /No
Socio Economic: No
Equality and Health yes clinical Audit can have a role in identifying variation in population health outcomes and supporting the improvements to reduce this variation

Decarbonisation: /No

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

NHS Wales National Clinical Audit and Outcome Review Plan

Annual Rolling Programme from 2022/23

June 2022

The annual National Clinical Audit and Outcomes Review Plan confirms the list of National Clinical Audits and Outcome Reviews all health boards and trusts are expected to participate in 2022-23 (where they provide the service). The plan confirms how the findings from audits and reviews will be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

Section 1 of the National Health Service (Wales) Act 2006 places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.

1. What do we want to achieve?

NHS Wales needs to be a learning organisation, which regularly seeks to measure the quality of its services against consistently improving standards and, in comparison with other healthcare systems across the UK, Europe and the World. This measurement should be used to set improvement priorities.

The Welsh Government and NHS Wales are committed to the principles of value-based healthcare to help meet the challenges of rising costs and increasing demand, while continuing to improve the quality of care.

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards.

2. The programme of audits

The agreed NHS Wales programme of audits includes the majority of audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) managed by the Healthcare Quality Improvement Partnership (HQIP), but can also include a number of other national or multi-organisational audits recognised as being essential.

The Clinical Outcome Review Programme (formerly Confidential Enquiries) is commissioned by HQIP on behalf of the Welsh Government, NHS England, NHSSPS Northern Ireland, ISD Scotland and the Channel Island and Isle of Man governments. The programme is designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by

systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

The final agreed list of audits and reviews is published annually. The programme for 2022-23 is attached at Annex A.

3. How will participation, learning and action on findings be encouraged throughout Wales?

Continued encouragement of audit:

- Feedback relating to the benchmarked performance of individual providers within clinical audits and reviews to organisations as appropriate for reflection and action.
- By raising the profile of clinical audit with boards, patient groups, clinicians and all staff working within the NHS. To include, organisational visits and liaison with professional bodies in Wales to encourage audit amongst their disciplines and specialism.
- Developing closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.
- Working in partnership with other healthcare organisations e.g. Public Health Wales, Digital Health and Care Wales (DHCW) to promote and encourage a culture of participation in audit and action on findings.

Identifying areas needing a national approach to improvement:

- Reviewing common issues for all Welsh healthcare providers arising from audit and reviews and sharing solutions.
- By ensuring the findings and recommendations from audits are fully considered by the appropriate national advisory groups/networks.
- Working in partnership, via HQIP and with audit project teams to ensure the provision of Welsh-specific findings and potential solutions, and develop and organise workshops and events to disseminate them.

Addressing clinical services where performance may give cause for concern:

- Clearly identifying the comparative performance of individual provider organisations and understanding the reasons for any disparity.
- Ensuring issues are considered in regular performance review meetings between health boards/trusts and in Welsh Government Quality Delivery Board meetings.
- Protocol confirming the arrangements for the identification and handling of organisations identified in audits and reviews as being “Outliers” including such activity designed to improve and encourage quality improvement.

Greater transparency:

- By seeking to improve the way in which the findings, recommendations and improvement actions from audit and reviews are made available to patients, public and all staff working in the NHS.

4. What is the Role of Welsh Government?

In partnership with NHS England and HQIP, the Welsh Government supports and funds the cost of NHS Wales' participation in the National Clinical Audit and Clinical Outcome Review Programme. The Welsh Government along with DHCW will seek to encourage greater participation and learning from clinical audits and reviews leading to improved services, better patient outcomes and safer patient care.

The Welsh Government is a member of the NCAPOP Partners Group and provides the Welsh Government's position and context to ensure the audits align with the long-term plan in Wales.

5. What is the Role of Digital Health and Care Wales

DHCW has become the joint data controller with HQIP for the delivery of any audits commissioned by HQIP as part of NCAPOP.

As part of its Statutory functions as a Special Health Authority, Welsh Government has requested that DHCW identify data sharing opportunities to support clinicians and networks in Wales and provide advice and support to health boards.

6. What are the responsibilities of Welsh health boards and trusts?

Welsh health boards and trusts should provide the resources to enable their staff to participate in all audits, reviews and national registers included in the annual plan (where they provide the service). They should ensure the full audit cycle is completed and that findings and recommendations from audit link directly into the quality improvement programme and lead to improved patient care and outcomes.

To ensure the maximum benefit is derived from the clinical audit programme health boards and trusts should:

- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Appoint a clinical lead to act as a champion and point of contact for every National Clinical Audit and Outcome Review, which the health board is participating in. Health boards and trusts should also encourage and support clinical leads to take on the role of all-Wales representative on audit steering groups and networks where required.

- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.
- Have clear lines of communication, which ensures full board engagement in the consideration of audit and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.
- Work with DHCW to facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.
- Existing Data Sharing Agreements between the Health Boards and NHS Trusts shall be utilised for the information sharing event, and this should be documented on the National Information Flows Register as held by DHCW.
- DHCW, Local Health Boards and the Trusts shall produce such Data Privacy Impact Assessments (DPIAs) as may be necessary to comply with the GDPR where new identifiable data is to be shared or otherwise processed.

In previous years health boards were tasked with completing a proforma to provide to Welsh Government for each published audit report. As the audit process has matured, audit results feed into a range of networks and policy development and as such it has been determined these proformas are an additional layer, which are no longer required. From 2022/23 routine profromas to the Welsh Government for every audit will no longer be required. Welsh Government policy officials may ask for feedback when required.

7. How Will We Measure Success?

By year on year consideration of audit reports and in comparison with other UK, European and International healthcare systems to determine how compliance with best practice and achievement of healthcare outcomes compares to national and international benchmarks.

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.

- Less variation between local services and measurable year on year improvements in performance to achieve the highest standards. Organisations recognised as being above the audit “average” or within the top quartile for each audit and maintaining that level.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

8. How Will We Maintain Success?

The audit and quality improvement approach has the advantage of engaging those placed to make change and those expected to deliver and maintain change on a daily basis. This approach has a demonstrated track record of delivering and maintaining service improvement for a range of issues in a range of settings. Where there are expectations of delivering and maintaining better quality care and outcomes, the audit and quality improvement should be the normally used first-line approach.

9. Conclusion

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

In line with our stated ambition to develop a healthcare service that is recognised as being one of the best in the world, and to drive forward improvement, the clinical audit process will also be used to assess Welsh healthcare services against similar services being provided in other countries across the UK, Europe and Internationally.

Annex A

Annual Programme for 2022 - 23 of National Clinical Audit and Outcome Reviews in which all Welsh health boards and trusts must participate (where services are provided)

Acute	Audit website homepage	Contact	Collecting data in 2022/23
National Joint Registry	www.njrcentre.org.uk	enquiries@njrcentre.org.uk	Yes (W, E & NI)
National Emergency Laparotomy Audit *	www.nela.org.uk	info@rcoa.ac.uk	Yes (W & E)
Case Mix Programme (CMP)	www.icnarc.org	cmp@icnarc.org	Yes (W, E & NI)
Major Trauma Audit Trauma Audit and Research Network #	https://www.tarn.ac.uk/	support@tarn.ac.uk	Yes (W, E & NI)

Long Term Conditions	Audit website homepage	Contact	Collecting data in 2022/23
National Diabetes Audit *	General: https://digital.nhs.uk		(W & E)
Note this covers the following areas : National Diabetes Foot Care Audit	Footcare: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-foot-care-audit	ndfa@nhs.net	Yes
• National Diabetes Inpatient Safety Audit (NDISA)	NaDia: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-inpatient-audit	nadia@nhs.net	Yes
• National Pregnancy in Diabetes Audit	Pregnancy: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-pregnancy-in-diabetes-audit	npid@nhs.net	Yes
• National Diabetes	Core: https://digital.nhs.uk/data-	diabetes@nhs.net	Yes

Core Audit	and-information/clinical-audits-and-registries/national-diabetes-audit		
National Paediatric Diabetes Audit (NPDA) * #	www.rcpch.ac.uk/npda	npda@rcpch.ac.uk	Yes (W & E)
National Asthma and COPD Audit Programme (NACAP)* # **Note this covers the following areas :** • COPD Secondary Care • Adult Asthma • Paediatric Asthma Secondary Care • Pulmonary Rehabilitation	https://www.rcplondon.ac.uk/projects/national-copd-audit-programme https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-copd https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult-asthma https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-children-and-young https://www.rcplondon.ac.uk/projects/national-asthma-and-copd-audit-programme-nacap-pulmonary-rehabilitation-workstream	copd@rcplondon.ac.uk	Yes (W & E)
Renal Registry (Renal Replacement Therapy) #	https://ukkidney.org/about-us/who-we-are/uk-renal-registry	renalregistry@renalregistry.nhs.uk	Yes (W, E & NI)
National Early Inflammatory Arthritis Audit * #	https://www.rheumatology.org.uk/Practice-Quality/Audits/NEIA-Audit	bsr@rheumatology.org.uk	Yes (W & E)
All Wales Audiology Audit #			Yes (Wales only)

Older People	Audit website homepage	Contact	Collecting data in 2022/23
Sentinel Stroke National Audit Programme (SSNAP) *	www.strokeaudit.org	ssnap@rcplondon.ac.uk	Yes (W, E & NI))
Falls and Fragility Fracture Audit Programme Including: • National Audit of Inpatient Falls • National Hip Fracture Database • Fracture Liaison Service Database *	https://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-fffap	FFFAP@rcplondon.ac.uk Inpatient Falls falls@rcplondon.ac.uk Hip Fracture Database nhfd@rcplondon.ac.uk Fracture Liaison Service Database FLSDB@rcplondon.ac.uk	Yes (W, E, NI))
National Audit of Dementia *	www.nationalauditofdementia.org.uk	nad@rcpsych.ac.uk	Yes (W & E)

End of Life	Audit website homepage	Contact	Collecting data in 2022/23
National Audit of Care at the End of Life (NACEL) *	https://www.nhsbenchmarking.nhs.uk/nacel	enquiries@nhsbenchmarking.nhs.uk	TBC (W & E)

Heart	Audit website homepage	Contact	Collecting data in 2022/23
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * • National Audit of Cardiac Rhythm Management *	https://www.nicor.org.uk/ https://www.nicor.org.uk/national-cardiac-audit-programme/heart-failure-heart-failure-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/cardiac-rhythm-management-arrhythmia-audit/	nicor-auditenquiries@bartshealth.nhs.uk	(W & E) Yes Yes

• National Adult Cardiac Surgery Audit* • National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) * • National Congenital Heart Disease Audit * # • Myocardial Ischaemia National Audit Project (MINAP)*	https://www.nicor.org.uk/national-cardiac-audit-programme/adult-cardiac-surgery-surgery-audit/ https://www.nicor.org.uk/adult-percutaneous-coronary-interventions-angioplasty-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/congenital-heart-disease-in-children-and-adults-congenital-audit/ https://www.nicor.org.uk/national-cardiac-audit-programme/myocardial-ischaemia-minap-heart-attack-audit/		Yes Yes Yes Yes
National Audit of Cardiac Rehabilitation	http://www.cardiacrehabilitation.org.uk/	corinna.petre@york.ac.uk	Yes (W, E & NI)
National Vascular Registry Audit *	www.vsqip.org.uk	nvr@rcseng.ac.uk	Yes

Cancer	**Audit website homepage**	**Contact**	**Collecting data in 2022/23**
National Lung Cancer Audit *	https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit On 1 February 2022, the project transferred to the Royal College of Surgeons of England. It was previously run by the Royal College of Physicians.	nlca@rcplondon.ac.uk	Yes (W & E_
National Prostate Cancer Audit *	www.npca.org.uk	npca@rcseng.ac.uk	Yes (W & E)
Gastrointestinal Cancer Audit Programme (GICAP) *			Yes (W & E)

• National Bowel Cancer Audit • National Oesophago-gastic Cancer Audit	www.nboca.org.uk https://www.nogca.org.uk/	bowelcancer@nhs.net og.cancer@nhs.net	
National Audit of Breast Cancer in Older People (NABCOP) *	https://www.nabcop.org.uk/	nabcop@rcseng.ac.uk	Yes (W&E)

Women's and Children's Health	**Audit website homepage**	**Contact**	**Collecting data in 2022/23**
Paediatric Intensive Care Audit (PICaNet) * #	www.picanet.org.uk	picanet@leeds.ac.uk	Yes (UK)
National Neonatal Audit Programme Audit * #	www.rcpch.ac.uk/nnap	enquiries@rcpch.ac.uk	Yes (W & E)
National Maternity and Perinatal Audit *#	http://www.maternityaudit.org.uk/pages/home	nmpa@rcog.org.uk	Yes (W, E & S)
National Perinatal Mortality Review Tool	https://www.npeu.ox.ac.uk/pmrt	general@npeu.ox.ac.uk	Yes (W, E & S)

Other	**Audit website homepage**	**Contact**	**Collecting data in 2022/23**
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12) *#	https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety/epilepsy12-audit	enquiries@rcpch.ac.uk	TBC
National Clinical Audit of Psychosis *	https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis	NCAP@rcpch.ac.uk	Yes (W & EW)

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)

Annex B

Clinical Outcomes Review Programme

The **Clinical Outcome Review Programme** (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies, which support changes to improve NHS healthcare.

Without high quality data, improvement in clinical care is unlikely to occur. National clinical audits and outcome reviews are focused on areas of healthcare considered to be important, where there are often issues of concern and where national results are considered essential to improve practice and standards.

With the ability to measure against recognised standards and compare services on a local, regional or national basis, clinical audit and outcome reviews are very powerful tools for assessing the quality of services being provided. When used as part of the wider quality improvement cycle, they provide a strong mechanism for driving service change and improving patient outcomes, but full participation and a determination to learn from the findings is essential.

Service provider contracts for these programmes have been awarded to the following suppliers (links are provided to website homepages):

Clinical Outcomes Review Programme	**Programme website homepage**	**Contact**	**Collecting data in 2022/23**
Medical and Surgical Clinical Outcome Review Programme *	http://www.ncepod.org.uk/ To include: - Community acquired pneumonia - Crohn's Disease - Endometriosis - End of life care	ncepod@nhs.net	(W, E) Yes Yes Yes Yes
Mental Health Clinical Outcome Review Programme *	http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicidepreventionn/nci - National Confidential Inquiry into Suicide and Safety in Mental Health	ncish@manchester.ac.uk	(W, E) Yes

Child Health Clinical Outcome Review Programme *#	http://www.ncepod.org.uk/ - Transition from child to adult health services - Testicular torsion	ncepod@nhs.net	(W, E) Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme *#	https://www.npeu.ox.ac.uk/mbrrace-uk	general@npeu.ox.ac.uk	(UK) Yes

Appendix 2

CLINICAL AUDIT ACTION PLAN			
No.	**Recommendation**	**Actions**	**Anticipated Date of Completion**
1	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.	A Clinical Audit Strategy is under development and will be presented at the September CEC for ratification.	Dec-22
2	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.	A Clinical Audit Strategy is under development and will be presented at the September CEC for ratification.	Dec-22

3	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.	The Clinical Effectiveness lead commenced in September 2022. A further 2 WTE band 5 posts have been appointed in to and will support clinical audit facilitation and the project management of the AMaT system . AMaT has been procured as a digital clinical audit quality management system and training for all clinical Board will be complete by the end of 2022.	Dec-22
4	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.	The Clinical Effectivness Lead commenced in post in September 2022 and will support the delivery of the clinical audit policy and strategy. AMaT training has been delivered to Women and Children's Clinical Board and will commence in the remaining Clinical Board in November 2022. Ongoing monitoring of clinal audit plans and audit outcomes will be overseen by the Clinical Effectiveness Committee	Dec-22

Report Title:	UHB Policies and Procedures Review			Agenda Item no.	7.14
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	8 November 2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

Cardiff and Vale University Health Board ("the Health Board") has a responsibility to ensure compliance with legislative, statutory and regulatory requirements. One of the ways in which the Health Board seeks to meet those requirements is via the Corporate Policies, procedures and other written control documents ("Policy Documents"). These Policy Documents set out how the Health Board operates and the parameters within which its staff are expected to work in order to meet the Health Board's statutory requirements.

It is therefore essential that the Health Board maintains a robust and clear governance framework for the management of its Policy Documents in order to minimise risk to patients, staff, contractors, the public and the organisation itself.

In December 2020, Internal Audit undertook an audit in relation to the Health Board's management of its Policy Documents and made a number of recommendations, namely that the Health Board should:-

a) ensure that its policies are reviewed and updated within appropriate timescales;
b) review the Corporate Policy Register ("the Register") for completeness – in particular, to ensure that any Policy Documents published on the intranet and the Health Board's website, are current and are recorded appropriately on the Register;
c) review the readability of Policy Documents to make sure they are clearer, correct and improve accessibility of Policy Documents, that, where appropriate, a combined Equalities and Health Impact Assessment is undertaken for all policies, and that the Corporate Governance Department should ensure the integrity of the Register by reviewing accuracy of all key information;
d) review the record keeping process for when a request is made to create a new Policy Document, from receipt of request to create, to issue/publish the draft for consultation and any feedback received; and
e) review of record keeping process for notifying stakeholders of new, amended and existing policies.

Unfortunately, this piece of work has not been completed within the timescales originally agreed due to a number of factors, including the limited resource within the Corporate Governance Department together with the turnover in the Head of Corporate Governance post. Further, the emergence of COVID and the ongoing pandemic during the last couple of years has made it impossible to achieve the original agreed timescales. The Corporate Governance Department now has more resource and, accordingly, as a matter of priority, it is progressing the necessary actions in order to address the recommendations made.

During the last few months, actions have been taken to address the recommendations referred to under paragraphs d) and e) above. That is, a Standard Operating Procedure ("SOP") has been developed, in particular to detail a clear process to be followed with regards to the Policy Documents

consultation exercise. The SOP has been put into practice by the Corporate Development Team. Since August 2022 any requests to the Corporate Governance Team to assist with (i) the creation and/or review of a Policy Document, and (ii) publishing documents for consultation, are dealt with in accordance with the SOP. Further, any Policy Documents which are issued for publication via SharePoint (that is, they are made available for the Health Board's staff to view and provide any feedback during the consultation period), are also sent to the Chairs of the Community Health Council, Stakeholder Reference Group and the Local Partnership Forum in order to ensure engagement with a wider audience during the consultation period.

Whilst a number of other actions have been undertaken to date in order to address the recommendations referred to under paragraphs a) to c) above, it will no doubt be appreciated that given the size of the task (there are circa 500 Policy Documents logged on the Register), it will take some time before the Health Board's Policy Register is put on a much better footing. To that end, a plan has been developed in order to map out the work that is required, together with proposed timescales, to address all of the audit recommendations and to produce an up to date and efficient Policy Documents management system. A copy of plan is attached as Appendix 1 to this report.

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

As mentioned above, putting in place an improved and more effective Policies Management System will take some time to complete as this constitutes a large piece of work not only for the Corporate Governance Department, but also for the individual Directorates within the Health Board. Whilst every effort is being made to carry out this work as a matter of urgency, it should be noted that the Corporate Policy Register as it currently stands is not an accurate and update to date Register. In particular:-

- Some of the Policy Documents have long expired review dates and may be out of date. To that end, the Executive Leads have been asked to identify those Policy Documents that require an urgent review and to prioritise the same;

- Some of the published links to access Policy Documents on the Website and/or SharePoint are incorrect. Whilst some work has been undertaken to address this, it is anticipated that a full review and update of the Policy Documents published links will be completed by the end of this year. In mitigation, where any such links are not accurate and/or do not work, copies of the relevant Policy Documents are available, upon request, from the Corporate Governance Team.

- At the moment, searching for a particular Policy Document on the Health Board's Website is not an easy task, given the way in which the Policy Documents are stored on the Website. Work is underway to address this, including consideration as to how the published Policy Documents can be catalogued and stored on the Website (and SharePoint), and to develop a search tool within the "Policies, Procedures and Guidelines" section of the Health Board's Website.

In light of the scale of this piece of work, many of the different stands of work are being carried out in parallel so that the Health Board can have a fully functioning and up to date Policies Management System in place as soon as possible. It is proposed that this will be by the end of May 2023.

Recommendation:

The Committee is requested to:

a) **Note** the action taken to date to address the audit recommendations as set out in this report, together with the proposed actions and timescales set out in Appendix 1.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: Yes
The current status of the Corporate Policy Register could give rise to potential Staff or Patient safety implications, given that some of the published Policy Documents have long expired review dates. The body of the report sets out the actions being taken to address this.
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
03/11/2022 16:33:19

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

Appendix 1

Corporate Policies Management System Plan 2022/23

No.	Action	Timescale	Complete / Partially Complete / Incomplete
1	**Review/Update the Health Board's Corporate "Policy on Policies"** The Management of Policies, Procedures and Other Written Control Documents Policy (UHB 001) and the Written Control Documents – Development and Approval Procedure (UHB 242) have been reviewed/updated and were approved by Audit Committee in July 2022. The Policy on Policies" outlines the process for development, consultation, approval, dissemination and review of key organisational documents, such as policies, strategies, procedures, guidelines and protocols. It includes guidance with regards to (i) the readability of documents (eg ways to write clearer, especially those available through internet to wider audience) and (ii) where appropriate, undertaking a combined EHIA for all policies.	April – July 2022	Completed
2	**Develop a Standing Operating Procedure with regards to the Corporate Governance Team's management of the Corporate Policies**	August 2022	Completed

	An SOP has been developed which sets out the Corporate Governance's responsibilities and processes in relation to (i) the maintenance of the Corporate Policy Register, (ii) assistance with policy consultation and approval queries, (iii) the consultation process (including consultation with staff and the public), (iv) the policy approval process and (v) review of policies/other controlled documents. The Corporate Governance Team has been following the SOP since August 2022.		
3	**Initial review of Corporate Register to identify out of date polices**. An initial review of all policies/other controlled documents held with the Corporate Governance Department has been undertaken. Two Excel Tracker spreadsheets have been produced: - 1. One lists all policies and other controlled documents currently registered on S drive/Intranet site ("Policy Tracker – Draft v1.1). All policies/other controlled documents have been colour coded as follows: - **Red** - where out of date **Amber** - where less than 12 months left before published review date **Green** - where the policies are currently within date and have more than 12 months before next review date is due. 2. The other Tracker lists all policies and other controlled documents registered on the Health Board's Website (CAV Web Policies).	June to July 2022	Completed
4	**The Head of Corporate Governance to meet with each Exec Lead to discuss those policies/other written controlled documents listed as falling in their respective portfolios.**	August – November 2022	Partially Completed

	Following the initial review of the Corporate Register, the Head of Corporate Governance wrote to the Executive Directors with a copy Policy Tracker – Draft v1.1 and asked for their assistance to: - (i) Identify those policies which require an urgent review; (ii) Carry out a "cleansing" exercise of those documents on the Policy Tracker – Draft v1.1 which fall within their respective portfolios, including that the correct terminology is checked/used (eg a document may be labelled as a "Protocol", or a "Procedure" where it should be labelled as a Policy and vice versa). (iii) Identify those policies/other controlled documents which may be obsolete and/or may have been superseded by new documentation. (iv) Identify which policies / other controlled documents should be published on the Website (public facing). The Head of Corporate Governance has met with each of the Executive Leads. A meeting is to be rescheduled with the new Chief Operating Officer (to be arranged for November 2022).		
5	**Update Policy Tracker – Draft v1.1 following meeting held with individual Executive Leads.** The Policy Tracker – Draft v1.1 has been updated to include the initial comments received from the individual Lead Executives with regards to the current status of particular policies/other controlled documents, contact details for those policies/other written control documents which require review, and to register the correct Executive Lead per policy/document. This document is kept "live" and is updated continually as and when:- - the Corporate Governance Team receive instructions to assist with requests to publish policy documents for consultation (ie when papers were published for consultation and expiry date of consultation period). - To log the proposed Committee/Board date where the policy/document requires formal approval by the same.	September – November 2022	Partially Completed

	- Confirm the date of approval, approval route and date the documents have been published. - To register those policies/other controlled documents which have been published on the website. - To indicate if the policy/other controlled documents are available in Welsh.		
6	**Produce individual Policy Trackers for each Executive Lead.** Following each meeting with each individual Executive Lead, Corporate Governance Team to produce a separate Policy Tracker to:- - reflect those policies/other written controlled documents which should fall within the Executive Lead's respective portfolio as confirmed by the individual Executive Lead; - detail the current status of each policy/document within the respective Executive Lead's portfolio; - where appropriate, include the contact details of the policy author. Individual Trackers have been produced for:- Director of Digital & Health Intelligence Executive Director of Therapies and Healthcare Sciences Executive Medical Director Executive Nurse Director Individual Trackers to be produced for:- Executive Director of Finance Executive Director of Strategic Planning Executive Director of Public Health Executive Director of People and Culture Chief Operating Officer Director of Corporate Governance Proposed to complete this action by end of December 2022	October – December 2022	Partially Completed
7	**Head of Corporate Governance to follow up with relevant contacts where provided by Exec Leads.**	October – December 2022	Partially Completed

	Head of Corporate Governance to follow up with relevant contacts where instructed. Some Executive Leads are following up actions with their own teams. This action has been completed in relation to those contacts provided by the Executive Director of Therapies and Healthcare Sciences. Head of Corporate Governance to follow up with the contacts provided by the Executive Medical Director (anticipated to be carried out by the end of November 2022).		
8	**Issue updated Executive Trackers to Executives for comment and action** The Head of Corporate Governance to issue the Executive Policy Tracker to each Executive Lead to:- - Check that all of the policies / documents which fall within their portfolio are captured on the Tracker and to provide details of those policies/procedures which have not been registered on the Tracker. - Provide the Head of Corporate Governance with timescales within which any out of date policies/documents will be reviewed. - Confirm if the policy/document should be published on the Website.	November 2022 to January 2023	Not completed
9	**Carry out review of all policies / other controlled documents stored on the Website for accuracy (eg to ensure correct links are published, documents published on Website reflect those documents that are published on Sharepoint).** To date, this piece of work is only partially complete. Each Website published link to a policy/other written controlled document is being checked to ensure that it accurate and links to the correct policy/document and works. Further checks are being undertaken to ensure that the policy/document published on the Website mirrors the policy/document that is published on SharePoint. The Tracker relating to the Health Board's Website (CAV Web Policies) is being updated accordingly as and when these checks are being completed.	September – December 2022	Partially Completed

	It is proposed this will be completed in full by the end of December 2022.		
10	**Meet with Welsh Language Officer to gain an understanding of the requirements to produce policies and/or other written controlled documents bilingually.** The Head of Corporate Governance met with the Welsh Language Officer on 9 September to discuss the Welsh Language Standards (69-71) in relation to impact upon the Health Board's policy developing process. The Welsh Language Officer is re-developing the EHIA process to ensure that policies are assessed according to these standards. No further action required by the Corporate Governance Team. In response to a request from the Welsh Language Officer, the Head of Corporate Governance undertook a review of all policies/other written documents which were approved by Board and/or a Committee of the Board from 1 April 2021 to July 2022 and which had included a completed EHIA (to determine where an assessment for impact upon the Welsh Language).	August – September 2022	Completed
11	**Move Policies page from Intranet to SharePoint.** The Health Board's Intranet site has been moved to SharePoint as of the end of August 2022. Accordingly, the Policies page has been migrated to a new page on Sharepoint**.** A new landing page has been created which currently shows:- - the current list of policies and other controlled documents held and available for viewing by internal staff. A consultation section showing those policies/other controlled documents out to consultation, contact details to provide any feedback, expiry date of consultation period.	August – September 2022	Completed
12	**Initial Meeting with the Health Board's Archivist to discuss an improved/more efficient Policies Management System.**	September – October 2022	Completed

	The Head of Corporate Governance has met with the Health Board's Archivist to discuss potential approaches to store/archive the policies/other controlled written documents on the Website and SharePoint. Approaches discussed included: - - better categorisation and sub categorisation of policies to provide effective storage and search tool on the Website and SharePoint. - Develop an effective search tool within the dedicated Policies, Procedures and Guidelines page on the Health Board's Website. - Develop an effective tool to alert policy authors/Corporate Governance Team to forthcoming policy/other controlled documents review dates.		
13	**Follow up meeting with Archivist End of November.** A meeting has been arranged with the Archivist to develop an improved Policies Management System, including:- - A review the current categorisation of the Policies/documents held on the website. - Develop a more effective model of categorisation, to include sub-categorisation (subject to Exec approval). - Consider a potential mechanism to build in policy/document review date alerts within the Policy Management System. Once a "template" which sets out the proposed categorisation and sub-categorisation of policies/documents for the Website and SharePoint has been produced, a copy will be circulated to the Exec Leads for comment.	End of November 2022	Not Completed
14	**Circulate proposed template for the Policies Management System to Exec Leads.** The Head of Corporate Governance to circulate the draft "template" which sets out the proposed categorisation and sub-categorisation of policies/documents for the Website and SharePoint to be circulated to the Exec Leads for comment.	December – January 2023	Not completed
15	**Executive Leads to respond to Action number 14 above**	End of February 2023	Not completed

16	**Knowledge share with Policy Lead peers across other Health Boards.** The Head of Corporate Governance has met with some of her peers across other Health Boards to share learning regarding their approaches to Policy Management Systems. Two Health Boards have established their Policy Management Systems on SharePoint and have agreed to share their templates for their Policy Management Systems. A follow up meeting December has been scheduled for 9 December 2022.	October – December 2022	Completed
17	**Follow up meeting with Policy Lead peers from other Welsh Health Boards**	December 2022	Not Completed
18	**Meet with IT to discuss SharePoint page to see how this can be utilised for the Policy Management System and/or whether there are any other options.** Meeting to be arranged once the template for proposed categorisation of policies has been agreed by Executive Leads.	November – December 2022	Not Completed
19	**Follow up meeting with IT to progress the establishment of the Policy Management System**	January – February 2023	Not Completed
20	**Follow up with Exec Leads with up to date Policy Tracker** Circulate to each Executive Lead, the latest version of the Policy Tracker Policy Tracker – Draft v1.1 plus the individual Policy Tracker for the respective Executive Lead, and seek:- - confirmation as to the current status of any policy/documents which are still recorded as having expired Review Dates, proposed action regarding the same together with indicative timescales; and	March – April 2023	Not Completed

	- clarification as to whether the Tracker provides a complete register of all current corporate policies/documents which fall within his/her respective portfolio and which should be recorded on the Corporate Register.		
21	**Fully functioning Policy Management System in place.** Which serves to: - - Provide the Corporate Policy Register which is an accurate register of all up to date Corporate Policies and other written controlled documents. - Identifies review dates for all policies/documents held on the register. - Includes details such as:- - UHB Policy Reference number - Document title - Publication Date - Whether a policy/document has been published on the Website. - Date of next review of policy/document - Mechanism to alert Corporate Governance Team to a policy/document review date. - Relevant Executive Lead - Policy Author - Whether the Policy/document is available bi-lingually. - Comment box – to record current status of a policy/document (eg if a policy is out for consultation, due to go to Board/Committee for approval etc).	By May 2023	Not Completed

Report Title:	**Internal Audit Reports for Information**				Agenda Item no.	9.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	08/11/22	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report
Background and current situation:

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

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

The 2022/23 plan was formally approved by the Audit Committee at its April 21 meeting.

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

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

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

- Two Substantial Assurance
- Five Reasonable Assurance

Recommendation:

The Audit & Assurance Committee are requested to:

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

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

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

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

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

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

Mohamed,Sarah
03/11/2022 16:33:19

Follow-up: Five Steps to Safer Surgery

Final Internal Audit Report

September 2022

Cardiff & Vale University Health Board

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

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

Contents

Review reference:	CVU-2223-18
Report status:	Final Report
Fieldwork commencement:	18 July 2022
Fieldwork completion:	30 August 2022
Draft report issued:	1 September 2022
Debrief meeting:	30 August 2022
Management response received:	5 September 2022
Final report issued:	6 September 2022
Auditors:	Andrea Calise, Principal Auditor Wendy Wright-Davies, Deputy Head of Internal Auditor
Executive sign-off:	Meriel Jenney, Executive Medical Director
Distribution:	Clare Wade, Director of Nursing, Surgery Clinical Board Christopher John, Interim Clinical Governance Lead, Peri-operative Care Directorate
Committee:	Audit and 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 and 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 Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the 'Five Steps to Safer Surgery' Audit (CVU-2122-16) that was undertaken as part of our 2021/22 work programme, which reported 'Limited' assurance.

Overview of findings

Significant progress has been made in addressing the seven recommendations arising from the previous internal audit, completed in October 2021. Management acted promptly to review and update guidance documentation and to strengthen the monitoring of compliance within this area.

Agreed actions relating to all recommendations have been addressed and closed. Our review of documentation and discussions with lead staff confirmed a number of key actions which mitigated the risks posed in the initial audit, which include:

- Senior management took a key role in leading the actions to be taken to address the recommendations;
- A new risk assessment has been undertaken and is continuously reviewed by senior staff;
- Procedures have been updated and reissued to staff; and
- New modules have been implemented within the TheatreMan system to address the original findings from the audit.

The outcome of the follow up review does not aim to provide assurance against the full scope and objectives of the original audit. Rather the 'Substantial' assurance opinion reported, provides an assurance level against the implementation of the agreed action plan only.

Follow-up Report Classification

		Trend
Substantial 	**Follow up:** All high, medium and low priority recommendations implemented	

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Current Progress
1	Lack of evidence to demonstrate compliance with Five Steps to Safer Surgery	High	Complete
2	Incomplete patient files to evidence Five steps to Safer Surgery (Steps 2, 3 & 4)	High	Complete
3	Observations from Theatre Visits	Medium	Complete
4	Culture towards 'Five Steps to Safer Surgery'	Medium	Complete
5	Procedures require update to support Five Steps to Safer Surgery	Medium	Complete
6	Risk Assessment to be finalised	Medium	Complete
7	Visibility of themed issues associated with Five Steps to Safer Surgery	Low	Complete

1. Introduction

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

1.2 This is a follow-up review of the original report that was issued in October 2021. This identified seven issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The executive lead for the review is the Executive Medical Director.

Audit Risks

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

- Patient harm due to non-compliance with the checklist;
- A lack of clinical ownership of the checklist results in a culture of non-compliance amongst surgical teams;
- Reputational and potential financial loss to the Health Board due to patient harm caused by ineffective us of the checklist; and
- Monitoring and reporting processes fail to address non-compliance.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations, which highlights that all are complete. We have no further findings to report.

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	2 (R1 & R2)	-	-
Medium	4	4 (R3, R4, R5 & R6)	-	-
Low	1	1 (R7)	-	-
Total	**7**	**7**	**0**	**0**

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

Priority	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.

NHS Wales Shared Services Partnership
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Heol Billingsley
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CF15 7QZ

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

Medical and Dental Staff Bank
Final Internal Audit Report

October 2022

Cardiff & Vale University Health Board

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

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

Contents

Review reference:	CVU 2223-06
Report status:	Final Report
Fieldwork commencement:	4 August 2022
Fieldwork completion:	28 September 2022
Debrief meeting:	10 October 2022
Draft report issued:	11 October 2022
Management response received:	21 October 2022
Final report issued:	24 October 2022
Auditors:	Wendy Wright-Davies, Deputy Head of Internal Audit Lucy Jugessur, Internal Audit Manager
Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
Distribution:	Lianne Morse, Assistant Director of People and Culture Hilary Sharp, Head of Medical 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.

Executive Summary

Purpose

The overall objective of the audit was to review the effectiveness of the processes and controls operating within the Health Board's new Medical and Dental Staff Bank managed by Medacs Healthcare.

Overview

We have issued substantial assurance on this area.

A framework agreement is in place for the Medical and Dental Managed Bank Service. We found that robust processes are operating to ensure appropriate employment checks are completed and terms & conditions are issued for all bank staff. Bank shifts are verified and authorised prior to payment and regular performance reporting and monitoring is undertaken.

There is only one key matter requiring management consideration, which relates to the timeliness of shifts entered on the Envoy system. From our review, a third of our sample identified that available shifts had been added to the system retrospectively, after the shift had taken place.

We also raise two low priority recommendations which are detailed within Section 2 and Appendix A of the report.

Report Opinion

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Objectives	Assurance
1	Approved contract in place for the managed service of the Medical and Dental Staff Bank	Substantial
2	All Bank staff have had appropriate employment checks	Substantial
3	Terms of Engagement is issued to all Bank Staff	Substantial
4	All completed Bank shifts are verified and authorised	Reasonable
5	Reports on bank usage and costs are produced	Substantial

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

Key Matter Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Retrospective requests for Bank Shifts entered on the Envoy system	4	Operation	Medium

1. Introduction

1.1 Our audit review of the Medical and Dental Staff Bank was completed in line with the 2022/23 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 In September 2020 the Management Executive received a report, 'Additional Resource to Support Medical Workforce Productivity Programme'. The report recognised the need to establish a Medical Staff Bank to 'extend the supply of doctors, maintain quality and reduce cost'. There were a number of benefits identified within the report to moving to a central fully outsourced managed service:

- Patient benefits such as continuity of care and improved patient safety outcomes;
- UHB benefits such as expanding the locum register by exposing skills of doctors who may be able to work across specialities, and that all new doctors will be credentialed to Health Board compliance standards; and
- Doctor benefits including equity and fairness in shifts being advertised and filled, and one point of contact for all doctors wishing to pick up extra hours, regardless of speciality.

1.3 The Health Board has partnered with a managed service provider to supplement the medical workforce, which is directed by a call-off contract. The call-off terms and conditions continue subject to annual review until August 2026. The services provided as part of the contract includes:

- Supply of management services for the filling of locum shifts with staff registered with the Health Board's own staff bank;
- Supply of a portal for use in engaging with clinical staff on a direct engagement basis.

1.4 There is a monthly 'Medical & Dental Staff Bank Dashboard' which provides data on Operational Performance, Savings Performance and Financial Performance. The March 2022 Dashboard identified that 15,861 hours were filled by bank staff.

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

Audit Risks

1.6 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 staff resources;
- The allocation and completion of bank shifts does not meet the priorities of the Clinical Boards; and
- Financial loss due to unnecessary usage or incorrect payment of bank staff.

2. Detailed Audit Findings

Objective 1: There is an approved contract in place for the managed service of the Medical and Dental Staff Bank, which clearly determines the responsibilities of the provider and that of the Health Board

2.1 Prior to agreeing the current contract terms, the Health Board had a contract with Medacs Healthcare for them to recruit agency locums. In September 2020 the Management Executive received a report, 'Additional Resource to support Medical Workforce Productivity Programme'. The report recognised the need to establish a Medical Staff Bank to extend the supply of doctors, maintain quality and reduce cost. The arrangement with Medacs was expanded when the managed service went live in 2021, for an initial period of 12 months. The arrangement is directed by call-off terms and conditions, from a Multidisciplinary Framework Agreement for Temporary Healthcare Personnel (RM3711). As noted within the agreement, unless the Health Board terminates the Call-Off Contract on three months' notice, the contract will automatically renew annually until August 2026.

2.2 The framework agreement confirms that the service comprises the filling of locum shifts with staff registered with the Health Board's own staff bank. The framework agreement includes an embedded specification document, which sets out the responsibilities of the Health Board, Medacs and the Worker.

2.3 Our review of the Health Board website highlighted a 'Recruitment of Locum Doctors and Dentists Operation Procedure', which was approved a decade ago. We found the content of the Procedure was out of date and reflected the previous arrangements with Medacs to recruit agency locums and has been superseded by further information available on the Health Board's website. *(Matter Arising 1 – Low Priority)*

Conclusion 1: There is a 'Multidisciplinary Framework Agreement: RM3711' in place between the Health Board and Medacs and the responsibilities of all parties are clearly outlined within the document. (Substantial Assurance)

Whilst we identified helpful resources available on the Health Board's website to outline roles and responsibilities for Medical Bank Staff, we identified conflicting messages detailed in an out of date procedure within the Workforce and Organisation Development section of the Website.

Objective 2: All bank staff have had appropriate employment checks and are credentialed to Health Board compliance standards

2.4 The Multidisciplinary Framework Agreement states that *"all compliance checks for staff bank workers who are also on permanent or fixed term direct contracts of employment or engagement with the Health Board outside of its staff bank, whether directly or through a personal services company or umbrella company, will be the responsibility of the Health Board".*

2.5 The Health Board's 'Medical and Dental Staff Bank Terms and Conditions' confirms the checks that are required for Bank staff to undertake shifts via the Managed Bank Service.

2.6 There are a number of compliance checks undertaken on Medical and Dental staff, but these can vary by role and status of the staff member. As a minimum the following are undertaken, Disclosure and Barring Service checks, occupational health clearance, evidence of identification checks, and references.

2.7 We selected a sample of Medical and Dental Bank Staff to ensure that the necessary compliance checks had been undertaken and the relevant documentation was maintained on the MISL system (Health Board document management system). From our sample of 30 staff selected we identified that the relevant documentation was available in line with the status of the Medical and Dental staff for 26 employees. However, for the four members of staff whereby the necessary documentation was not initially available, the employee had either been temporarily suspended or a further exception gained from the service, or the required documentation was subsequently made available.

Conclusion 2: We were able to confirm that Bank Staff have had the appropriate employment checks and are credentialed to Health Board compliance standards. The Managed Bank will chase documentation in cases whereby the documentation is unavailable. If after 4 weeks, the documentation is still unavailable the worker would either be temporarily suspended, or a further exception gained from the service. (Substantial Assurance)

Objective 3: Terms of Engagement documentation is issued to all new Medical and Dental Bank Staff

2.8 The Health Board's 'Medical and Dental Staff Bank Terms and Conditions' was drawn up with the NWSSP Legal Team, and came into place in August 2021. Once approved, the Managed Bank (Medacs) issued all registered Medical and Dental staff with a terms and conditions, which covers several items such as allocation of work, hours of work and registration. Bank staff were advised to confirm that they agreed to the terms and conditions, however, if they had not confirmed within 14 days the document states that acceptance will be assumed.

2.9 A Microsoft Excel spreadsheet, 'C&V Staff Bank – Terms and Conditions Update Tracker' is maintained of all Bank Staff that have been issued with the terms and conditions. The tracker records the date the terms and conditions were circulated to each member of the Staff Bank. The Health Board has had to assume acceptance for the majority of Bank Staff, given the limited receipt of formal acceptance.

2.10 All new starters that register to join the Managed Bank via the website are provided with the terms and conditions which they have to agree. If they do not agree, they are unable to continue to register and the Managed Bank service will contact them to find out the reason.

Conclusion 3: The Health Board's 'Medical and Dental Staff Bank Terms and Conditions' are provided to all registered Bank Staff and evidence of issue is captured on a tracker. All new starters are required to confirm that they agree to the terms and conditions as part of the registration process to join the Managed Bank Service. (Substantial Assurance)

Objective 4: All completed shifts by bank staff are appropriately verified and authorised

2.11 To prompt the use of Medical Bank Staff, a Rota Coordinator is required to confirm on the Envoy system that there is a gap in the rota, and will also confirm the rate to be paid for the vacant shift. The Envoy system will highlight available shifts and the number of hours required. Bank Staff can access the Envoy system through an application and can confirm an expression of interest in a shift. A shift will show as pending once a staff member has recorded an interest.

2.12 Expressions of interest in a shift are sent to the Directorate for them to confirm whether they want to accept the Bank Staff to a shift. By confirming the member of the Bank to the shift, a timesheet is automatically created and on completion of the shift the Bank Staff is required to complete it detailing the hours worked. The timesheet is then sent to the approver that has been set up in the Envoy system for them to authorise the timesheet.

2.13 Any differences in the request on Envoy to the completed shift details, such as additional hours worked, will turn the narrative red and the member of the Bank will complete the supporting narrative confirming the reason. The authoriser is required to check with the relevant Consultant that the member of the Bank has worked the said hours and if it agrees they will approve. However, if they dispute the variation, the timesheet will be returned to the member of the Bank detailing the reason for the dispute.

2.14 We selected a sample of Medical and Dental Bank Staff that carried out shifts in July 2022 to ensure that they had been approved in line with the signatory list and that approval had been actioned following the shift being worked. In all cases they had been approved following completion of the shift. However, it was noted that a number of shifts were requested on the Envoy system retrospectively. *(Matters Arising 2 – Medium Priority)*

Conclusion 4: Timesheets were completed following each shift and were appropriately authorised following completion of the shift. However, there were instances whereby shifts were requested the same day as the shift was required or requested days after the shift had been completed. (Reasonable Assurance)

Objective 5: Reports on bank usage and costs are produced for the Health Board, which includes specific performance measures. The Health Board scrutinise the reports and actions are taken where required

2.15 Medacs produce a monthly 'Staff Bank Dashboard' providing data on total fill rates, hours filled by bank and agency, the number of Staff Bank members and Staff Bank and agency invoiced spend. The reports have developed and now include a narrative section including any highlights during the month.

2.16 We were advised by management that an update on Bank usage is presented to the Medical Workforce Advisory Group, in the form of the Dashboard, which is attended by members of the Executive.

2.17 We were also made aware of a far more detailed spreadsheet beyond the Dashboard, provided by Medacs, referred to as 'Doctors MI', which provides performance information on the Managed Bank Service. The spreadsheet includes data on fill rates for the month and the number of hours covered by the Bank, Agencies and not covered, the number of filled hours split by Directorate and the spend on bank and agency.

2.18 The Dashboard, along with the 'Doctors MI' spreadsheet is taken to the performance meeting between Medacs and staff in the Health Board. There is an action log that runs parallel to the meeting to capture all actions which is used at the start of the next meeting and closed or left open dependent on the outcome. However, there has not been a meeting for a number of months, but we were advised that the Health Board and Medacs have regular informal meetings. *(Matters Arising 3 - Low Priority)*

2.19 There are also reports produced for the Clinical Boards and Directorates, which are used for discussion. Meetings take place between Clinical Boards and Medical Workforce, attended by the Clinical Board Director, Directorate Manager, Service Manager, General Manager and Finance Business Partner. The Management Information includes fill rates and breakdown of grade utilisation, reason for bank staff and savings / efficiencies. We were able to evidence the debrief notes / actions taken from the meetings held.

Conclusion 5: Medacs produces a number of detailed reports on the Managed Bank Service for the Health Board and also for the Clinical Boards and Directorates. The formal performance meetings between Medacs and the Health Board have not taken place as frequently as required due to service pressures and changes in staff, but we could evidence that plans are in place to reconvene in October 2022. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Out of date 'Recruitment of Locum Doctors and Dentists Operational Procedure' (UHB 131) (Operation)	**Impact**
A review of the Health Board's website highlighted an operational procedure which is out of date, the 'Recruitment of Locum Doctors and Dentists Operational Procedure' (UHB 131). The procedure can be found within the workforce and organisational development policies section of the Website. We found the procedure is considerably out of date, which was approved in July 2012, with the date of review noted as July 2015.[1] To inform our audit testing we were signposted by management to the Medical and Dental Managed Locum Bank pages on the Health Board's website, which includes a comprehensive Medical and Dental Staff Pack FAQs.[2]	Potential risk of: • Wards and departments are unable to consistently operate in a safe manner due to conflicting advice available on the Health Board's website.

	Recommendation	**Priority**
1	Management need to review the 'Recruitment of Locum Doctors and Dentists Operational Procedure' (UHB 131), which has been superseded by online resources and consider whether they update it in line with current processes.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	The 'Recruitment of Locum Doctors and Dentists Operational Procedure' to be deleted off the online resources as the new Terms of Business for the Medical and Dental Staffbank now override.	31 October 2022	Head of Medical Workforce

[1] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/workforce-and-od-policies/r-workforce-and-od/recruitment-of-locum-procedure-pdf/
[2] https://cavuhb.nhs.wales/jobs/managed-locum-bank/faqs-medical-bank/

Matter Arising 2: Retrospective requests for Bank Shifts entered on the Envoy system (Operation)	**Impact**
Within the Multidisciplinary Framework Agreement, 3.1 Schedule 2 – Specifications, outlines Health Board Responsibilities, which notes, *"AB01 Rota Co-Ordinators to publish rotas at least 6 weeks in advance or as soon as identified for short notice unplanned gaps".* We reviewed a sample of 30 Bank shifts to ascertain the timeliness of requests to the Managed Bank Service and identified that a number of shifts had been entered on the Envoy system after the shift had taken place:	Potential risk of: • Wards and departments are unable to consistently operate in a safe manner due to insufficient staff resources.

Retrospective Bank shifts entered on the Envoy system	**Number of Medical and Dental staff**
Same day as the shift worked	4
2 days post shift	1
3 days post shift	1
4 days post shift	1
8 days post shift	2
13 days post shift	1
Total	**10**

We were advised that the possible reasons for the retrospective requests were due to:

- The Medical or Dental staff member not being live on the Bank but the Directorate knowing them (for example a Health Board employee), but they would not be paid until fully registered;
- The rota co-ordinator is absent due to leave so they have to retrospectively enter on return;
- The Directorate is new to using the Managed Bank Service, so they have retrospectively put shifts on as there are no other routes of payment for the Bank Staff; or
- The rota co-ordinator could be late updating the system from the main rota.

Recommendation		Priority
2	Rota-Coordinators need to ensure that shifts are made available in a timely manner on the Envoy system to ensure a greater chance of take up by Bank Staff. In instances where the Rota-Coordinator is unavailable, contingency and cover arrangements should be considered.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2	Short term absence will inevitably take place which will not always allow for a shift to be put on prospectively e.g. same day sickness etc. There will also be occasions whereby a locum will be required over a weekend/bank holiday that was not planned within the week and as the rota co-ordinator only work M-F/BH this will require action on their return. We can adopt a measure that all retrospective shifts are to be put on no later than 72 hours. The Medical and Dental Staffbank team will create a communication to go out to all service areas to update them of the above and will monitor over the next quarter to monitor adherence and report into MWAG.	31 October 2022	Head of Medical Workforce

Continued over page

Matter Arising 3: Formal contract monitoring meetings with Medacs are not being held regularly (Operation)	**Impact**
Within the Multidisciplinary Framework Agreement, the specification document states that the Health Board are to *"attend contract meetings... a minimum of 1 meeting per quarter should be held."* To inform the contract meetings, Medacs produce a monthly 'Staff Bank Dashboard' and 'Doctors MI report' to review performance with the Health Board. There has not been a formal contract monitoring meeting since March 2022, but the meetings are due to reconvene on 24th October 2022. Although we do note that regular informal meetings have been taking place. We were advised that the meetings have not occurred due to service pressures and changes in personnel.	Potential risk of: • Financial loss due to unnecessary usage or incorrect payment of bank staff.

	Recommendation	**Priority**
3	Management need to ensure that they meet regularly with Medacs, in accordance with the requirements of the Framework Agreement, so that the performance is regularly reviewed, and any issues can be discussed during the meeting.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3	These meetings are now scheduled monthly. Audience to include, Head of Medical Resourcing and Systems, Deputy Director of People & Culture, Deputy Medical Director and Medacs Healthcare.	Complete	Head of Medical 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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Staff Wellbeing – Culture and Values
Final Internal Audit Report

October 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:	Rachel Gidman, Executive Director of People and Culture
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Committee:	Audit & Assurance Committee

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

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

Executive Summary

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Staff Wellbeing – Culture and Values'.

Overview

We have issued reasonable assurance on this area.

The findings of our audit have highlighted that the Health Board has clear plans in place of how it intends to support staff wellbeing, principally driven by the People and Culture Plan 2022 – 2025. The Plan is now moving into the delivery phase and our recommendations focus on the mechanisms and means of evaluation to support the implementation of the ambitious aspirations. The majority of our recommendations reflect this, and sit within objective three.

We make further recommendations around references within the Board Assurance Framework, and the need to verify source material signposted on the new SharePoint site.

Low priority recommendations are detailed within Section 2 and Appendix A of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Documented set of values	Substantial
2	Acceptable and unacceptable workplace behaviours	Reasonable
3	Governance arrangements to manage and monitor wellbeing	Reasonable
4	Risks are captured and monitored	Substantial
5	Engagement with all staff	Reasonable
6	Training and resources are available to all staff	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Out of date references to the former Values and Behaviours Framework	2	Operation	Medium
2	Completeness of the People and Culture Plan's Priority Action Plan	3	Design	Medium
3	Tracking and monitoring the People and Culture Plan	3 & 5	Design	Medium
4	Terms of Reference for the Strategic Wellbeing Group	3	Design	Medium
6	Monitoring and delivery of the Wellbeing Plan	3	Design	Medium
7	Cultural assessment toolkit	3 & 5	Operation	Medium
10	Board Assurance Framework: Staff Wellbeing Risk (Occupational Health)	6	Operation	Medium

1. Introduction

1.1 Our audit review of 'Staff Wellbeing – Culture and Values' was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 In January 2022, the Board approved the draft People and Culture Plan 2022-25. As noted on the Health Board's website, "It 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."

1.3 In May 2022 the Management Executive Team considered the Board Assurance Framework (BAF) 2022-23, which was subsequently presented to the Board. Both the 2021/22 and 2022/23 BAF include 'Staff Wellbeing' as a strategic risk, which could impact upon the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'.

1.4 In October 2021 Audit Wales published an all-Wales report, 'How NHS bodies supported staff wellbeing during the COVID-19 pandemic'. The Health Board responded to the report and presented a management response to the February 2022 Audit Committee.

1.5 The Health Board holds the Gold Corporate Health Standard, the national quality mark for health and wellbeing. Further, the Platinum Standard has also been awarded, which focuses on corporate social responsibility activity.

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

Audit Risks

1.7 The following risks were taken from the Board Assurance Framework (May 2022).[1]

- Staff Wellbeing – There is a risk that staff sickness will increase, and staff wellbeing will decrease due to the psychological and physical impact of the ongoing pandemic. Which together with limited time to reflect and recover will increase the risk of burnout in staff.
- Leading Sustainable Culture Change – There is a risk that the cultural change required will not be implemented in a sustainable way.

Limitations to scope

1.8 The outline scope within the Audit Plan noted the inclusion of Occupational Health Services, but from planning discussions with management it was considered that it would be more appropriate to undertake as a standalone review, and this will be considered in future Audit Plans. However, where reference is made to Occupational Health Services within key documents under this review we have considered them.

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

2. Detailed Audit Findings

Objective 1: The Health Board has a documented set of values, and these are intrinsic to the People and Culture Plan

2.1 We found the Health Board has a documented set of values which were revised in 2018 following an engagement exercise with staff and patients. The next review, scheduled in the Board Plan of Business 2022-23 notes, *"Approve / Review Values and Standards of Behaviour Framework (part of SoFW Strategy), 29 September 2022".*[2]

2.2 The Values Framework document is clear, concise and reader friendly. The Values clearly align to the themes outlined in the People and Culture Plan.

Conclusion 1: We can confirm the Health Board has a documented set of values which align to the People and Culture Plan (Substantial Assurance)

Objective 2: Acceptable and unacceptable workplace behaviours have been identified, documented and communicated

2.3 The Health Board illustrates and communicates acceptable and unacceptable behaviours on their 'Values Poster'. The poster is easily accessible to all staff, patients and visitors on the Health Board's website. We were advised that the Poster is displayed across Health Board sites, but we did not test this.

2.4 The Health Board is progressing the role out of a SharePoint site to replace the intranet. We found references within the SharePoint site to the 'Values and Behaviours Framework' devised in 2012. *(Matters Arising 1 – Medium Priority)*

2.5 The Health Board's Values and Behaviours are promoted to staff via Values Based Appraisals, and are also included in the corporate recruitment programme. The Director of People and Culture attends all induction sessions to deliver a session focused on the Values Framework.

2.6 Whilst reviewing corporate induction material, we found medical job description templates referenced the previous Values Framework and therefore require updating to reflect the current framework. *(Matters Arising 1 – Medium Priority)*

2.7 Plans to promote the values further are included as part of the People and Culture Plan 2022 - 2025.

Conclusion 2: We can confirm the Health Board has a documented set of acceptable and unacceptable behaviours, as outlined in their Values and Behaviour poster. This document is easily accessible via the Health Board's website. Whilst we found no issues with the Values and Behaviour Framework, we did find instances where the previous Values Framework is being referred to, which requires updating. (Reasonable Assurance)

[2] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/ (Item 7.5)

Objective 3: An appropriate framework and governance arrangements are in place to manage and monitor wellbeing

The Framework and Governance of Staff Wellbeing

2.8 The People and Culture Plan 2022 – 2025 is the overarching framework to manage and monitor staff wellbeing, which was approved by the Board in January 2022. It is due to be reviewed by the Board in January 2023. The plan is described by the People and Culture Director as *'our opportunity to improve the experience of staff, to ensure the improvements we have made over recent years continue, and to confront the challenges which have arisen as a result of the pandemic and subsequent recovery period. It 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'.*

2.9 The Plan recognises the effects of the pandemic and the impact it has had on staff. There is a clear focus on how the Health Board will recover and adapt to the 'new normal' following the pandemic, and it outlines a number of post-COVID-19 specific initiatives and resources for staff to access.

2.10 To underpin the People and Culture Plan, we understand the Health Board are in the process of developing a Wellbeing Framework, which will focus solely on the staff wellbeing elements of the Plan. It is anticipated that this will be ready for proposal by late 2022.

2.11 We found the Plan aligns to the Health Board's Integrated Medium Term Plan and other key strategies, as well as to Welsh Government's 'A Healthier Wales' framework.

2.12 The People and Culture Plan is an ambitious framework, we found it outlined more than thirty deliverables directly relatable to staff wellbeing. We compared these deliverables to the People and Culture Plan's Priority Action Plan, a log which details objectives of the framework. We found all deliverables were included in the Priority Action Plan, except for one that related to the strengthening and building of networks for those who have shared protected characteristics. *(Matters Arising 2 – Medium Priority)*

2.13 The Health Board is moving into the delivery phase of the People and Culture Plan. The People and Culture Plan's Priority Action Plan supports this, but greater clarity is needed to effectively monitor progress against all actions outlined in the plan. *(Matters Arising 3 – Medium Priority)*

Monitoring and Oversight of Staff Wellbeing

2.14 The People and Culture Plan, and staff wellbeing in general, is monitored regularly via several different committees and groups, namely, the Strategic Wellbeing Group, the Strategy and Delivery Committee and the Local Partnership Forum. We found that the People and Culture Plan is reported to the Board through the two

latter groups, via Committee Chair's reports, which are reviewed and noted bi-monthly.

2.15 The principal management forum which focuses on staff wellbeing is the Strategic Wellbeing Group. It has representation from the Health Intervention Team, the Employee Wellbeing Service, Clinical Boards and Corporate Departments, and is chaired by the Executive Director of People and Culture. We understand this group was set up in response to the pandemic and now needs to evolve to meet current needs of the workforce. Management acknowledge that the Group requires a Terms of Reference to clarify purpose and positioning. *(Matters Arising 4 – Medium Priority)*

2.16 Whilst reviewing online content relating to these relevant groups and committees, we found the Health Board's website refers to the Health and Wellbeing Advisory Group as the overarching group in monitoring wellbeing. We understand this was the predecessor to the Strategic Wellbeing Group, and therefore the website requires updating. *(Matters Arising 5 – Low Priority)*

<u>The impact and value of approaches to Staff Wellbeing</u>

2.17 A Wellbeing Plan was developed in early 2022, we were advised that the Plan is resourced by a Wellbeing Bid, from 'Non Recurring Corporate Investment Proposals 2021/22' and that there is a limited time to spend these funds. Whilst objectives of this plan were not included in the People and Culture Plan, they did align with the Plan's core themes. Although updates have been shared at the Strategic Wellbeing Group, we found no action log for the Wellbeing Plan. Therefore, we were unable to ascertain if the plan is on course to meet timescales and / or anticipated expenditures. We were advised that an update of this nature will be presented to the Strategy and Delivery Committee on 27 September 2022. *(Matters Arising 6 – Medium Priority)*

2.18 Whilst reviewing the Health Board's approach to staff wellbeing, we found the Health Board has introduced a number of positive initiatives aimed at improving staff wellbeing. However, we note a lack of mechanisms to gauge and evaluate the impact and success of these initiatives, such as a cultural assessment toolkit. *(Matters Arising 7 – Medium Priority)*

Conclusion 3: We were able to evidence the framework and governance arrangements in place to manage and monitor staff wellbeing, which is principally driven by the People and Culture Plan 2022 - 2025. We acknowledge the infancy of the Plan and the mechanisms available to track delivery against the Plan. The recommendations made under this objective once implemented will strengthen the continuing development and maturity of the Plan to realise the ambitious aspirations, in advance of the next scheduled report on progress to the Board. (Reasonable Assurance)

Objective 4: Related risks are captured and monitored

2.19 We identified through our audit planning processes that the Health Board's, Board Assurance Framework (May 2022) included two risks relevant to this review, Staff Wellbeing, and Leading Sustainable Culture Change.

2.20 We could evidence these risks are regularly monitored, but found some missing information in the 'gaps in assurances' and 'gaps in controls' sections for the Sustainable Change Culture risk. *(Matters Arising 8 – Low Priority)*

Conclusion 4: We can confirm two risks relating to staff wellbeing are captured on the Board Assurance Framework and these are regularly monitored. (Substantial Assurance)

Objective 5: Appropriate engagement with all staff has occurred and effective measures / wellbeing initiatives have been implemented

2.21 We understand that following the pressures of the pandemic, the Health Intervention Team was established with the aim of focusing solely on the wellbeing of staff. This team was contracted on a two-year fixed-term basis from April 2020 using charity funds. The Health Intervention Team was tasked with generating a report of wellbeing recommendations, which was finalised in November 2021 and published following the approval of the People and Culture Plan in early 2022. We understand that feedback gathered from staff engagement was shared with the Executive Director of People and Culture to inform the themes outlined in the People and Culture Plan.

2.22 The Health Intervention Team engaged with staff via a survey, drop-in sessions, team meetings and focus groups. An action plan was developed from feedback gathered, which aligns with the People and Culture Plan. We reviewed this action plan, and whilst we acknowledge it is in draft format, we have made suggestions which can be built into the final iteration of the Plan. *(Matters Arising 9 – Low Priority)*

2.23 In 2017, the Health Board was revalidated for the Gold Corporate Health Standard. Numerous key strengths were identified, but it was highlighted some target groups (namely estates, porters, catering and community staff) had been missed by Health Board initiatives. It was recommended that effort was needed to empower these demographics. We found the Health Intervention Team intentionally focused on these target demographics during their initial engagement exercises, to ensure these frontline workers received the recognition for their work during the pandemic. We found their engagement with these target demographics is ongoing.

2.24 The Health Intervention Team hold fortnightly meetings to discuss ongoing staff engagement and are represented in the monthly Strategic Wellbeing Group.

2.25 We understand that aside from work undertaken by the Health Intervention Team, various engagement initiatives have been launched by the Health Board such as

staff surveys, medical staff surveys, minority networks, and WinningTemp (an engagement application being trialled at the time of the audit).

2.26 The Executive Director of People and Culture continues the 14,000 Voices initiative, which involves visiting teams on-sites throughout the Health Board to discuss matters concerning them and matters for celebration. This is done through both active monitoring of workforce data, and invitation from individuals / teams. Additional information on anticipated engagement activities are outlined in the Taking Care of The Carers audit response - a review undertaken by Audit Wales which focused on the Health Board's response to staff wellbeing following the pandemic. We note the Executive Director of People and Culture provided comprehensive responses relating to the Health Board's commitment to improving staff wellbeing.

2.27 We acknowledge that much effort has gone into the roll-out of various wellbeing initiatives. However, without an action log to evidence the progress made against the People and Culture Plan objectives, or an appropriate cultural assessment toolkit, we were unable to measure the success and impact of these initiatives to date. *(See related actions raised in Matters Arising 3 and 7)*

Conclusion 5: We can confirm the Health Board is committed to the ongoing roll-out of staff engagement activities and has already engaged with the workforce via several mediums. Primarily this has been through the Health Intervention Team which was created to focus solely on staff wellbeing. We can confirm the Health Intervention Team have effectively engaged with various staffing groups across the Health Board, including the target demographics highlighted in the 2017 Gold Corporate Health Standard Review. This engagement on staff wellbeing is ongoing. (Reasonable Assurance)

Objective 6: Appropriate training and resources are available to all staff

2.28 We found the Health Board provide a wide range of wellbeing training and resources, many of which are tailored to post-pandemic fatigue. Most of these resources can be found on the user-friendly staff wellbeing page on the Health Board's website, which include:

- The Employee Wellbeing Service – A mental wellbeing self-referral service is offered which staff can access via information on the web page. We found that the service was within Welsh Government KPI referral targets throughout 2022. The service also offers advice on alternative mental health support, physical health support and legal and debt advice providers;
- Occupation Health Service – At the time of the audit fieldwork we noted that there were significant waiting times for occupational health referrals. A target of 20 days has been set, from initial referral to the first appointment. However, as noted on the Health Board's website, the average wait time was

4-5 weeks, but this had decreased from 8 weeks earlier in the year;[3] *(Matters Arising 10 – Medium Priority)*

- Occupational Health Physiotherapy – This includes workplace assessments to prevent muscular-skeletal conditions and offers pain management resources;
- Mental Health Support Services – This includes support for domestic abuse, stress awareness workshops and self-help leaflets; and
- Physical Health Support - This includes the Eating for Life programme, Change 4 Life, diabetes awareness sessions and smoking cessation services.

2.29 In addition to reviewing online material promoted via the Health Board's web page, we also reviewed the staff SharePoint site. The SharePoint site lacked information in the way of staff wellbeing resources or appropriate signposting. *(Matter Arising 5 – Low Priority)*

2.30 Whilst we acknowledge the wide range of wellbeing resources and training on offer, there are limitations for staff who do not have a Health Board email address, for example an awareness of emails to communicate upcoming workshops and newsletters. As a further example, the Health Intervention Team's staff survey was designed to be inclusive. In addition to email, the survey was promoted by word of mouth, and posters were displayed around the Health Board with a QR code which staff could scan to access the survey. Despite the efforts made, 97% of the participants were email address holders. We understand the Health Board has proposed a plan for all staff to be given email addresses to remedy this issue, and therefore we have not raised a matter arising.

Conclusion 6: We can confirm the Health Board offer a wide range of wellbeing resources and training. These are largely easily accessible via the Health Board's website. We note that Occupational Health wait times have exceeded the Health Board's target during 2021-22, which is likely to have impacted the wellbeing of some staff who have attempted to access the service. We found that staff without email addresses are more at risk of missing wellbeing resources, particularly those communicated via email but note the Health Board's plan to remedy this issue. (Reasonable Assurance)

[3] https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/people-health-and-wellbeing-service/occupational-health-service/urgent-information/ (Accessed 11.08.2022)

Appendix A: Management Action Plan

Matter Arising 1: Out of date references to the former Values and Behaviours Framework (Operation)	**Impact**
We reviewed a number of key documents and sources to ascertain if acceptable and unacceptable workplace behaviours have been identified, documented and communicated, and noted the following: • Whilst reviewing the recently launched staff SharePoint site, we found a page dedicated to the Values and Behaviours Framework.[4] However, it outlines the previous Values and Behaviours Framework from 2012. Further, the Values and Behaviours Guide for Managers,[5] which can be found on this page, also refers to this previous framework, as well as to the Performance and Development Review which was a predecessor to the Values Based Appraisal; and • Whilst reviewing corporate recruitment material, we found medical staff job description templates (namely Speciality Doctor, Consultant, Clinical Fellow / Clinical Research Fellow, and Specialist) refer to the former Values Framework that was devised in 2012.	Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way

	Recommendation	**Priority**
1	A review of key documentation and sources should be undertaken to ensure the current 'Values and Behaviours Framework' is referenced appropriately. An update of the following is required: • The SharePoint intranet site 'Values and Behaviours' page; and • Medical job description templates.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	As the staff intranet pages have been moved into the SharePoint site, this has brought with it some pages that are now out of date. The Assistant Director of OD, Culture	November 2022	Assistant Director of OD, Wellbeing and Culture

[4] https://nhswales365.sharepoint.com/sites/CAV_Audience%20with%20Adam/SitePages/Values-%26-Behaviours.aspx (Accessed 11.08.2022)
[5] http://nww.cardiffandvale.wales.nhs.uk/pls/portal/url/ITEM/DBA527EB5969E600E0400489923C5332 (Accessed 11.08.2022)

	and Wellbeing will work with the Head of Education, Culture and OD and the IT Directorate to ensure that the incorrect information is removed from the site. The Assistant Director of OD, Wellbeing and Culture will liaise with the Head of Medical Workforce to ensure that all templates are referencing the current values framework. Assurances have been provided that vacancies going out to advert are checked to ensure current values are communicated, and the incorrect templates will be removed and/or amended.	January 2023	Head of Medical Workforce

Matter Arising 2: Completeness of the People and Culture Plan's Priority Action Plan (Design)	**Impact**
We identified 33 deliverables that directly relate to staff wellbeing in the People and Culture Plan. We compared these to the People and Culture Plan's Priority Action Plan and found that one deliverable was not listed as an objective. This deliverable outlined, *'Provide a voice for our people by strengthening and building networks for those who have shared protected characteristics, including individuals from our ethnic minority communities', the LGTBQ+ Rainbow Fflag network, and people with a disability.'* We acknowledge that minority groups are referenced twice within the Priority Action Plan. These relate to the recruitment of minority groups, and to staff belonging to minority groups being developed into managerial roles. However, the strengthening and building of minority networks is not outlined as a specific objective.	Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way

	Recommendation	**Priority**
2	An objective should be added to the People and Culture Plan's Priority Action Plan, relating to the deliverable, *'Provide a voice for our people by strengthening and building networks for those who have shared protected characteristics'.* The objective should outline how the Health Board plan to achieve this and how success will be measured.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2	The Assistant Director of OD, Culture and Wellbeing will work with the Senior Manager for Equity and Inclusion to ensure that the objective is added to the priority action plan under the theme, Engaged, Motivated and Healthy Workforce and further detail on milestones and measures will be included in this document and reported upon in the monthly flash reporting system.	December 2022	Assistant Director of OD, Wellbeing and Culture

Matter Arising 3: Tracking and monitoring the People and Culture Plan (Design)	**Impact**
Following our review of the People and Culture Plan, and the Plan's Priority Action Plan through the lens of staff wellbeing, we make the following observations, which if addressed may enhance the mechanisms for monitoring and delivering the objectives: • We note that whilst the Priority Action Plan was comprehensive, it lacked information about progress or outcomes of objectives; • There were no risk assessments applied to the objectives, RAG (red, amber, and green) ratings would assist in differentiating those at greatest risk; • The Priority Action Plan is held in a Microsoft Word document, Microsoft Excel would enhance the capabilities to track and monitor through increased functionality; and • We found the 'how will we know the objective has been achieved' sections of the plan often failed to outline measurable targets or indicators. We acknowledged that the Plan is in its infancy and progressing into its delivery phase, but at the time of our review we were unable to ascertain if the Health Board is on-track with achieving the staff wellbeing objectives.	Potential risks of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way.

Recommendation		**Priority**
3	To enhance the People and Culture Plan's Priority Action Plan, consideration should be given to the following:	**Medium**

	• Clarity of the progress made against each objective; • RAG rating objectives; • The use of Microsoft Excel to capture the Plan and utilise the functionality; and • Targets and indicators to measure implementation.		
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Work is currently underway in strengthening identified KPIs for the plan, and identifying additional KPIs. The first year of the plan has been a learning experience and the development of effective measures and systems will be a focus for the one year review in January 2023. This review will include these recommendations. The current monthly reporting of Flash Reports, which inform a 6 monthly update to Strategy and Delivery Committee currently use a RAG rating, but it is recognised this needs enhancing as recommended. The review in January 2023 will strengthen the reporting and tracking of the People and Culture Plan, utilising the most effective platform, e.g. Excel. Work has already started on this, drawing upon the expertise of the Innovation Team. There is the possibility of a slight delay with the review due to the focus on retention within 'Winter Pressures' and focus of effort upon supporting the wellbeing of staff.	January 2023	Executive Director of People and Culture Deputy Director of People and Culture Assistant Director of Resourcing Assistant Director of OD, Wellbeing and Culture

Matter Arising 4: Terms of Reference for the Strategic Wellbeing Group (Design)	**Impact**
We found the key group to monitor staff wellbeing is the Strategic Wellbeing Group (the Group). We understand this Group was set up in response to critical wellbeing issues at the height of the COVID-19 pandemic but has evolved and continues to function as a key wellbeing forum since this time. It is anticipated that an Operational Wellbeing Group will be developed, and this will feed into the Strategic Wellbeing Group. Whilst reviewing the Group, we found there is no terms of reference or set agenda, therefore we were unable to undertake meaningful testing in relation to membership, quoracy, or agenda topics. The absence of a terms of reference provides a lack of clarity of purpose. Management are aware of the need to undertake this task to reflect the current climate, and to incorporate the Operational Wellbeing Group.	Potential risks of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way.

	Recommendation	**Priority**
4	A Terms of Reference for the Strategic Wellbeing Group should be completed to define the Group's purpose in the current climate. Membership, priorities and reporting lines (including that of the anticipated Operational Wellbeing Group) should be clarified.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4	Work has started on drafting the Terms of Reference for the Strategic Wellbeing Group which was previously focused on supporting staff through the emerging and continuing pandemic. The group continues to function effectively, supporting direction through Winter Pressures but will take a more long-term, strategic approach to staff wellbeing as we move into 2023. The Terms of Reference will be discussed in the December 2022 meeting and agreed by January 2023.	January 2023	Executive Director of People and Culture Assistant Director of OD, Wellbeing and Culture

Matter Arising 5: Updates required to the Website and SharePoint for Staff Wellbeing information (Design)	**Impact**
We reviewed the Health Board's, 'Your Health and Wellbeing' section of the website, which refers to the Health and Wellbeing Advisory Group[6] as the principal group that monitors staff wellbeing. We were informed this group no longer exists as it was a predecessor to the Strategic Wellbeing Group. We also reviewed the new SharePoint intranet site, particularly the Employee Health and Wellbeing Service, and Employee Wellbeing Service. The site signposts to the Health Board's website, but only to the homepage, as opposed to the designated wellbeing pages.[7]	Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way

	Recommendation	**Priority**
5	Wellbeing information contained on the Health Board's website and staff SharePoint site, require an update, specifically: • The 'Your Health and Wellbeing' section of the website should be updated to reflect the role of the Strategic Wellbeing Group, and information relating to the former Health and Wellbeing Advisory Group should be removed; and • Links within the SharePoint site require review to ensure effective signposting to dedicated wellbeing pages on the Health Board's website.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
5	The Assistant Director of OD, Wellbeing and Culture will work with the Employee Wellbeing Services Team to ensure that all content is up-to-date, links corrected and out of date information removed. This will be a 'work in progress' as the team are currently responding to increased demand, however, we will work closely with the IT Department to rectify this. The new TORs for the Strategic Wellbeing Group will be agreed in January 2023 and uploaded upon sign-off.	February 2023 January 2023	Assistant Director of OD, Culture and Wellbeing

[6] https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/health-and-wellbeing-advisory-group/ (Accessed 16.08.2022)
[7] A-Z Index (sharepoint.com) (Accessed 16.08.2022)

Matter Arising 6: Monitoring and delivery of the Wellbeing Plan (Design)	**Impact**
We were unable to ascertain if the Wellbeing Plan is on course to meet timescales and/or anticipated expenditure. The Health Board has a limited period in which to utilise this budget, which funds the initiatives in the Wellbeing Plan. We found that whilst regular updates of the plan had been given to the Strategic Wellbeing Group, the plan lacked any action plan or log and so we were unable to track timescales or costs. The aim of the plan was to make positive improvements to staff wellbeing using feedback collated during the pandemic. Several holistic type initiatives were implemented, which included the installation of hydration stations, Schwartz rounds and staff room refurbishments.	Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way

	Recommendation	**Priority**
6	The monitoring arrangements for the Wellbeing Plan should be enhanced to ensure the timely delivery of agreed actions, within agreed funds available.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
6	The UHB are currently developing the Wellbeing Strategy and Framework, which will include information on measures and monitoring. This will be put to Board for approval in February 2023. The Assistant Director of OD, Wellbeing and Culture is currently working with the Innovation and Improvement Team to develop the monitoring mechanism for the wellbeing projects, which will align with the measurements under the P&C Plan.	February 2023	Assistant Director of OD, Wellbeing and Culture

Matter Arising 7: Cultural Assessment Toolkit (Operation)			**Impact**
We acknowledge the positive efforts made by the Health Board to improve staff wellbeing, but we note a lack of mechanisms or tools to gauge the success of these initiatives. We consulted with audit colleagues for examples of measures of success and shared our findings with the Assistant Director of People and Culture. We note the Assistant Director had already liaised with the same NHS Organisation that had instigated a cultural assessment toolkit.			Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way
Recommendation			**Priority**
7	To evaluate the success of wellbeing initiatives, the Health Board should instigate a cultural assessment toolkit, or an alternative means of evaluation which will support the effective delivery of the People and Culture Plan.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
7	Monitoring and Evaluation methodology will be developed alongside the Wellbeing Strategy and Framework.	January 2023	Assistant Director of OD, Culture and Wellbeing.
	In terms of Cultural Assessment Toolkits, the UHB are currently piloting the 'Leadership and Compassion' Programme, designed by Prof Michael West and The King's Fund with NHSE/I, with support from HEIW. This trial will take place Oct-Dec 2022.	December 2022	
	The UHB is currently undertaking an options appraisal of Cultural Assessment Tools to identify the most appropriate.	January 2023	

Matter Arising 8: Board Assurance Framework – Leading Sustainable Culture Change Risk (Design)	**Impact**
Whilst reviewing the Board Assurance Framework, (May 2022), we found the 'gaps in controls' and 'gaps in assurances' sections of the Leading Sustainable Culture Change risk were incomplete.[8]	Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way

Recommendation		**Priority**
8	Efforts should be made at the next review of the Board Assurance Framework to populate the incomplete sections of the Leading Sustainable Culture Change risk, particularly the 'gaps in controls' and 'gaps in assurances' sections.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
8	This is being addressed and will be updated by November 2022.	November 2022	Assistant Director of OD, Culture and Wellbeing.

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

Matter Arising 9: Health Intervention Team - Draft Action Plan (Design)	**Impact**
The Health Intervention Team have developed an Action Plan from findings outlined in their November 2021 report. We reviewed the Plan and found it aligned to the People and Culture Plan. We note that the status of the Plan is draft, and we make the following observations in the spirit of enhancing the plan prior to finalisation: • Some actions had already been completed; these are contained in a separate spreadsheet tab. However, the information contained in the progress column was often limited, and it was difficult to understand how the actions had been achieved; • The Plan includes a 'Lead and Timeframe' column. Whilst leads were mostly established, timeframes were rarely specified, and so we were unable to ascertain if an action was on-track to meet anticipated timeframes; and • A 'Measurement' column is included to outline how the Health Intervention Team will determine when an action has been achieved. We found that a number of these sections were either blank or lacked clarity in content, and so it is difficult to determine when an action has been achieved.	Potential risk of: • BAF Risk: Sustainable Culture Change – the cultural change required will not be implemented in a sustainable way

Recommendation		**Priority**
9	In advance of finalising the Health Intervention Team's Action Plan, the following enhancements should be considered: • To include an additional column to the 'completed actions' tab, which should outline how and when an action was achieved; • To separate the 'lead and timeframe' column for clarity; • A RAG rating should be used where appropriate; and • To review the information currently outlined in the 'measurement' column to ensure it is quantifiable.	**Low**

Agreed Management Action		Target Date	Responsible Officer
9	This is currently in development and work is being completed to ensure alignment with the P&C Plan and the developing Wellbeing Strategy and Framework. It is noted that some actions will fall out of the remit of the Health Intervention Team and will be passed to the relevant Clinical Board for implementation and monitoring.	January 2023	Assistant Director of OD, Wellbeing and Culture

Continued over page.

Matter Arising 10: Board Assurance Framework: Staff Wellbeing Risk (Occupational Health) (Operation)	**Impact**
Occupational Health referral times have exceeded the Health Board's target of 20 days during 2021-22. At the time of our audit fieldwork, wait times averaged between 4-5 weeks, as noted on the Health Board's website. We understand increased referrals are associated with the pandemic, but note the current average has reduced from 8 weeks earlier in the year. We acknowledge efforts have been made to tackle this issue and wait times have improved somewhat since early 2022. However, wait times are still over target, which may have a negative impact on the wellbeing of staff who attempt to access the service. We note there are currently no actions relating to this captured in the 'Board Assurance Framework: Staff Wellbeing risk' (May 2022).	Potential risk of: • BAF risk: Staff Wellbeing - staff sickness will increase and staff wellbeing will decrease due to the psychological and physical impact of the ongoing pandemic. Which together with limited time to reflect and recover will increase the risk of burnout in staff

Recommendation		**Priority**
10	The 'Board Assurance Framework Risk: Staff Wellbeing', should be reviewed to ensure key actions being taken to address the Occupational Health referral wait times are included. Where gaps in controls and assurances are identified these should be considered too.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
10	Development is underway to ensure the KPIs of the People Health Services Team, which includes Occupational Health, Physiotherapy, and Employee Wellbeing Services are reported upon monthly as part of the wider reporting within People and Culture. This will be added onto the Board Assurance Framework. It is important to note that the issue is exacerbated by absence within the team due to sickness absence, and the relevant support is being provided to staff to enable timely return to work, including phased return etc.	January 2023	Assistant Director of OD, Wellbeing and Culture Head of Occupational Health for CAV and CTM

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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Implementation of National IT Systems (WNCR)

Final Internal Audit Report

October 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:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Aron White, Nurse Informatics Lead
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

To evaluate and determine the adequacy of the systems and controls in place within the Health Board for the implementation and use of national IT systems.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- There is no overall programme for uptake of national systems within the Health Board;
- There is no project plan for the roll out of WNCR across the Health Board; and
- There has been no baselining work to enable the Health Board to demonstrate the benefits of WNCR.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Programme in place	Reasonable
2	Plan for WNCR	Limited
3	Testing	Substantial
4	Readiness Assessment	Substantial
5	Lessons Learned	Substantial
6	Benefits	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	National Systems Plan	1	Operation	Medium
2	Project Governance	2	Operation	Medium
3	Project Plan	2	Operation	Medium
4	Benefits	6	Operation	Medium

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1. Introduction

1.1 The review of the processes in place for the implementation and use of nationally developed IT systems has been completed in line with the Cardiff and Vale University Health Board's 2022/23 Internal Audit Plan.

1.2 In addition to IT systems that are developed or procured by the Health Board, there are a number of systems that are developed or procured by Digital Health and Care Wales (DHCW). The Health Board takes these on via local implementations.

1.3 The review focused on the Welsh Nursing Care Record (WNCR) roll out.

1.4 The lead for the review is the Director of Digital and Health Intelligence.

1.5 The risks considered as part of this review are:

- The implementation projects do not meet deadlines; and
- The Health Board does not gain the anticipated benefits from the deployment of national systems.

2. Detailed Audit Findings

Objective 1: A programme is in place for the local implementation of national systems which is clear about timescales and anticipated resources.

2.1 The Cardiff and Vale UHB Digital Roadmap is defined according to the organisations strategic priorities, some of the component parts of the roadmap are national systems.

2.2 National systems are identified and moved into the digital plan via the strategic channel programme boards which have been established to oversee the implementation of the UHB Digital Strategy. The programme boards discuss the relevant systems and feed into the Digital Directorate ("Digital").

2.3 The Health Board is also establishing a "digital front door" process within the Digital Directorate. This will act as a request portal and enable Digital to fully evaluate the resource needs for requested digital projects.

2.4 Historically we note that DHCW have pushed national systems into client organisations when communication has sometimes been limited. For example, the Welsh Emergency Department System is in their plan for all organisations this year, Welsh Clinical Portal (WCP) updates and all single tenant installations.

2.5 Without appropriate communication with the Health Board there is a risk of causing resource issues as the Digital Directorate may not have planned for the national system and so will then need to find resource both for implementation and for ongoing maintenance.

2.6 We note that the processes for communication and synchronising work plans has now improved and processes have been established for communication of

workplans with DHCW, so now it feels more like "planning with" rather than "done to". The processes established include:

- Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work;
- Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence the DHCW plans; and
- Informal executive to executive meetings every 3 months.

2.7 However, at present there is no full 3-5 year plan for the implementation of national system with the identified expected resource needs from the Health Board. (Matter Arising 1)

Conclusion:

2.8 National systems are included within the digital roadmap for the Health Board. The organisation has historically had less control over the timing of these compared to its own sourced systems, however communications are improving, although we note that a formal plan and programme for national systems implementation is not yet in place. Accordingly, we have provided reasonable assurance for this objective.

Objective 2: An appropriately resourced plan for roll out of the WNCR is in place.

2.9 WNCR was originally piloted within the Health Board pre-covid, using different devices. Following that, the decision was made to utilise iPads and roll out wider within the organisation.

2.10 The original intent from the service lead was to commence roll out in May 2022, however the roll out has been subject to delays and the current status is that WNCR has just gone live within one ward in Barry. In addition, the current ward is only using laptops and not iPads as intended, this will necessitate further training once the iPad configuration is confirmed.

2.11 WNCR was set up as a project, led by the service lead (nursing). A risk register was established and project board meetings were held, however these weren't minuted. The project board stopped meeting in May 2021 and re-commenced at the end of June 2022. This is at the start of the implementation stage and so the business case stage and planning stages have not been subject to full project governance.

2.12 We note that the Implementation Board as now established is appropriate for the management of the project, with a formal Terms of Reference and good membership.

2.13 The previous lack of the programme/project governance structure has contributed to delays in the implementation of WNCR. The delays occurred due to a number of reasons, including the purchased devices not being configured, and the lack of a

secure Wi-Fi provision, both of which relate to resource constraints combined with a lack of clarity over the required resources from within Digital.

2.14 We note that the risks to the project have been raised with Digital and escalated to executive level, however as the project structure was not operating, there is no risk monitoring. In addition, the delays and risks have not been included within risk reporting to the Digital Health and Intelligence Committee (DHIC), despite the status of the project moving from green to amber in the October 2021 DHIC performance report. (Matter Arising 2)

2.15 As noted above, the current implementation is using laptops only due to the delays in configuring secure Wi-Fi and the iPads, this will impact on the success of the ward roll out and necessitate additional training in the future.

2.16 An outline schedule for the roll out of WNCR was done, however this could not be met as the timing was on the assumption that the devices are ready to be issued. As this was not the case the timing and scheduling will change. In particular we note that the service lead does not intend to roll out to acute wards over the winter period in order to minimise the risk to operational services.

2.17 There is no detailed plan for implementation within wards, although there is an awareness of the key stages of implementation at a ward level, and there is a technical plan developed by Digital for how to roll out within a ward which includes configuration of devices, Wi-Fi setup, account set up and Patient Management System (PMS) integration. However, without a formal project plan, the communication of scheduling and resource requirements is not clear to all stakeholders. (Matter Arising 3)

Conclusion:

2.18 The local implementation was not established as a formal project or program at the outset, with the project structure only recently having been defined. The implementation has been subject to delays which may have been exacerbated by the lack of a governance structure. There is no detailed plan for roll out which defines stages and resources, although we note that the general outline of this is understood. Accordingly, we have provided limited assurance over this objective.

Objective 3: Implementation plans for national systems ensure that appropriate testing is performed prior to roll out, including system capacity, and appropriate training on the use of the system is provided to users prior to roll out.

2.19 As WNCR is a national product, DHCW undertook a week of testing before releasing the 'live' version of WNCR to use throughout NHS Wales. As part of the DHCW release process the system was passed to Health Boards, including Cardiff & Vale for user testing which was undertaken. As such there is no requirement for further local testing within the Health Board.

2.20 We note that the system is designed to be easy to use, as it replicates forms that already exist in hard copy within an electronic environment. However, training is part of the roll out process to ensure staff know how to use the system.

2.21 Training is delivered on site and as part of the roll out to Sam Davies ward there was a detailed training plan identifying who would be trained on a daily basis, and a training prompt sheet was in place.

2.22 User guides are in place and available to staff to access for reference, these set out the key stages in the use of the system.

2.23 A support model for WNCR is in place to ensure that any issues raised by staff are dealt with and this support is enhanced for 2 weeks after go live to reflect the potential for issues created by staff new to the system.

Conclusion:

2.24 Testing has been undertaken on the system on a national basis prior to release to the Health Board. Training is considered as part of the roll out to individual wards, and user guides are in place, together with a support model. Accordingly, we have provided substantial assurance over this objective.

Objective 4: An assessment of readiness for roll out is undertaken for national systems prior to go live.

2.25 A readiness checklist has been developed. This includes the responsible officers for each of the checks. It covers staff training and access, equipment provision, continuity arrangements and support arrangements.

2.26 We note that as the only ward to go live was Sam Davies the readiness assessment was not fully completed. As the project team was focused on that one ward the situational knowledge was complete and so the check not needed. Going forward we note that there would be a requirement to ensure that the readiness assessment is completed for each ward prior to a formal stop/go decisions. This should be included within the project plan recommended in matter arising 2.

Conclusion:

2.27 A readiness checklist has been developed for use on a ward by ward basis for rollout. Accordingly, we have provided substantial assurance over this objective.

Objective 5: Issues identified as part of the deployment in other organisations are shared and lessons learned to prevent the same issues arising within the Health Board.

2.28 The service lead has been in contact with other organisations who have implemented WNCR, and with DHCW in order to learn lessons from previous implementations and avoid pitfalls which have impacted elsewhere.

2.29 This learning process resulted in the business case being restated to include the use of iPads instead of laptops to ensure that the system provided the most benefits.

2.30 We also note that there is a dedicated Teams channel for WNCR in NHS Wales which enables staff across Wales to share knowledge and hints for implementation and use of the system. In addition, we note that the service lead is also part of a Whatsapp group for WNCR and he noted that there is a lot of info sharing within that forum.

2.31 The national pilot evaluation of WNCR had some lessons noted which should feed into further implementations. Our discussions with key staff within the Health Board confirmed that these lessons have been taken into consideration as part of the Cardiff and Vale WNCR implementation and include ensuring ward readiness in terms of staff access and communication of business continuity arrangements.

Conclusion:

2.32 The service lead has been active in the NHS Wales community and actively sought out lessons and information on WNCR implementation, and these, together with the lessons identified from the national pilot have been factored into the Health Board implementation. Accordingly, we have provided substantial assurance over this objective.

Objective 6: The benefits of national systems in relation to the Health Board are clearly defined and a mechanism is in place for ensuring realisation of these and use of the system.

2.33 Benefits are included in the business case for the implementation of WNCR within the Health Board. These include the benefits identified as part of the pilot, and are stated as:

- reduction in printing costs;
- 27% improvement in the completion in the documentation of a patients care domains during admission;
- 100% legibility of documents including date and time stamped;
- 35% improvement in documenting patients preferred language; and
- 39% improvement in documenting patients cultural and spiritual needs.

2.34 The business case further notes that the full anticipated benefits are in the benefits roadmap, and these are listed as:

- reduction of time completing documentation;
- decreased duplication of processes;
- improved document quality / legibility;
- decreased printing cost;

- increased number of completed documentation;
- decreased transcribing errors;
- improved identification of priority patients;
- improved communications between health professionals; and
- improved audit trail and business intelligence.

2.35 The benefits described are a combination of qualitive and quantitative benefits and we note that some are longer term benefits and not immediate.

2.36 There has been some work on establishing a baseline position from which to measure the benefits of the system. A documentation audit has been undertaken within the Barry ward, and the intent is to replicate within each ward as part of the roll out and the costs of printing are also identifiable to a ward level.

2.37 However, at present there is no benefits register established and no benefits realisation process formally defined within the project which would allow the Health Board to demonstrate the value of the system in the future. (Matter Arising 4)

Conclusion:

2.38 Benefits are included within the business case, however there is no quantification of these, and as yet there has been no baselining work undertaken. Accordingly, we have provided reasonable assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: National Systems Plan (Operation)	**Impact**
At present there is no full 3-5 year plan for the implementation of national systems with the identified expected resource needs from the Health Board.	Potential risk of: • The implementation projects do not meet deadlines. • The Health Board does not gain the anticipated benefits from the deployment of national systems.

Recommendations		**Priority**
1.1	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue: The process established includes: • Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work;	Dec 2022	Director of Digital & Health Intelligence

Mohamed.Sarah 03/11/2022 16:33:19

	• Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; • Informal executive to executive meetings planned for every 3 months		

Matter Arising 2: Project Governance (Operation)	**Impact**
WNCR was set up as a project, led by the service lead (nursing). A risk register was established and project board meetings were held, however these weren't minuted. The project board stopped meeting in May 2021 and re-commenced at the end of June 2022. This is at the start of the implementation stage and so the business case stage and planning stages have not been subject to full project governance. The gap in the programme/project governance structure has contributed to delays in the implementation of WNCR. The delays occurred due to a number of reasons, including the purchased devices not being configured, and the lack of a secure Wi-Fi provision, both of which relate to resource constraints combined with a lack of clarity over the required resources from within digital. We note that the risks to the project have been raised with digital, however as there has been no project structure, there is no risk monitoring. In addition, the delays and risks have not been included within risk reporting to DHIC, despite the status of the project moving from green to amber in the October 2021 DHIC performance report.	Potential risk of: • The implementation projects do not meet deadlines. • The Health Board does not gain the anticipated benefits from the deployment of national systems.

Recommendations		**Priority**
2.1	All digital projects should be subject to a formal governance structure.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	A formal project governance structure has been put in place including risk monitoring for the whole of the programme including digital. Formal monitoring will be provided via the WNCR Board meetings and any digital risks arising will be reported upwards to exec director level and, if necessary, to the Senior Leadership Board (formerly HSMB). Regular updates will also be submitted to the Digital & Health Intelligence committee.	October 2022	Nurse Informatics Lead / IT Programme Manager

Matter Arising 3: Project Plan (Operation)			**Impact**
There is no detailed plan for implementation of WNCR within wards, although there is an awareness of the key stages of implementation at a ward level, and there is a technical plan developed by digital for how to roll out within a ward which includes configuration of devices, Wi-Fi setup, account set up and PMS integration. However, without a formal project plan, the communication of scheduling and resource requirements is not clear to all stakeholders.			Potential risk of: • The implementation projects do not meet deadlines. • The Health Board does not gain the anticipated benefits from the deployment of national systems.
Recommendations			**Priority**
3.1a	A project plan should be developed that shows the scheduling of wards, and the processes required to implement within wards, along with the timescales and resource requirements.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	There are two components to this recommendation: **1. Development of an implementation schedule** A provision roll-out schedule was devised in March 2022. This schedule indicated the data for implementation and equipment required on each ward. However, further WNCR implementation is unlikely to progress in the UHB until April 2023. This pause is necessitated to accommodate the launch of another digital platform Safecare. The UHB will also enter its ePMA implementation phase in April 2023. **Actions:** - Revise the WNCR roll out schedule in response to the Safecare and ePMA schedule (in to prevent wards having to adopt more than one digital platform at a time).	1. Dec 2022 2. Dec 2022	Nurse Informatics Lead

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	- Include within this schedule: • Number of colleagues to train • Quantity/type of equipment to deliver • Training times • Post 'go live' support times **2. Development of process required to implement** Following the pilot of WNCR to three wards, the project team is now able to develop a detailed process that includes: - Device configuration - User account and email set up - Active Directory maintenance - Business continuity configuration on designated PCs - Training guides - Trouble shooting guides - Out of hours support - Provision of supplementary booklets - Additional equipment requirements - PMS integration The project team members responsible for each component will be identified within the project plan		

Matter Arising 4: Benefits (Operation)			**Impact**
Benefits are included within the business case and some baselining work has been undertaken, however, at present there is no benefits register as part of the benefits realisation process.			Potential risk of: • The implementation projects do not meet deadlines. • The Health Board does not gain the anticipated benefits from the deployment of national systems.
Recommendations			**Priority**
4.1	The baseline assessment should be fed into a benefits register, and a benefits assessment and realisation process should be included within the project plan.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	A benefits register will be developed to record: - Digital skills of nursing workforce - Comparison of documentation completion rates before/after WNCR implementation - Use of WNCR analytics to inform improvement work - Staff feedback - Patient feedback (undertaken by patient experience team) - Cost savings (based on removal of paper documents) - Time savings	Development of benefits register Dec 2022 - Complete Assessment of benefits by Aug 2023 (or following completion of implementation)	Nurse Informatics Lead

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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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Digital Strategy
Final Internal Audit Report

October 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:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Angela Parratt, Director of Digital Transformation
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

To ensure that the refreshed Digital Strategy meets the needs of the UHB and there is a roadmap for delivery.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The roadmap should be enhanced with greater detail;
- The resources for completion of the roadmap should be fully defined;
- The level of funding allocated to Digital should be reviewed to ensure that the organisational strategies and transformation can be realised;
- Attendance from Clinical Boards should be sought at DHIC; and
- The Programme Channel Boards should be re-invigorated.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Appropriateness of Strategy	Substantial
2	Roadmap	Reasonable
3	Resources	Reasonable
4	Governance	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Roadmap Detail	2	Operation	Medium
2	Resources	3	Operation	Medium
3	Funding	3	Operation	Medium
4	DHIC	4	Operation	Medium
5	Channel Boards	4	Operation	Medium

1. Introduction

1.1 The review of the Digital Strategy and roadmap has been completed in line with the Cardiff and Vale University Health Board's 2022/23 Internal Audit Plan.

1.2 The Health Board has a Digital Strategy in place, and this has recently been reviewed to ensure that it is still current and meets the overall Health Board Strategy.

1.3 The Digital Strategy is underpinned by a roadmap for delivery which identifies the key component work streams which have been prioritised, alongside target implementation dates.

1.4 The lead for the review is the Director of Digital and Health Intelligence.

1.5 The risk considered as part of this review is:

- The Digital Strategy does not fully provide the required digital systems to enable the Health Board to deliver its strategic aims.

2. Detailed Audit Findings

Objective 1: The Digital Strategy is appropriate for the needs and objectives of the organisation and its organisational strategy.

2.1 The original Digital Strategy was published in 2020. From our review of the Strategy, we note that it is still valid and appropriate, with a focus on user centred design.

2.2 The Digital Strategy has been subject to a refresh. This process has utilised the services of an external consultancy and the remit of the refresh was to focus on the digital foundations for the future and specifically those that support the delivery of the Shaping Our Future Hospitals Programme and clinical model.

2.3 The refresh also included testing the assumptions relating to funding and coincided with a review of the Digital and Health Intelligence Directorate to ensure it is fit for purpose and adequately resourced.

2.4 The Digital Strategy refresh also notes the impact of Covid-19 on delivery of the Strategy and the timing of key strategic items and links to the updated organisational Integrated Medium Term Plan (IMTP) 2022/25.

2.5 The updated IMTP references the Digital Strategy links to it. Accordingly, the Digital Strategy supports the organisational objectives and updated IMTP together with the organisational transformation agenda.

Conclusion:

2.6 The Digital Strategy has been kept up to date and subject to a recent refresh. It is appropriate and matches the needs and objectives of the organisation and the transformation agenda. Accordingly, we have provided substantial assurance for this objective.

Objective 2: An appropriate process is in place for defining the roadmap for delivery of the Digital Strategy, identifying the key component work streams and ensuring the appropriate prioritisation of these.

2.7 The Digital Roadmap has been defined, and is made up out of solutions that meet the requirements of the Digital Strategy. The Roadmap was developed by the senior (Digital) team and scheduled through discussions within the team.

2.8 The update provided to the Digital and Health Intelligence Committee on October 2021 in relation to the development of the Roadmap noted that the intent is to improve against the Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model (EMRAM). As such components have been identified to enable the Health Board to move towards that.

2.9 The updated IMTP contains a section on digital and digital transformation, it also contains the digital priorities, which match those within the Roadmap, with timings of the components being consistent.

2.10 Solutions that meet the requirements of the Digital Strategy can be identified through a variety of means, and we note that the Digital Directorate is establishing a "digital front door" to enable greater visibility and coordination. Stakeholders such as clinicians have the ability to raise potential components via the Channel Programme Boards which were established to manage the strategic workstreams within the Digital Strategy, and the Chief Clinical Information Officer (CCIO) asks for input.

2.11 The Roadmap was presented to the Channel Programme Boards, although we note that there was limited discussion or ability to feed into the prioritisation or scheduling of the components.

2.12 We note that it can be difficult for the Digital Directorate to know what clinicians want, and that the Clinician Channel Programme is a forum for enabling this communication. As management throughout the organisation are better placed for highlighting their requirements, we note that the Clinician Channel should be further embedded to ensure that clinical voices are heard and feed into prioritisation.

2.13 The current roadmap is a basic one which shows the component projects and outline timings by years. There is no detail over key activities, resourcing, milestones and no information on key underlying themes such as people, processes and technology. We note that the IMTP contains some more detail, however the roadmap as provides states that it is to be supported by a funded plan, and this is missing. (Matter Arising 1)

Conclusion:

2.14 There is a process in place for defining the Roadmap for delivery of the digital strategy, this includes identifying the key component work streams, and is linked to an accepted framework for improving digital use within healthcare. The scheduling and prioritisation is currently led by the Digital Directorate, although we note the structures in place to improve stakeholder feed in. At present the

Roadmap contains component projects organised within years, and there is no detail such as key activities and milestones. Accordingly, we have provided reasonable assurance over this objective.

Objective 3: The required resources for delivery of the roadmap have been identified and mechanisms are in place to ensure these are in place.

2.15 There has been work to identify the resources required for delivering the Digital Strategy, with the resources for some of the components known. The Digital Directorate has produced a 10 year capital plan as per Welsh Government request so there is an outline / estimate of the funding requirements.

2.16 However the Target Operating Model (TOM) is not yet fully defined and in many cases the detail of the required resources for the components within the Roadmap is not known and mapped to the current resource within the Health Board. (Matter Arising 2)

2.17 The overall spend on digital within the Health Board is hard to clarify due to the level of autonomy and spend within Clinical Boards, however the funding is approximately:

- £8m in Digital;
- £7m in Clinical Boards;
- £2m Digital Priorities Investment Fund (DPIF); and
- £1m Capital.

2.18 This equates to approximately £20m which represents 1.7% of turnover, and we note that recommended spend on digital technologies would be 4%.

2.19 Funding for Digital is subject to structural weaknesses due to a combination of underfunding and reliance on end of year funding which makes it hard for the Directorate to plan effectively.

2.20 The reliance on end of year funding results in expenditure on older, more established technology and so locks in a technical deficit, and the requirement for seeking funding on a case by case basis results in a risk to delivery of the Roadmap. (Matter Arising 3)

2.21 The IMTP refers to the value of digital in the Health Board in a number of places:

- ".. digital 5 year plan...is a critical agent for change";
- In terms of bridging the gap between recovery and transformation it notes that "will be highly contingent ...on digital enabling activities";
- Clearly states that "Shaping our Future Wellbeing strategy is utterly dependent upon digital, data and technology to deliver the needs and wants of its communities and the people of Wales "; and
- "Recognising the criticality of digital as an enabler for the UHB to meet its aspirations, our Board approved a Digital Strategy for the organisation in September 2020. ".

2.22 The IMTP also notes that the scale of investment is challenging, and lists out the priorities for digital, with an indication of where funding is missing for strategy components. We note that some of the unfunded projects are ranked as priority 1 e.g. Electronic Patient Record (EPR), shared records and the signals from noise work.

2.23 Accordingly, the level of funding provided for Digital does not support the assertions in the IMTP regarding the value of digital with the impact being that underfunding of Digital will delay or prevent organisational transformation.

2.24 The risk associated with the funding in relation to the delivery of the Digital Strategy is included within the risk register that is provided to DHIC, with actions defined to try and manage this.

2.25 The funding picture for Digital is subject to ongoing change and discussions are continually ongoing with Finance in order to enable the funding provision for the next 2-3 years.

2.26 The Digital Directorate has also recently been successful in a number of business cases for increased resource such as within IT Support, Cyber Security and Office 365. Although we note these were for delivery of business as usual and support for the increased digital estate and not resourcing for new, transformational digital items.

Conclusion:

2.27 The resources required for full delivery of the Digital Roadmap are not known, with the target operating model not fully defined. The near-term items are defined however and work is continually ongoing. There is a funding gap for delivery of the Digital Strategy, although Digital is stated as a priority for the organisation and some increased funding has been provided. The risk to the organisation and its Strategy in relation to digital funding has been defined. Accordingly, we have provided reasonable assurance for this objective.

Objective 4: Appropriate governance arrangements are in place for monitoring and reporting the development and delivery of the roadmap.

2.28 There is a well defined governance and reporting structure for overseeing the delivery of the Digital Strategy. The formal governing committee is the Digital and Health Intelligence Committee (DHIC). The terms of reference of which explicitly state that responsibility for ensuring a Digital Strategy is defined and implemented rests within the Committee.

2.29 We do note however, that the representation from Clinical Boards at DHIC is poor, with limited attendance. As the Clinical Boards have a large amount of autonomy and ability to pursue their own digital projects the UHB Committee may be missing the holistic picture of digital within the Health Board. (Matter Arising 4)

2.30 The Digital Strategy Roadmap is included as regular updates to DHIC and Board, especially as changes occur, and the reporting process discusses the impact of funding shortfalls.

2.31 Underneath this lies the Digital Services Management Board (DSMB) which is the managing group and decision making body. The terms of reference make clear that representatives from Clinical Boards are included and that the group is to direct, prioritise and oversee the digital workplan and also to resolve resource conflicts. We note however that the meetings of the DSMB have dropped off with no recent meeting.

2.32 The strategic workstreams are managed within the Channel Programme Boards, however the meetings of these have also dropped off. We also note that although the Channel receives updates on projects, there is no formal, structured update report that covers all the relevant projects. (Matter Arising 5)

2.33 The risk to delivery of the Digital Strategy related to funding is included within the risk register and is regularly monitored by DHIC and updated. The reporting on the roadmap and progress against digital transformation also notes funding constraints, and explicitly shows those programmes where funding is incomplete.

Conclusion:

2.34 The governance arrangements for overseeing the development and delivery of the Digital Strategy are clearly stated and established. We note that the frequency of meetings has dropped off however, and representation and feed in from Clinical Boards at the Committee level is not complete. Accordingly, we have provided reasonable assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Roadmap Detail (Operation)			**Impact**
The current roadmap is a basic one which shows the component projects and outline timings by years. There is no detail over key activities, resourcing, milestones and no information on key underlying themes such as people, processes and technology.			Potential risk of: • The Digital Strategy does not fully provide the required digital systems to enable the Health Board to deliver its strategic aims.
Recommendations			**Priority**
1.1	The roadmap should be further developed so that it defines a full plan towards digital transformation. Additional information should be built into the roadmap such as: • key activities; • resourcing; • milestones; and • links to recognised themes such as peoples, processes and technology.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The roadmap will continue to develop and evolve with those key elements around activities, required resources and milestones set out. We will align to the themes of People, Processes and Technology however, the resources and senior management capacity will dictate the speed and pace of delivery. This is a significant amount of work and corelates directly with 2.1.	Q1 2023/24	Angela Parratt – Director of Digital Transformation

Matter Arising 2: Resources (Operation)	**Impact**
The TOM is not fully defined yet, with work on this being in progress. The Digital directorate has produced a 10 year capital plan which provides an outline / estimate of the funding requirements for delivering the Strategic Roadmap, however in many cases the resources required for components within the Roadmap are not fully identified.	Potential risk of: • The Digital Strategy does not fully provide the required digital systems to enable the Health Board to deliver its strategic aims.

Recommendations		**Priority**
2.1	The resources required to deliver each component within the roadmap should be defined to enable the Digital Directorate to map to available resources, identify gaps and enable planning.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	A TOM will be produced following the Enterprise Architecture (EA) review (first stage) which is in progress. Further work and subsequent iteration of the EA will build on strategic documents business cases, the "Case for Investment" and Roadmap documentation. This will also include a high level cut of what is needed to support the SOFs programme as it iterates through its own blueprint and TOM development. These outputs will help populate a mid-term (5 to 10 year) view of the resource plan to support the TOM and subsequent updated roadmap. Delivery plans will be dependent upon investment decisions, Resources and senior management capacity will dictate the speed and pace of delivery.	Q1 2023/24	Angela Parratt

Matter Arising 3: Funding (Operation)	**Impact**
The level of funding for Digital within the Health Board does not support the assertions in the IMTP regarding the value of Digital. Currently the funding equates to approximately 1.7% of the Health Boards turnover, compared to a recommended 4%. Without appropriate funding for Digital the organisational strategies and transformation may not be completely realised.	Potential risk of: • The Digital Strategy does not fully provide the required digital systems to enable the Health Board to deliver its strategic aims.

Recommendations		**Priority**
3.1	The Health Board should review the level of funding allocated to Digital to ensure that the organisational strategies and transformation can be realised.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The deliverables in 2.1 will enable the organisation to consider its options on how to achieve the necessary investment in Digital against a strategic investment plan. This investment will be for the transformation required to take the organisation to its New State.	Q1 2023/2024	Angela Parratt
	3.1 refers to funding the day to day business of supporting the organisation with some limited capacity to support change. Discussions are taking place with the Director of Finance on an ongoing basis re: support to fund Digital for business as usual however this requires additionality which is challenging in the current economic climate. Resourcing Digital is on the corporate risk register and will continue to be reviewed there and progress reported at DHIC.	Ongoing	David Thomas

Matter Arising 4: DHIC (Operation)			**Impact**
The representation from Clinical Boards at DHIC is poor with limited attendance. As the Clinical Boards have a large amount of autonomy and ability to pursue their own digital projects the UHB Committee may be missing the holistic picture of digital within the Health Board.			Potential risk of: • The Digital Strategy does not fully provide the required digital systems to enable the Health Board to deliver its strategic aims.
Recommendations			**Priority**
4.1	The UHB should consider increased representation from Clinical Boards on DHIC.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	DHIC membership will be reviewed in light of the changes to the ME and CB governance model whereby a new Senior Leadership Board has been established. Wider representation from the SLB will be sought for DHIC committee membership (pending discussion with committee chair)	Q1 2023/24	David Thomas

Matter Arising 5: Channel Programme Boards (Operation)	**Impact**
The operation of the Channel Programme Boards has dropped off with meetings having had large gaps. The Clinician Channel receives updates on ongoing projects but not within a formal update position paper. In addition, the Clinician Channel was not involved in the setting of priorities and scheduling for the components of the Roadmap. This may mean that some of the priorities may not suit the clinical workforce.	Potential risk of: • The Digital Strategy does not fully provide the required digital systems to enable the Health Board to deliver its strategic aims.

Recommendations		**Priority**
5.1	The operation of the Channel Programme Boards should be re-invigorated with regular meetings scheduled. The agenda for these should include an update position for the relevant strategy components. The purpose of the groups should be restated to enable clinicians and other stakeholders to have a greater say in the identification, prioritisation and scheduling of pertinent Digital items.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Governance arrangements were discussed at DSMB October 2022. Channel Boards were established when there was no space for digital conversations with the business providers of the UHB and have worked well to date. The DSMB Chair is leading the review with the CCIO and Directors in Digital to establish a revised governance model that can support digital with *identification, prioritisation and scheduling of pertinent Digital items*. Operational pressures in the UHB will though continue to potentially have an impact on attendance.	Q4 2022/23	David Thomas Angela Parratt

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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Medical Equipment and Devices
Final Internal Audit Report

October 2022

Cardiff & Vale University Health Board

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Executive sign-off:	Fiona Jenkins, Executive Director for Therapies and Health Science
Distribution:	Paul Rogers, Interim Assistant Director of Therapies Edward Chapman, Head of Clinical Engineering
Committee:	Audit & Assurance Committee

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

Executive Summary

Purpose

The overall objective of this audit was to review the arrangements in place for recording, monitoring and replacing medical equipment and devices.

Overview

We have issued reasonable assurance on this area.

The Health Board has an up to date policy and procedure in place, with effective processes for the purchase and maintenance of Medical Equipment and Devices. Risk assessments are being undertaken on new items and actions are taken following reported incidents.

We make a number of medium priority recommendations within our review which relate to:

- The increased awareness and dissemination of the updated Medical Equipment Policy and Procedure;
- Formal approval of the Policy by Quality, Safety and Experience Committee;
- The accuracy of location and presence of loaned and substantive medical equipment as stated within the Medusa database;
- Absence of medical equipment contamination documentation; and
- Available evidence to support training undertaken of equipment prior to first use.

A further low priority recommendation which is best practice in nature is captured within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policy and Procedures	Reasonable
2	Procurement and Contract Monitoring	Substantial
3	Inventory and Records Management	Reasonable
4	Operational Arrangements	Reasonable
5	Risks and Incidents	Substantial
6	Training	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Awareness of the revised Policy and Procedure	1	Operation	Medium
2	Quality, Safety & Experience Committee approval of the revised Policy (UHB 082 v.5)	1	Operation	Medium
4	Medusa Medical Equipment Database: Accuracy of Equipment Location	3	Operation	Medium
5	Management of Loaned Medical Equipment	3	Operation	Medium
6	Completion and submission of contamination status clearance certificates	4	Control Design	Medium
7	Evidence of training in use of medical equipment prior to first use	6	Control Design	Medium

1. Introduction

1.1 The review of Medical Equipment and Devices was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the Health Board). The audit was initially included within the 2021/22 Audit Plan and was deferred to 2022/23 due to operational pressures.

1.2 The term 'medical equipment or device' includes all products, excluding medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. The range of products is wide and includes dressings, tubing, syringes, infusion pumps, heart valves, surgical instruments, resuscitators, radiotherapy machines, wheelchairs, walking frames or other assistive technology products.

1.3 A systematic approach to the acquisition, deployment, maintenance, repair and disposal of medical devices aligned with appropriate staff training and quality assurance arrangements will ensure that the use of medical devices is done safely, competently and effectively for the best care of patients and complies with all relevant legislation and guidance.

1.4 We note that a 'Review of Medical Equipment: Update on Progress – Cardiff and Vale University Health Board' was issued by Audit Wales in June 2018. The key findings of the review concluded, *"Our overall conclusion is the Health Board has made progress in addressing recommendations made in our 2013 report, but more action is needed to improve the existing arrangements in place for managing medical equipment."*[1]

1.5 The basis of our review was informed by sampling and testing undertaken within the following areas:

- Critical Care Unit, University Hospital Wales; and
- Emergency Unit, University Hospital Wales.

1.6 The Executive Director for Therapies and Health Science is the executive lead for the review.

Audit Risks

1.7 The potential risks considered in this review include:

- Responsibilities and processes described in the policies and procedures are not adhered to resulting in harm and possible death; and
- Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

[1] https://www.audit.wales/publication/cardiff-and-vale-university-health-board-review-medical-equipment-update-progress-0

2. Detailed Audit Findings

Objective 1: Policy and Procedures

- The Health Board has appropriate policies and procedures in place for the management of Medical Equipment and Devices, which are reviewed and maintained by the Medical Equipment Group. Staff are made aware of their responsibilities or any revisions to responsibilities following a review.

2.1 The Health Board's 'Medical Equipment Management Policy' (UHB 082 v.5)[2] and 'Management of Medical Equipment Procedure' (UHB 082 v.5)[3] dated March 2022 are published on the Health Board's website.

2.2 The Medical Equipment Group led the review of the current iteration of the Policy and Procedure, but we were unable to obtain evidence that the revised changes had been communicated to relevant staff. In accordance with their Terms of Reference, it is the responsibility of the Medical Equipment Group to promote the Policy. *(Matter Arising 1 – Medium Priority)*

2.3 Whilst both the revised Medical Equipment Management Policy and Management of Medical Equipment Procedure have been published on the Health Board website, there is no evidence that the Policy has been approved by the Quality, Safety and Experience Committee prior to publication. Further, the current version of the Policy and Procedure refers to version four and five, which should be corrected to version five. *(Matter Arising 2 – Medium Priority)*

Conclusion 1: Whilst it is acknowledged that both the Medical Equipment Management Policy and Management of Medical Equipment Procedure are current, the Policy had not followed the required approval process but had been published on the Health Board's website. We were also unable to evidence the efforts of the Medical Equipment Group to promote the revised changes to relevant staff groups. (Reasonable Assurance)

Objective 2: Procurement and Contract Monitoring

- The Health Board has a recommended list of medical equipment and devices in place that staff are able to order from. Orders placed should be in accordance with existing procurement guidance; and
- For medical devices provided by a third party there is a clear process for contract monitoring.

2.4 We tested a sample of medical equipment items that were purchased between April 2021 and June 2022, greater than £5,000 in value, for use within the Emergency Unit and Critical Care Unit. The purpose of our testing was to ascertain compliance with the Health Board's Standing Financial Instructions relating to procurement thresholds, we found that all the sampled purchases were compliant.

[2] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/m-patient-safety/medical-equipment-management-policy-march-2022-docx/

[3] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/m-patient-safety/medical-equipment-management-procedure-march-2022-n-docx/

2.5 The Clinical Engineering Department holds a 'standardised and recommended equipment catalogue'[4] for use by clinical departments on its SharePoint site, which is subject to regular review and update. However, management and/or technical staff at the Emergency Unit and Critical Care Unit were not aware of its existence. *(Matter Arising 3 – Low Priority)*

2.6 We undertook further testing of the sample of medical equipment items purchased between April 2021 and June 2022 to ascertain whether they were subject to ongoing maintenance and contract monitoring. Evidence provided by the Clinical Engineering Department confirmed that there is a comprehensive process in place to support delivery of the maintenance contracts in place, and systems are in place that include escalation and resolution of any issues that may arise in the event of poor maintenance contract performance.

Conclusion 2: Our testing of procurement and contract monitoring highlighted no significant issues, we are satisfied that Health Board procurement guidance is being followed. The monitoring of maintenance contacts was found to be an established and embedded process. As a point of best practice we would encourage the wider promotion of the Clinical Engineering 'standardised and recommended equipment catalogue'. (Substantial Assurance)

Objective 3: Inventory and Records Management

- There is a medical equipment inventory database (other than in relation to ALAS) that accurately records the purchase and disposal of medical equipment and devices, with all equipment being disposed of appropriately;
- The inventory database is kept up to date, ensuring any transfers or movement of equipment is captured; and
- Appropriate records are maintained for medical equipment devices that are loaned out by the Health Board.

2.7 The Clinical Engineering Department maintains a live medical equipment inventory database called Medusa that records the purchases made and disposals undertaken of medical equipment and devices in use across the Health Board. For our sampled areas we found that no items had been recorded on the database as having been disposed of in the last 12 months. We undertook a wider review of the disposal process beyond our sampled areas and found that equipment had been disposed of appropriately and documented in accordance with the stated requirements of the Health Board's Management of Medical Equipment Procedure.

2.8 To test the accuracy of equipment recorded within the Medusa medical equipment database, a sample of items recorded on the database as being within the Emergency Unit and Critical Care Unit were inspected 'in-situ' to confirm this was the case. A small number of items within the Critical Care Unit could not be located,

[4] https://nhswales365.sharepoint.com/:x:/r/sites/CAV_Clinical%20Engineering/Shared%20Documents/catalogue.xlsx?d=wa576bade59a34e18b1c4acba559a94a8&csf=1&web=1&e=kEK5Ey

but the reasons for this were ascertained and related to the age/obsolescence of these items. *(Matter Arising 4 – Medium Priority)*

2.9 A further review of the Medusa database identified that there were no loaned equipment items within the Emergency Medicine Directorate, and this was confirmed by Directorate Management staff. However, two externally loaned items recorded as being within Critical Care Unit were not supported by documentation to substantiate any agreement terms. *(Matter Arising 5 – Medium Priority)*

Conclusion 3: The Medusa medical equipment inventory database provides a mechanism for collectively capturing medical equipment. There are further opportunities to enhance the database and the accuracy of items listed by undertaking periodic reviews of equipment within directorates, including items on loan. The Management of Medical Equipment Procedure provides limited information on the arrangements for externally loaned equipment, and this should be considered at the next review of the Procedure. (Reasonable Assurance)

Objective 4: Operational Arrangements

- Medical equipment and devices are cleaned and maintained and kept in an appropriate state of repair;
- Medical equipment and devices are suitably decontaminated after each patient use; and
- Medical equipment and devices are stored in a safe and secure location when not in use.

2.10 A review of medical equipment items awaiting use at both the Emergency Unit and the Critical Care Unit confirmed that all had been cleaned and were labelled and signed off as such.

2.11 Testing was undertaken to ensure that local decontamination certificates (within carbon copy books) were completed prior to medical equipment being submitted to the Clinical Engineering department for repair or maintenance. The carbon copy books were available in Critical Care, but we could not locate these within the Emergency Unit. The process relating to the use of local decontamination certificates is not currently stated within the Management of Medical Equipment Procedure. *(Matter Arising 6 – Medium Priority)*

2.12 We observed that medical equipment items awaiting use at both the Emergency Unit and the Critical Care Unit were held in specific storerooms.

Conclusion 4: We were able to evidence the clean state of equipment and the safe storage of equipment when not in use. Clinical departments should retain their carbon copy decontamination books to provide an accurate record evidencing the cleanliness of medical equipment items sent to Clinical Engineering. The Management of Medical Equipment Procedure should be updated to formalise this practice. (Reasonable Assurance)

Objective 5: Risks and Incidents

- Risk assessments are completed on devices and equipment which may pose a significant risk to patients or staff; and
- All incidents, defects and faults relating to medical equipment and devices are recorded on Datix.

2.13 Testing undertaken relating to both the Emergency Unit and Critical Care Unit confirmed that acceptance test safety checks (risk assessments) were completed and formally documented prior to first use of newly purchased medical equipment/devices in their clinical settings, in accordance with the requirements of the Management of Medical Equipment Procedure.

2.14 We sought to identify whether the Clinical Engineering Department have visibility and awareness of any incidences reported on the Datix Reporting system relating to faulty and/or defective medical equipment. The Directorate Management leads for the Critical Care Unit and the Emergency Unit, and the Clinical Engineering Department confirmed that there is ongoing liaison with clinical engineering staff regarding actions required as a result of reported incidents. Where applicable, lessons learned exercises were undertaken. Further, Clinical Engineering staff have visibility of reported incidents captured in the Datix system.

Conclusion 5: Risk assessments are completed on devices and equipment which may pose a significant risk to patients or staff. The Clinical Engineering Department has visibility of incidents, defects and faults relating to medical equipment and devices, which are recorded on the Datix Incident Reporting system, with lessons learned exercises undertaken. (Substantial Assurance)

Objective 6: Training

- Staff receive appropriate training before using medical equipment and devices.

2.15 Health Board requirements regarding training for the use of medical equipment and devices as stated within the Medical Equipment Management Policy, as per Section 9 notes, *"Professional Users must have received appropriate training and be competent, before Medical Equipment is put into clinical use."*

2.16 Directorate Management within the Emergency Medicine Unit and Critical Care Unit confirmed that training is provided by a company representative or supplier prior to first use of equipment, and this approach to training was also confirmed as being the case by the Head of Clinical Engineering.

2.17 We requested training documentation from the Directorate Management, neither of the sampled areas were able to provide documentation to evidence that training had taken place relating to newly purchased and installed medical equipment. *(Matter Arising 7 – Medium Priority)*

Conclusion 6: Given the absence or availability of training records to verify that training had taken place of high risk equipment, assurance mechanisms to the Medical Equipment Group should be considered, to ensure any potential clinical risk through inadequate application of specifically high risk medical equipment is mitigated. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Awareness of the revised Policy and Procedure (Operation)	**Impact**
The current iterations of the Health Board's 'Medical Equipment Management Policy' (UHB 082 v.5)[5] and 'Management of Medical Equipment Procedure' (UHB 082 v.5)[6] dated March 2022 are published on the Health Board's website. We found no evidence to suggest that the updated documents had been promoted or disseminated by the Medical Equipment Group (MEG) or Clinical Engineering Department. The Terms of Reference for the MEG at paragraph 3.4 notes, *"Promoting the Health Board's 'Policy for the Management of Medical Equipment' and is responsible for the regular review of this policy"*. As such, there is a risk of a lack of awareness of the changes made to these documents.	Potential risk of: Responsibilities and processes described in the policies and procedures are not adhered to resulting in harm and possible death.

Recommendation		**Priority**
1	The Medical Equipment Group should seek assurance from its members that they have raised the awareness of the revised policy and procedure within their areas of the Health Board, to ensure staff are aware of any changes to their responsibilities.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Add agenda item to next MEG and MDSO meeting, asking membership to disseminate Policy and Procedure to ensure their staff are aware of the new versions. Senior Leadership Board to discuss policy and disseminate the revised policy.	7 December 2022	Head of Clinical Engineering Executive Director for Therapies and Health Science Director of Corporate Governance

[5] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/m-patient-safety/medical-equipment-management-policy-march-2022-docx/

[6] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/m-patient-safety/medical-equipment-management-procedure-march-2022-n-docx/

Matter Arising 2: Quality, Safety & Experience Committee approval of the revised Policy (UHB 082 v.5) (Operation)	**Impact**
The current iterations of the Medical Equipment Management Policy (UHB 082 v.5) and the Management of Medical Equipment Procedure (UHB 082 v.5) have been reviewed by the Medical Equipment Group and published on the Health Board's website. As noted within the Policy, it requires approval by the Quality, Safety and Experience Committee, but the published version (v.5) has not been approved by the Committee. The Procedure however, as detailed within the Policy, can be approved by the Medical Equipment Group. The Policy and Procedure refer to versions '4' and '5'. The references to version '4' are out of date, as an example: **Reference Number: UHB 082** **Version Number: 4** **Date of Next Review: 31 Mar 2023** **Previous LHB Reference Number: UHB 082**	Potential risk of: Responsibilities and processes described in the policies and procedures are not adhered to resulting in harm and possible death.

Recommendation		**Priority**
2	The updated Medical Equipment Management Policy (UHB 082 v.5) requires the approval of the Quality, Safety and Experience Committee. An accuracy check of the version controls noted in the Policy (UHB 082 v.5) and Procedure (UHB 082 v.5) should be undertaken and references to version '4' replaced with version '5'.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	Corporate Governance will submit revised copies of the documents at November's QSE committee for approval.	29 November 2022	Executive Director for Therapies and Health Science

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Matter Arising 3: Awareness of the 'Standardised and Recommended Equipment Catalogue' (Operation)	**Impact**
The Clinical Engineering Service holds and maintains a recommended list of medical equipment and devices that is current and is posted on their SharePoint site (formerly the intranet).[7] It is noted that the content of this list is still a work in progress as the SharePoint site has only recently been introduced and will be added to as time goes on and is subject to change given any changes to clinical practice, best practice or availability of the equipment itself. Our audit testing identified that the two sampled Directorates were unaware of the recommended list of medical equipment and devices.	Potential risk of: Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

	Recommendation	**Priority**
3	The recommended list of medical equipment and devices held on the Clinical Engineering Services SharePoint site (formerly the intranet) should be subject to wider awareness across the Health Board.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3	Clinical Engineering will publicise the recommended list of medical equipment and devices via the MEG and MDSO groups.	7 December 2022	Head of Clinical Engineering

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[7] https://nhswales365.sharepoint.com/sites/CAV_Clinical%20Engineering/SitePages/Clinical-Engineering-Technical-Services.aspx

Matter Arising 4: Medusa Medical Equipment Database: Accuracy of Equipment Location (Operation)	**Impact**
Our testing identified that all 10 items sampled from the Medusa medical equipment database relating to the Emergency Unit could be located therein, and 4 items sampled 'in-situ' within that location were accurately recorded on the Medusa medical equipment database. However, 3 of 10 items sampled from the Medusa medical equipment database could not be located within the Critical Care Unit, although the 4 items sampled 'in-situ' within the Unit were recorded on the database. The Department could not identify where these three medical equipment items are currently located, although on further investigation it was noted that two of the items are greater than 15 years in asset life age and one of these was a loaned item from the manufacturer and had not been seen on the ward for approximately ten years.	Potential risk of: Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

	Recommendation	**Priority**
4	The Clinical Engineering Department should liaise with Directorate and Ward Management on a planned and scheduled basis to confirm the ongoing existence and location of medical equipment items, to ensure the accuracy of the Medusa medical equipment database.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4	Initially, Clinical Engineering will perform an audit of items not seen for over 10 years. Confirmation of accuracy will be sought from Directorates and Ward Management. Depending on the results of this initial audit follow up audits will be scheduled on a regular basis.	1 February 2023	Head of Clinical Engineering

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Matter Arising 5: Management of Loaned Medical Equipment (Operation)	**Impact**
Within our audit sample of items obtained from the Medusa medical equipment database relating to the Critical Care Unit, there were two externally loaned items identified. Neither were supported by any documentation held by the Critical Care Directorate or the Clinical Engineering Department that outlined the nature of the loans and the terms of loan agreement. Further investigation highlighted that both items were obtained in the mid 2000's, and as such any formal records or supporting documentary evidence relating to these predates the use of the Medusa database, and more likely than not no longer exists. The current iteration of the Management of Medical Equipment Procedure gives no guidance as to the oversight, recording and active management of externally loaned equipment items, only internal loans through the Medical Equipment Loan Service.	Potential risk of: Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

Recommendation		**Priority**
5	A periodic review of the Medusa medical equipment database should be undertaken to ascertain the status and current use of loaned medical equipment items. At the next review, the Management of Medical Equipment Procedure should be revised to provide guidance relating to the recording, oversight and active management of externally loaned medical equipment items.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	The commissioning process for long term loan equipment will be changed to record information regarding the basis of the loan where available. Users will be reminded via the MEG and MDSO groups to record or share this information. The action in recommendation 4 will serve to audit old, loaned equipment.	1 February 2023	Head of Clinical Engineering

	The Medical Equipment and Devices Policy and Procedure task and finish group will incorporate guidance relating to this recommendation in its review.		

Matter Arising 6: Completion and submission of contamination status clearance certificates (Control)	**Impact**
Testing was undertaken to confirm that local decontamination of medical equipment is supported by a Contamination Status Clearance Certificate. The certificates are completed by ward staff prior to sending to Clinical Engineering for repair or inspection when required or requested. Decontamination undertaken by Ward staff within the Critical Care Unit was supported by Contamination Status Clearance Certificates submitted to the Clinical Engineering Department. However, we could not confirm whether any medical equipment items within the Emergency Unit were submitted to the Clinical Engineering Department after departmental decontamination, as the Unit was not able to provide evidence of any Contamination Status Clearance Certificates or the books from which they are issued. It is also noted that the process of using Contamination Status Clearance Certificates for submission to the Clinical Engineering Department is not documented within the current iteration of the Management of Medical Equipment Procedure.	Potential risk of: Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

	Recommendation	**Priority**
6	All medical equipment items that have undergone local decontamination prior to submission to the Clinical Engineering Department should be supported by a completed Contamination Status Clearance Certificate and the issuing book should be retained by the Emergency Unit. Additionally, the Management of Medical Equipment Procedure should be revised and updated to reflect the Ward/Unit based decontamination processes.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
6	Clinical Engineering will work with the EU management to ensure decontamination certificates are available and completed. The Medical Equipment and Devices task and finish group will include the decontamination process in their revisions of the Policy and Procedure.	7 December 2022	Head of Clinical Engineering

Continued over page

Matter Arising 7: Evidence of training in use of medical equipment prior to first use (Control)	**Impact**
Whilst Directorate Management confirmed that training is provided by a company representative or supplier prior to first use of equipment, there was no evidence available for us to verify. Both Directorates stated that training records would not be completed unless there was a perception or specific requirement to formally record the training, and that there was no scenario in which nursing or medical staff would use medical equipment without training given the clinical risk of not being appropriately trained in its use.	Potential risk of: Financial and reputational implications associated with the failure to effectively manage medical devices and equipment.

	Recommendation	**Priority**
7	The Medical Equipment Group should review the current arrangements in place for evidencing and verifying that appropriate training of medical equipment is taking place, particularly for equipment classified as high risk.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
7	The recording of medical equipment training will be discussed at the next MEG to agree on the best way forward and gather evidence of best practice. The existing training on high-risk devices such as Defibrillators, Infusion Devices, POCT and US will be shared with the MEG and MDSO groups to increase awareness. ECOD have some training records on ESR which will be evidenced on as part of this action.	1 April 2023	Head of Clinical Engineering

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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UHL Endoscopy Expansion
Final Internal Audit Report

October 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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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
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Executive Summary

Purpose

The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Endoscopy Expansion Project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Overall Audit Opinion and Overview

Reasonable assurance has been determined at this stage of the project.

Contractual arrangements were appropriately approved; however, they have deviated (for both contractor and advisers) from the requirements determined within the approved Business Justification Case (BJC); with no amended procurement strategy approved.

Despite this issue, with the agreed arrangements, a robust project governance structure was in place with continual liaison and effective reporting to the relevant forums.

At the date of fieldwork (8 weeks into the construction programme) the Project Manager was reporting a delay of seven weeks. This is due to the ongoing structural redesign due to the originally appointed structural designer going into administration. There is a risk that this could be further extended and will need to be monitored and managed appropriately by the UHB.

Key matters requiring management attention, include:

- The management of the risks associated with the changes to the defined procurement strategy (and associated contract forms).

Other recommendations are within the detail of the report.

Report Classification

Reasonable Assurance

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	Project Governance	Reasonable
2	Design Development	Reasonable
3	Procurement	Substantial
4	Contract Management	Reasonable
5	Project Management	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
1.1	Approval of the Senior Responsible Officer role.	1	Operation	Medium
1.2	Inclusion of assignment to key project roles within the Procedure Manual for Managing Capital Projects.	1	Operation	Medium
4.1	Inclusion of updates from the Principal Designer into established reporting mechanisms.	1	Operation	Medium
6.2	Retrospective approval of the amended contractual arrangements with the main contractor.	3	Design	Medium

6.3	Inclusion of the Contract strategy decision-making process at the Procedure Manual for Managing Capital Projects.	3	Design	Medium

Future Assurance Matters[2]		Assurance Objective	Control Design or Operation	Recommendation Priority
5.1	Application of the design control process, as per the Procedure Manual for Capital Projects.	2	Design	Medium
6.1	Amendments/virement from approved business cases to be documented, reported to an appropriate forum and approved.	3	Operation	Medium
7.1	Limitation period afforded under the contract arrangements.	4	Design	Medium

[2] Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken at this project, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report

1. Introduction

1.1 The audit reviewed the delivery and management arrangements in place to progress the development of the Endoscopy Development at UHL; and was commissioned in accordance with the agreed Audit Plan provided within the approved Business Justification Case (BJC) for this project. This was the first audit undertaken of the project.

1.2 The vision for the Cardiff and Vale Endoscopy service is to provide endoscopy services that enable the delivery of multi-disciplinary, patient focused care including diagnosis, treatment, and endoscopic surveillance procedures for both inpatients and outpatients. Due to the current constraints and the increasing demand on the current service, the vision includes expansion of the current endoscopy services to increase capacity to meet the ongoing, growing demand for endoscopy procedures and the ability to address the backlog created by the COVID-19 pandemic

1.3 The BJC identified the preferred development option to be remodelled and expand the existing Endoscopy Unit at UHL (which currently comprises four endoscopy rooms, a dedicated decontamination room and a waiting area for outpatients). The scope of works included the erection of a two-storey extension adjacent to the existing recovery area to house the new proposed recovery area. The existing recovery area will then be converted to provide two new theatres.

1.4 Funding for the project was received from the Welsh Government on 28 February 2022 (which supersedes that previously issued in January 2022) for the value of £6,689,000 including VAT:

Costs	Total
Total Works Costs	£4,525k
Non-Works Costs	£255k
Fees	£574k
Equipment	£1,059k
Planning Contingency	£372k
VAT reclaim	(£96k)
Total Capital Cost	**£6,689k**

1.5 The potential risks considered at this review were as follows:

- Failure to achieve key project objectives through poor governance and poor project management controls.
- Appropriate approvals may not be in place to progress through key junctures.

- Time, cost and/or quality may be adversely affected by key decisions that were not subject to appropriate approvals.
- Costs agreed with the contractor may not demonstrate value for money.
- Project costs escalate uncontrollably through an absence of adequate cost monitoring and reporting.

2. Detailed Audit Findings

Project Performance: At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the areas under review are suitably designed and applied effectively.

2.1 At this first audit of the UHL Endoscopy expansion, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.2 As reported within the Project Manager's report (August 2022) works were forecast to be delayed by seven weeks i.e.:

- Construction Start Date: 4 July 2022.
- Contract Duration: 55 Weeks.
- Planned Contract Completion: 24 July 2023.
- Current Anticipated Completion Date: 11 September 2023.

2.3 Key factors for this delay include the structural designer going into administration; associated design review and updates; and procurement of structural steelwork. It is acknowledged that these issues were outside of the control of the UHB.

2.4 It is acknowledged that the project programme will require further review once the final structural steel frame changes are approved; and the Contractor anticipates that further delays to the programme will be encountered associated with the same (see ***Project Management***).

Cost

2.5 At the date of fieldwork (August 2022), an underspend position of £9,505 was projected; with £274,975 (89%) of the project contingency remaining which includes the cost implications of the 7-week delay (£28k), but recognising, at the date of concluding the fieldwork, this had yet to be formally affirmed by the UHB.

Quality

2.6 The quality of the original structural design has been reviewed and challenged by the newly appointed structural design engineers (appointed following the original company being placed into administration). This has led to the redesign of structural elements which has impacted the delivery of the project.

The following sections of the report outline key observations which require management attention, with moderate impact on residual risk exposure until resolved.

Governance: Assurance that appropriate governance arrangements were in place for the current project phase

2.7 The BJC for this project (total: £6.181m) was submitted and approved at the UHB Board in May 2021. The BJC was approved by Welsh Government in January 2022.

2.8 However, project cost escalation/inflationary increases were reported noting the period of time between the original market testing exercise and Welsh Government approval.. Additional Welsh Government approvals were received in February 2022 to mitigate the cost escalation (total: £6.689m). The revised Welsh Government funding letter was accepted and signed by UHB's Chief Executive.

2.9 The Executive Director of Strategy and Planning was allocated the SRO role at the BJC. However, it was evident (from Project Team meetings), that the SRO role was being delivered by the Deputy General, Manager Medicine Clinical Board (see **MA1**).

2.10 The project operated within a well-defined governance structure, defined within the Project Execution Plan (PEP). Whilst the PEP reflected the current stage of the project, minor enhancements have been proposed (see **MA2*)**.

2.11 Project updates were provided to the monthly Project Team meetings and the quarterly Acute Infrastructure Sustainability Capital Programme Board, by the Project Director. Monthly Capital Management Group updates were also noted (as required).

2.12 Both the Project Team and Project Board had been routinely attended by the Project Director (Director of Capital and Estates & Facilities); and other key officers from the defined group memberships (as per the terms of reference).

2.13 Monthly internal Project Manger's reports were evidenced; these were produced for the attention of the Project Director to assist with wider reporting within project governance structure. Within the Project Manager's report appendices, there is provision for the inclusion of principal designer's and supervisor's reports. However, no principal designer's or supervisor's reports (roles being delivered in-house) were evidenced during the period of review (June - August 2022) (see **MA4**).

2.14 External project reporting was undertaken via Welsh Government dashboard reports which were submitted on a bi-monthly basis and include a breakdown the project's overall financial position.

2.15 The NHS Wales Infrastructure Investment Guidance requires all projects over £2m in value to have a Project Bank Account (PBA). However, the implementation of the PBA had been delayed at the project (see **MA3**).

2.16 Recognising the above, **reasonable assurance** has been determined.

Design Development: Assurance that the design was sufficiently progressed and signed off by users; and that the users were adequately supported with professional advice.

2.17 The Royal Institute of British Architects (RIBA) plan of work was not directly followed for this project (see **MA5**). Rather, management advised that the UHB followed a process whereby periodic meetings were held with the end users to agree the brief and progress the concept design, followed by spatial co-ordination and final technical design. Whilst the meetings with the end users were not minuted, management provided email correspondence which indicated end user sign off.

2.18 The UHB's Capital Project Manual defines the following checklists for completion at capital projects:

- Stage 2 design deliverables checklist; and
- Project Stage Deliverables.

2.19 These checklists require stage end reports to be completed but were absent at the current project (see **MA5**).

2.20 The Project Execution Plan (PEP) (Section 8) documents the change control process to be applied at the project. At the time of the fieldwork, most changes were originating from the new structural designer (as a consequence of the administration of the previous provider and associated design issues).

2.21 Whilst the design development process did not progress in the standard manner, end user sign-off was evidenced therefore, **reasonable assurance** has been determined in this instance.

Procurement: Assurance that the procurement mechanisms were operating effectively and were supported by sufficient evidence.

2.22 The main contractor for the project was procured through mini competition, via the UHB's Local Construction Framework.

2.23 The Project Manager, Cost Adviser and Structural Design Engineer(s) were appointed via a Service Level Agreement (SLA) based on a direct call off from the Shared Business Service (SBS) framework.

2.24 Noting the procurement process had followed due process, **substantial assurance** has been determined.

Contract Management: Assurance that appropriate contractual documentation was in place for the main contractor and the UHB's advisers

2.25 The approved BJC (Section 6.7: Key Contractual Clauses), detailed the contractual arrangements to be applied i.e., NEC Option C (target cost contract with an activity schedule). However, the NEC Short Contract has been applied.

2.26 The NEC Short Contract is a simple contract form which reduces the requirements of both the UHB (and its agents) and the contractor. Noting the same, UHB approval to the amended contract strategy (and reasons for the same) was not evidenced. Associated legal advice highlighting the potential risks/benefits of utilising the short form in place of Option C was also not identified (see **MA6**).

2.27 The NEC Short Contract was signed by both the UHB and the contractor prior to construction commencing (April 2022). The contract documentation has been signed 'under hand' as opposed to 'as a deed'; which is normal practice for capital projects within the UHB. This therefore reduces the contractor's period of contingent liability (from 12yrs to 6yrs) (see **MA7**).

2.28 Similarly, the approved contractual arrangements provided within the BJC for the appointed Project Manager and Cost Advisor was the NEC 3 Professional Services Contract (aligning with the NEC Option C). The BJC indicated that the approved contractual arrangements were being applied at the time of its approval. However, in practice, the Project Manager and Cost Adviser appointments were formalised in March 2022 (two months post approval), via a Service Level Agreement (SLA) (see **MA6**).

2.29 Whilst noting the variances in the approved Procurement Strategy (contractual arrangements), the absence of formal evaluation and approval of the selected approach, these changes are not considered material as the UHB has ensured an appropriate contractual framework is in place to mitigate any risks. **Reasonable assurance** has therefore been determined, noting the recommendation for a Contract Strategy decision-making process to be detailed at all future projects.

Project Management: Assurance effective arrangements are in place to administer and manage the project, including change management, risk management and programme management.

2.30 A construction risk register was maintained by the external Project Manager; and monitored and reported to the UHB as part of the monthly Project Manager's report. This risk register has been scored, risk owners assigned and costed accordingly.

2.31 A cashflow forecast has recently been developed (September 2022) for the financial years 2022/23 and 2023/24. Noting the timing of the cashflow

development, it is yet to be incorporated within the formal reporting mechanisms (see **MA8**).

2.32 As per *para 2.20* there is a defined change management process. Noting the early stage of construction, at the date of fieldwork, two Compensation Events had been raised (one approved by all parties: £6k; and one pending approval by the UHB: £28k). For both, due process had been followed relevant to their respective stage.

2.33 However, as per *para 2.5*, the Contractor has raised issues which could further impact the programme. At the date of fieldwork, as per the defined process (whilst varying from the agreed contractual arrangements) the expectation for raising an Early Warning Notice had not been actioned (see **MA9**).

2.34 Recognising the above, **reasonable assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Roles and Responsibilities (Operation)			**Impact**
A recent Gateway review, for another UHB project, recommended that *'the role of the Senior Responsible Officer (SRO) post OBC approval should be assigned to a Senior Clinical Board lead'*, required for *'the need to have more effective communications with clinical services staff, service users and the wider community to ensure timely and more productive participation at the project'.* The SRO, as per the BJC, was the Executive Director of Strategy and Planning. However, by the date of the August 2022 Project Team meeting, the named individual had changed twice – General Manager, Medicine Clinical Board and, more latterly, the Deputy General Manager, Medicine Clinical Board. It is unclear if the current SRO has the relevant experience, and training to effectively discharge the role.			Potential risk of: • Reduced ability to make the right decision for all parties.
Recommendations			**Priority**
1.1	The Project Board should confirm that the current named SRO has the necessary experience to discharge the role effectively and provide the relevant training as required.		**Medium**
1.2	The UHBs Capital Manual will be updated to reflect the requirements and assignment of key project roles (aligning with national guidance).		
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	The SRO is appointed by the executive lead and they are issued with a letter of appointment which details their roles and responsibilities. In addition, all clinical board directors of	March 2023	Director of Capital, Estates & Facilities

	Operations have been provided with Welsh Government guidance on the duties of an SRO. The UHB have been in discussion with WG to agree training for staff who are appointed as SRO.		
1.2a	A plan on a page has been developed with the intention to have links to relevant documentation for completion. Progress on this has been extremely slow due to lack of resource within the department. New staff will be commencing shortly and it is hoped to finalise the details to issue the updated manual.	March 2023	Director of Capital, Estates & Facilities

Matter Arising 2: Governance – Project Execution Plan (Operation)	**Impact**
A Project Execution Plan (PEP) is a governing document that defines how a project is to be executed, monitored, and controlled. The PEP was reviewed by the UHB in July 2022 and updated to reflect design team changes. However, there were still some areas which needed to be reviewed / updated for the current stage of the project e.g.: • Key Performance Indicators (KPIs) - there is limited reference to how performance of the contractors and advisers will be monitored and reviewed. • Key project plan milestones - there is no reference to the design start and complete target timeline (noting these activities have passed); and • External appointments - the Structural and Civil Engineers remain cited as the company which has ceased trading; and the cost advisers name and contact details require updating.	Potential risk of: • Inability to make decisions in a timely manner.

Recommendations		**Priority**
2.1	The Project Execution Plan (PEP) should be reviewed for accuracy and updated appropriately.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed. The PEP has been updated for the current juncture of the project.	Actioned since fieldwork	N/A

Mohamed.Sarah
03/11/2022 16:33:19

Matter Arising 3: Governance – Project Bank Account (Operation)	**Impact**
Welsh Procurement Policy Note (WPPN) 04/21 states that all Welsh Government construction and infrastructure contracts and any other 'appropriate contracts' valued at £2m or more which are delivered on behalf of Welsh Government Departments require a Project Bank Account (PBA), this is to be applied unless there are compelling reasons not to do so. Where such compelling reasons are identified, a decision report detailing those reasons must be completed and filed to allow for audit. There is no Project Bank Account (PBA) in place for this project and management has not confirmed a timescale for implementation. However, it is recognised that project payments are currently progressing through monthly valuation.	Potential risk of: • Non-compliance with Welsh Government policy.

Recommendations		**Priority**
3.1	Further work is required to ensure the Project Bank Account is established and operating in line with Welsh Government policy.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The comment is noted, however, the contract was tendered through the local framework which was established prior to the formal implementation of Project Bank Accounts. The framework is due for re-tendering and will include a requirement for contractors to implement project bank accounts where the value or timescale meets the relevant criteria.	March 2023	Project Manager

Matter Arising 4: Governance – Monitoring and Reporting (Operation)	**Impact**
Monthly Project Manager's reports were being produced during stage 5 construction. The standard appendices of these reports included: 1. Programme of works contractors report, 2. Change Control, 3. Risk Register, 4. Cost Adviser's Report, 5. Principal Designer's Report (UHB undertaking this role), 6. Supervisor's Report (UHB undertaking this role). However, no reports in respect of the Principal Designer have been received and included within the latest three Project Manager's reports (June - August 2022). Highlight reports were also submitted to the monthly Project Team meetings. The latest highlight report (August 2022) noted a minor inconsistency when reconciled to the Project Manager's report i.e., the change control section of the Highlight report noted that the approved Project Issue Forms totalled £8,338. However, the PM report highlights £6,171 and hence misstating the available contingency by the same amount (a variance of £2,167).	Potential risk of: • An informed, and timely, decision cannot be taken by relevant parties.

Recommendations		**Priority**
4.1	Updates on the ongoing design should be incorporated into the established reporting mechanism to highlight progress and any potential issues.	**Medium**
4.2	Cost associated with changes to the project, should be reported consistently, to ensure contingency sums are accurately reported and managed.	**Low**

Agreed Management Action		Target Date	Responsible Officer
4.1	Agreed. The design information is now incorporated in the highlight reports.	Actioned since fieldwork.	N/A
4.2	Agreed. The cost information has been updated accordingly, in the highlight reports, for consistency with the Project Manager report.	Actioned since fieldwork.	N/A

Matter Arising 5: Design Development – Process (Operation)	**Impact**
The Procedure Manual for Managing Capital Projects includes the following checklists as defined controls for capital projects, for which stage-end reports are required: • Stage 2 design deliverables checklist • Project Stage Deliverables The UHB followed a process whereby periodic meetings with the end users were held to agree the brief and carryout the concept design, following on with spatial co-ordination and final technical detail design. However, these meetings were not minuted and although there has been email correspondence indicating end user sign off; there were no documented stage end reports produced	Potential risk of: • The UHB may incur increased costs because of ineffective design. • The project design may not be fit for purpose.

Recommendations		**Priority**
5.1	***Future Assurance*** For future projects, in accordance with the Procedure Manual for Managing Capital Projects, a formalised design control process, including signed stage end reports, should be applied, clearly documented, and appropriately reported.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	End stage reports will be implemented where appropriate, and subject to the value and complexity of the project. This will be detailed in the project execution plan going forward.	At future projects	Director of Capital, Estates & Facilities

Mohamed.Sarah 03/11/2022 16:33:19

Matter Arising 6: Procurement –Variation to contract type (Operation)	**Impact**
The approved BJC states the following: ***Section 6.5: Procurement***: *The contract will be managed by Cardiff and Vale University Health Board under the NEC3 Option C Target Cost Contract.* ***Section 6.7: Key Contractual Clauses***: *Contractual arrangements have been entered into with all parties using the NEC contract as prescribed under the Framework. For the Project Manager and Cost Advisor, the NEC 3 Professional Services Contract has been used.* However: • The NEC Short Contract has been used, which is typically applied for contracts which "*do not required sophisticated management techniques, comprise straightforward work and impose only low risks on both the employer and the Contractor*" [1] The Welsh Government approval letter for the project, dated 28 February 2022, provides for 'notification events' including to '*inform us (i.e. Welsh Government) immediately if any of the declarations made in Condition 8 is incorrect in any respect…'*. Effectively, Welsh Government should be notified if there are material changes to the business case arising from inaccuracies, factual content, financial assumptions or misleading in nature.	Potential risk of: • Signing an inappropriate contract potentially leading to financial/legal disputes.

[1] NEC3: Engineering and Construction Short Contract | NEC Products | NEC Contracts

	Management advised that the NEC Option C contract, as per the approved BJC, would not have been appropriate for this type of project. Whilst noting this may not be considered a material change to the BJC, there is no evidence of the UHB approval for this change; or any legal advice surrounding the potential risks/benefits of utilising the NEC Short Contract form at a project of this value/nature (or notification to Welsh Government) • Similarly, the NEC3 Professional Services Contract has not been applied; rather the advisers were appointed via a Service Level Agreement using the SBS framework. Appointments were formalised/signed off in March 2022, i.e., after the date of the BJC approval rather than active at time of submission (as the narrative suggests). No provision is made within the NEC Short Contract for the role of the project manager or any other contract administrator or certifier of professional standing [2]. Again, there is no evidence of UHB approval, or notification to Welsh Government, for this change. Management advised that the appointments were made due to resource constraints within the Capital, Estates & Facilities team.	
Recommendations		**Priority**
6.1	***Future assurance*** For future projects, any amendments/virement from approved business cases should be documented, reported to an appropriate forum and approved (with any appropriate risks/benefits highlighted).	**Medium**

[2] The NEC 3 Engineering and Construction Contract second edition publication.

6.2	In this instance (changes in contract terms) retrospective approval should be sought through a paper, to a relevant forum, detailing the rationale, risks, benefits etc., associated with the current contractual arrangements (noting particularly in this instance reduced contractual obligations for all parties and reduced contingent liability period (see **MA7**)).	
6.3	The Contract Strategy decision making process should be detailed at the Capital Manual including appropriate contract forms to be utilised and the associated advantages, disadvantages, risks, contingent liability periods etc., of the preferred approach. The same will be applied at all future projects.	

Agreed Management Action		Target Date	Responsible Officer
6.1	Noted. The procurement strategy contained within the BJC was not updated to reflect the chosen contract.	At future projects	Director of Capital, Estates & Facilities
6.2	Noted. A paper will be drafted for consideration at the January 2023 UHB Board meeting.	January 2023	
6.3	The revised capital manual will include guidance on appropriate contracts and a method of determining the strategy for each project.	March 2023	

Matter Arising 7: Contract Management – Short Contract (Operation)	**Impact**
Section 2.4.12 of the Procedure Manual for Managing Capital Projects details the requirements for contracts to be executed under seal (as a deed). The NEC Short form contract, for this project, has been signed 'under hand' as opposed to being signed 'under seal'. Contracts signed 'under hand' and contracts 'under seal' have different limitation periods. An action founded on a simple contract cannot be brought after six years from the date on which the cause of the action accrued. The limitation period for a contract under seal is 12 years. Limitation of action is a statutory remedy, which prevents a claimant from bringing proceedings after the expiration of specified time limits. In this instance, the UHB are effectively accepting any additional risks / defects arising for a 6-year period. The reasons for the change in the contract strategy were not reported / approved at an appropriate forum (see **MA6**).	Potential risk of: • The UHB may incur less legal protection than they otherwise could.

Recommendations		**Priority**
7.1	***Future Assurance*** For future projects, all contracts of a significant value/complexity should be completed as a deed i.e., affording the maximum period of contingent liability (12 years).	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
7.1 This action is linked to 6.3 and consideration of the type of contract if the project is of a significant value or complexity, it will be considered for formal sealing.	At future projects	Director of Capital, Estates & Facilities

Matter Arising 8: Project Management –Cashflow (Operation)			**Impact**
A cashflow forecast was prepared in September 2022, circa two months since construction begun). Noting the timescales involved, the cashflow yet to be formally reported to the Project Team or Project Board for scrutiny.			Potential risk of: • The UHB may not meet its financial commitments.
Recommendations			**Priority**
8.1	The cashflow forecast should be incorporated within the established reporting mechanisms, so that scrutiny and challenge can occur.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
8.1	The in year spend is included on the project leads report as is the spend up to the proceeding month.	November 2022	Project Manager

Mohamed,Sarah
03/11/2022 16:33:19

Matter Arising 9: Change Management Process (Operation)	**Impact**
It has been reported, in the August Project Manager report, that a further review of the project programme will be required once the final structural steel frame changes are approved; and that the Contractor had subsequently reported the review process is further behind than anticipated - due to revised information provided by the Structural Designer. This has led to a delay in the issue of fabrication drawings for approval. This has an implication on the project programme and is not reflected within the 7-week delay currently reported. The change control register noted that no Early Warning Notice (EWN), for the above, had yet to be raised. Whilst there is no contractual obligation, under the NEC Short Contract, for an EWN to be raised, this process has been included within the PEP and, out of goodwill, the Contractor has been applying the same for changes noted to date.	Potential risk of: • Amendment to project programme is not transparent / appropriately approved.

Recommendations		**Priority**
9.1	An Early Warning Notice should be raised for the further impact on the project programme of the delay in issue of the fabrication drawing for issue.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
9.1	An Early Warning Notice (EWN) should be raised where there is a perceived impact on cost or programme. In the example given, the project lead will consider the issuing of an EWN.	Actioned since Fieldwork	N/A

Mohamed Sarah 03/11/2022 16:33:19

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that the project achieves its key delivery objectives (time, cost, and quality) and 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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