Public Digital & Infrastructure Committee

Tue 10 February 2026, 09:00 - 10:45

Virtual - MS Teams

Agenda

09:00 - 09:05
5 min

1. Standing Items

1.1. Welcome, Introductions & Apologies

David Edwards

1.2. Declarations of Interest

David Edwards

1.3. Minutes from the committee meeting held on 11th November 2025

David Edwards

1.3 - Draft Public Digital & Health Intelligence Mins 11.11.25.pdf (10 pages)

1.4. Action log following the committee meeting held on 11th November 2025

David Edwards

1.5. Chairs Actions

David Edwards

09:05 - 09:45
40 min

2. Infrastructure

2.1. Estates Risk Register

Geoff Walsh

2.1 - Estate Infrastructure and Risk.pdf (4 pages)

2.2. Board Assurance Framework

Geoff Walsh

2.2 - BAF - Infrastructure.pdf (7 pages)

2.3. Estates Briefing- Condition Survey

Geoff Walsh

2.3 - Infrastructure Surveys.pdf (3 pages)
2.3a - Exec Summary V3.pdf (22 pages)

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09:45 - 10:25
40 min

3. Digital

3.1. Digital Roadmap and work programme update

David Thomas

- 3.1 Digital Roadmap and work programme update - public (1).pdf (12 pages)

3.2. Corporate Digital Risk Register

David Thomas

- 3.2 - Digital Risk Register Cover.pdf (2 pages)
- 3.2a - DHI Combined Risk Register MASTER October '25 v2.pdf (17 pages)

3.3. IG Data Compliance

James Webb

- 3.3 - IG compliance paper.pdf (9 pages)

3.4. Data Strategy

David Thomas

- 3.4 - Data Strategy Cover.pdf (3 pages)
- 3.4a - Data Strategy - Appendix 1.pdf (18 pages)

10:25 - 10:40
15 min

4. Items for Approval / Ratification

4.1. Car Parking Policy

Geoff Walsh

- 4.1 - Car Parking Policy cover report.pdf (4 pages)
- 4.1a - Car Parking Policy EqIA and HIA V1.pdf (9 pages)

4.2. Counter Fraud Procedure

Henry Bales

- 4.2 - Counter Fraud Procedure Covering Report.pdf (2 pages)
- 4.2a - CAVUHB CFBC PROCEDURE V4.pdf (26 pages)

4.3. Waste Management Procedure

Geoff Walsh

- 4.3 - CAV Board Committee Covering Report Waste Management Policy.pdf (2 pages)
- 4.3a - Waste Management Policy & Procedures 2025.pdf (56 pages)

10:40 - 10:45
5 min

5. Items for Noting & Information

5.1. Minutes: Digital Directors Peer Group

- 5.1 - Digital Directors' Peer Group.pdf (2 pages)
- 5.1a - Appendix 1 - DODs Notes - November 2025.pdf (9 pages)
- 5.1b - Appendix 2 - DODs Notes - December 2025.pdf (5 pages)
- 5.1c - Appendix 3 - DODs Notes - January 2026.pdf (6 pages)

10:45 - 10:45
0 min

6. Agenda for Private Digital & Infrastructure Committee Meeting

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6.1. Cyber Security

6.2. Caldicott Guardian

10:45 - 10:45 0 min

7. Review of the meeting

10:45 - 10:45 0 min

8. Date & Time of next meeting: Tuesday 05th May at 9am via MS Teams

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Minutes of the Public Digital & Health Intelligence Committee Meeting
Held On 11 November 2025
Via MS Teams

To view a recording of the meeting click here.

Chair:		
David Edwards	DE	Independent Member – Information Communication & Technology (IM-ICT)
Present:		
Kirsty Williams	KW	CAV UHB Chair
Rachna Upadhya	RU	Independent Member - General
In Attendance:		
Suzanne Rankin	SR	Chief Executive Officer
David Thomas	DT	Director of Digital & Health Intelligence
Catherine Phillips	CP	Executive Director of Finance
James Webb	JW	Head of Information Governance & Cyber Security
Geoff Walsh	GW	Director of Capital, Estates & Facilities
Francesca Thomas	FT	Head of Corporate Governance
Angela Parratt	AP	Director of Digital Transformation
David Fluck	DF	Executive Medical Director
Secretariat		
Rachel Chilcott	NR	Corporate Governance Officer
Apologies		
Richard Skone	RS	Deputy Medical Director
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Steve Riley	SR	Independent Member - University

Item No	Agenda Item	Action
D&IC 11/11/1.1	**Welcomes Introductions & Apologies** The Committee Chair (CC) welcomed everyone to the public meeting and confirmed the meeting was quorate.	
D&IC 11/11/1.2	**Declarations of Interest** **The Committee resolved that:** a) No Declaration of Interest were noted.	
D&IC 11/11/1.3	**Minutes of the Meeting Held 12.08.2025** The Committee accepted the minutes from 12th August 2025 as a true and accurate record. **The Committee Resolved that:** a) The Minutes of the Meeting held on the 12th August 2025 were confirmed as a true and accurate record.	

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D&IC 11/11/1.4	**Action Log – Following the Meeting held on 12.08.2025** **Completed Actions**: The Director of Digital & Health Intelligence - David Edwards (DE) confirmed that several actions were completed, including "essential script," "strategic property," and "IG data compliance." The IG data compliance action is still in progress. **Strategic Priorities Action**: The Executive Director of Finance – Catherine Phillips (CP) raised that the "strategic priorities" action (noted as 2526) was about the longer-term digital and estates plan alignment. She emphasized ongoing work needed by herself, The Director of Capital, Estates & Facilities – Geoff Walsh (GW), and DT to define the journey, milestones, and ensure alignment, suggesting it was not a quick action but should remain on the forward plan for further development. **Forward Plan Update**: CP proposed that she, GW and DT refined the timing and products for the forward plan to ensure it meets needs and allows input. DT agreed, noting this reflected previous board discussions and supports keeping it on the agenda. He proposed removing it from the action log as it was on the forward plan. **The Committee Resolved that:** a) The Action Log was discussed and noted.	
D&IC 11/11/1.5	**Chair's Action taken since the last Committee Meeting** No chairs actions taken since the previous meeting. **The Committee Resolved that:** a) There were no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance - Infrastructure	
D&IC 11/11/2.1	**Estates Risk Register** The Director of Capital, Estates & Facilities – Geoff Walsh (GW) highlighted the following points on the Estates risk register: • Very high risks were being managed across estates and infrastructure, with all risks above 20 transferred to the corporate governance risk system, and those between 15 and 20 in the process of being transferred. • Attention was drawn to three key areas: main theatres' feasibility, important refurbishment, and infrastructure issues identified in a service review. • Approximately £4.5m in short-to-medium-term work was identified, mainly for infection prevention and control, but this did not address ventilation and air conditioning upgrades, which required an additional £61m. Even with this investment, full compliance with health building standards would not be achieved due to theatre size limitations. • Annual validation showed current ventilation was within parameters, but the building was not designed to the latest standards, which was a significant point for awareness. • For ITU, issues were highlighted with UPS (backup power) systems, noting that only one of seven areas currently meets the required N+1 standard. Work is underway to upgrade all areas to N+1 before Christmas.	

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	• Problems with infrastructure availability, such as obsolete trunking systems for medical gases and electrical sockets, and ongoing discussions about implementing changes. • "Operation Poet," a total power outage test at UHW, was considered successful despite minor issues. Lessons learned and an action plan would follow, and a similar exercise was planned for UHL in the future. The Executive Director of Finance – Catherine Phillips (CP) asked GW to provide an update on the condition survey and when it would return to the Committee, noting that the work was currently being finalised and suggested it would be helpful for the committee to hear about its status if there were no other questions GW responded that the fieldwork for the condition survey was complete, and the data was entered into a database. He was meeting with the suppliers to discuss how to condense the large volume of detailed information into an overview suitable for executives and the Board. He hoped to have a draft document to bring to the next D&I Committee meeting. The UHB Chair – Kirsty Williams (KW) thanked GW for his paper and said she looked forward to a wider briefing on capital issues. She then raised several questions: the priority on infection prevention and control improvements in theatre and whether there was a similar programme for ICU; issues in ICU such as hand washing and toileting facilities for staff; how the team communicates improvements and investments to staff; and CAV UHB's track record in securing end-of-year capital flexibilities from Welsh Government (WG). GW responded to the questions and highlighted the following: • **end-of-year capital flexibility**: CAV UHB has a close relationship with WG and was very successful in securing last-minute capital funding, often being called upon to deliver quickly. He explained that digital and medical equipment colleagues benefit most from late funding, as infrastructure projects are harder to deliver quickly. • **ICU**: a business justification case was in progress for refurbishment, with phased work planned to maintain bed capacity. He described the upcoming availability of ward C3 and the need to juggle decant space for theatres and recovery, noting a project team is working on solutions and discussions with WG were ongoing to bring forward the first phase. • **Hand washing and toileting facilities**: recent issues were part of a planned shutdown for foul drainage replacement, with ITU staff involved in the planning and agreed isolations, and that facilities would be restored once works were complete. • **Communication with staff:** local workforce information was presumed to be relayed by clinical board and department leads on project teams, but admitted the team was not very good at broader communication or highlighting successes and acknowledge a need to improve in this area. The Chief Executive - Suzanne Rankin (SR), noted that GW and other colleagues came to "ask Suzanne" and talked about their work but agreed there was a definite need for a campaign to better communicate successes and ongoing work. She offered to support	

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	GW and the comms team. She asked GW about the theatre's refurbishment, specifically raising concern that losing two theatres at a time during the work was likely to have an effect on planned care recovery. She wanted assurance that the right people were involved to work through the impact on any trajectory the organization has committed to or is developing for next year. GW responded that Adam Wright was leading the work with all concerned parties, including meetings with ITU and theatre teams to address the impact and ensure recovery was located appropriately. SR asked about the recovery area, referencing previous work done to make it child-friendly for paediatric cases. She stressed the importance of ensuring that whatever was done it was replicated in the temporary facility during the refurbishment and in the new facility afterward. The Medical Director - David Fluck (DF) commented on the risk register section in the report, describing it as "fairly scary" and offered to sit down with GW to review it from a quality and clinical perspective, noting the presence of several high risks. GW responded that things were changing rapidly, and some risks had been on the register for a long time were now becoming reality. He emphasized the need to be mindful of this, noting that the Estates team were dealing with almost weekly reactive and significant issues. DF suggested there may be an opportunity to drive a new clinical model or reorganize to try and avoid some of the risks, and recommended mapping this with the Clinical Services Plan, referencing GW's earlier outline of his thoughts. The Independent Member - General - Rachna Upadhya (RU), asked GW to expand on the lessons learned from the power outage electrical testing performed in October at UHB, emphasizing its importance for emergency generators and electrical infrastructure. She requested an explanation for why the UHL Poet exercise was deferred by a year and whether anything was anything being done to cover the interim period. GW responded by stating the UHW Poet exercise was considered successful overall, with failures in some key equipment (specifically batteries on switch gear), and described ongoing investigations and maintenance plans to prevent future failures. He mentioned considering a dedicated generator for the third floor due to its critical areas (ITU and theatres). He explained the complexity of the system, the reliance on local generators, and the importance of planned testing versus real outages. Regarding UHL, he said the delay was due to ongoing replacement of a main switchboard at UHW, which required significant planning and impacted pre-planning for UHL. He clarified that UHL's electrical system is less complex and relies more on local generators, which are tested weekly, so the risk was lower than at UHW. CP reminded the Committee that this was the third year for Operation Poet at UHW and emphasized the importance of conducting a once-a-year power outage to test the system. She noted that this testing led to investment, making CAV UHB more resilient. She highlighted the need to bring together efforts to address	

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	infrastructure risks over time, describing it as a significant piece of work, especially given the limited investment available from WG. RU asked about the battery failure at UHW and whether similar testing could be done for UHL in the meantime. GW confirmed that this testing would be done as part of the plan. **The Committee Resolved that:** • The content of the paper and in particular the prioritisation process undertaken for the 2025/26 draft capital plan was noted.	
	Items for Review & Assurance – Digital	
D&IC 11/11/3.1	**Digital Roadmap and Work Programme Update** David Thomas (DT), the Director of Digital, Health & Intelligence and Angela Parratt (AP), the Director of Digital Transformation summarised the progress on the digital foundations programme business case • The focus for the Committee meeting was the Digital Foundations Programme business case, which was the primary vehicle for advancing the digital maturity journey. • The Digital Foundations Programme business case outlined a five-year plan seeking investment from WG. It was described as a response to the need for improved digital maturity, aiming to reduce avoidable harm caused by missing data and poor infrastructure, and to prepare for a future national electronic health record solution. • The programme's objectives were detailed, alignment with national strategies, and the importance of securing a revenue funding stream for its implementation KW praised AP for framing the digital foundations work as an enabler with a strong focus on patient outcomes, quality, and safety. She asked how, alongside building the plan, they engage with staff and the public, emphasizing that the public will ultimately need to see the benefit of this work. AP responded that there were 40 workshops and over 150 meetings, which included deep dives with various stakeholders such as the patient experience team, clinicians, and operational staff. She emphasized that this was not a new initiative, with about five years of discovery work behind it, and that previous engagement included attendance at a patient panel. She noted that it was not yet clear what the NHS Wales App roadmap looks like in terms of delivering capability for patients. KW asked whether the system would be able to cope with the regional footprint of working, specifically regarding patients moving in and out of different HB's to receive treatment. AP responded that there were national and local standards for data interoperability, and if these were followed, data could move and be accessible across regions. She highlighted a regional initiative—the digital care region—where multiple agencies, including councils, can view individual care information, moving towards a shared care	

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	record. She acknowledged the challenge of integrating systems across organizations with different applications and ways of working and noted that part of the digital foundations work was to modernize infrastructure to make access easier. She also mentioned ongoing workshops and discussions with neighbouring organizations to support regional collaboration and patient flows. DT added that there was a digital regional workshop happening in a couple of weeks with Aneurin Bevan UHB and Cwm Taf Morgannwg UHB to look at how to support patient flows and regional initiatives that were underway or in development. **The Committee Resolved that:** a) The Digital Roadmap and Work Programme Update was noted.	
D&IC 11/11/3.2	**Corporate Digital Risk Register** DT highlighted: • The corporate digital risk register scores are unchanged since last month, but there are updates in the template regarding progress. • He emphasized that cybersecurity remained the top risk and will be discussed further in the private agenda. Other risks have actions underway, but none could be materially reduced at this time. He confirmed that risks were reviewed monthly and invited questions. • He also clarified, when asked, that discussions to capture Clinical Board cyber risks have already started, with actions in progress to engage with clinical boards and complete the work within the next month or two. DE asked about the update around cybersecurity and its transfer to AMAT, specifically referencing the work to capture Clinical Board cyber risks and inquired when this work would be completed. DT explained that discussions had started, a proposal was taken to the senior leadership team in October, and actions were underway to engage with clinical boards and complete the work within the next month or two. **The Committee resolved that:** a) The progress and updated to the Risk Register report was noted.	
D&IC 11/11/3.3	**Information Governance (IG) Data Compliance** The Head of Information Governance & Cyber Security - James Webb (JW) provided an update on key information governance performance indicators: • The department was resourced to five whole time equivalents (WTE) and continued to review a substantial volume of incidents via the Datix system, with 129 incidents reviewed between July and September. • Two breaches met the threshold to report to the Information Commissioner's Office, with further details in the private papers.	

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	• Freedom of Information compliance remained largely unchanged at 63 requests and 90% compliance per month. • Medical Records request compliance improved to 48%, with a steady month-on-month increase since November 2024, but still below an acceptable threshold. Request volumes average 318 per month, response times were within regulatory timeframes, and outstanding requests were relatively low. • For non-health records requests, compliance was achieved in 30 out of 34 cases, and 56 requests for CCTV footage were mainly to investigate vehicle damage incidents in car parks, which rose significantly. • Over 1253 letters were sent to staff regarding accessing clinical systems inappropriately • Mandatory IG training figures had increased to 74% for all staff, but remain below the required 85% for a satisfactory ITIG toolkit submission. DE asked about Freedom of Information (FOI) requests, noting that the data (questions and information provided) was published to prevent further similar requests. He asked how much this was being used to prevent similar requests or if it was just getting easier to answer questions because similar ones had asked previously, essentially asking about volume versus effort. JW responded that while submissions were published on the public website as a legal requirement, the impact on reducing requests was limited because questions, though similar, were often nuanced or had different dates, making it challenging to rely on previous responses. He noted that the published format was not particularly helpful for public searching, so improvements could be made, but the main challenge remained the specificity of each request. KW asked about the significance of the figure for staff accessing records and the number of letters sent, expressing that even one instance was too many. She questioned what the figure indicates, how it benchmarked against other organisations, and what actions were being taken with the workforce to address this issue. JW responded that he would address this in the private agenda, where a graph would illustrate the issue and further detail would be provided. No benchmarking data or detailed workforce actions were discussed in the public section; further information was deferred to the private session. **The Committee resolved that:** a) The series of updates relating to significant IG issues were received and noted.	
D&IC 11/11/3.4	**Board Assurance Framework – Digital** • DT highlighted that actions were being taken to progress the Digital Foundations business case, emphasizing its importance for achieving many planned developments. He noted that this was a key focus area and referenced ongoing efforts but did not provide specific action details in the public section.	

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	• AP previously explained that the Digital Foundations programme business case set out a five-year plan seeking investment from WG, aiming to improve digital maturity, reduce avoidable harm, and prepare for a future national electronic health record. The programme involved annual iterative planning, alignment with national strategies, and ongoing engagement with clinical and non-clinical colleagues. • There would be further discussion on resourcing and the revenue ask for Digital Foundations in the private agenda. **The committee resolved to:** a) The Board Assurance Framework – Digital was discussed and noted.	
	Items for Approval / Ratification	
D&IC 11/11//4.1	**Records Management Policy & Procedure / Procedure for External Emails** JW summarised and highlighted the following points: • The records management framework was not new but was updated to reflect the implementation of the WG's records management code of practice. • The purpose of these documents and the overall framework was to ensure all departments, whether dealing with health or corporate records, were aware of records management requirements and do not retain records longer than necessary, which helped manage storage, cost, and regulatory risks. • New guidance was produced for clinical teams to communicate directly and timely with patients outside of traditional phone calls and letters. While this guidance was previously provided informally, it was formally documented. The guidance was designed to balance the relatively low cyber risk with the clinical benefits and cost-effective communication, provided it is used in appropriate circumstances. DE asked whether there is a policy or procedure template available across all health boards in Wales, or if each board is reinventing the wheel every time they develop such documents. JW responded that there was a national emailing policy, but in their view, it was restrictive. They had tried to deviate from that national policy where clinical teams believe it was relevant and where patients were happy to receive results and other information via email. **The Committee resolved that:** a) The Procedure for External Emails and the updates to the Records Management Policy, Procedure and Retention Destruction Schedule of the Management Framework were approved.	
D&IC 11/11/4.2	**Disaster Recovery Policy** JW highlighted the following:	

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	• introduced a new document outlining key roles and responsibilities once a business continuity event has been declared, such as a major incident. • The policy establishes a disaster recovery (DR) team responsible for responding to and managing the recovery effort following a cyber incident. • It covers legal reporting thresholds requiring certain incidents to be reported to Welsh Government and provides a definition of what constitutes a mission critical service. • James noted that while the DR policy is key, they also need to urgently update their disaster recovery plan, but thought it would be beneficial for the organisation to have the policy approved first before updating the more detailed plan. DE commented that if a major event occurred, it would not be isolated to the digital IT teams; across the whole UHB, disaster recovery teams would need to take action. He expressed uncertainty about how the digital disaster recovery policy plugged into broader organisational plans and how it avoided duplication of terminology, especially during stressful times. JW clarified that the document is a digital disaster recovery policy specifically for those responsible for restoring critical digital infrastructure. He emphasized that it is not a business continuity plan for clinical services, but rather a document for digital teams who are responsible for digital systems, applications, and the network. DT stated that the digital disaster recovery policy would be shared with and plugged into the EPRR (Emergency Preparedness, Resilience and Response) system. He mentioned that they would probably need to test it at some point and are scheduling a desktop exercise with input from EPRR colleagues. JW said he would take the feedback away and try to provide further clarity in the document. He noted that it was due to be tested early next spring and expressed his hope to have it approved by then so it can be relied on and tested. SR commented that the priority during business continuity was the delivery of safe care to patients, which lied with the clinical operational teams. She explained that if there was an outage and loss of data or a digital platform that contributes to patient care, there was often an alternative way of managing or delivering that care (such as converting to paper or using plain X-ray). She clarified that the document describes the digital team's approach to recovering the platform or data associated with it, which was a technical responsibility, while the management of care remained with the Chief Operating Officer and clinical boards as part of the business continuity plan. The Committee approved the policy on the basis that JW and DT would review and provide further clarity to ensure absolute clarity about the document's purpose. **The Committee Resolved that:** a) The digital disaster recovery policy was approved.	
	Items for Noting and Information	

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D&IC 11/11//5.1	**Minutes: Digital Directors Peer Group** • The minutes from the Digital Directors Peer Group were noted. • The group evolved into a digital advisory group providing advice to the national D DAT board, which included all chief executives and is chaired by the Minister. • There was a greater commitment to collaboration and joint working, particularly with DHCW, as national programmes were delivered. . **The Committee Resolved that:** a) The minutes of the Digital Directors Peer Group from 02.09.25 & 07.10.25 were noted.	
	Agenda for Private Meeting	

D&IC 11/11/6.1	• *Cyber Security*
	  • *Caldicott Guardian*
	  • *Digital Foundations*	

	Any Other Business	
D&IC 11/11/7.1	*No Other Business was discussed.*	
	Items to bring to the attention of the Committee	
D&IC 11/11/8.1	**Date & Time of next Meeting:** *Tuesday 10th February 2026 at 9am via MS Teams*	

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Report Title:	Estate Infrastructure & Risk Register			Agenda Item no.	*2.1*
Meeting:	Digital & Infrastructure Committee	Public	√	Meeting Date:	10th February 2026
		Private			
Status *(please tick one only):*	Assurance	√	Approval		Information
Lead Executive Title:	Director of Finance				
Report Author (Title):	Director of Captial, Estates and Facilities				

Main Report
Background and current situation:

The purpose of this report is to provide the Digital & Infrastructure Committee with an overview of the current estate infrastructure including:

- The risk register, highlighting the current position and any specific changes that have developed in the reporting period
- An update on the electrical infrastructure works, feedback on the recent Operation 'POET' Exercise undertaken at UHW and the plans for the UHL main event
- Progress on the capital programme and confirmation of any additional funding received within the reporting period and further potential funding opportunities.

Risk Management & Current Status

Capital, Estates and Facilities currently manage 18 departmental risk registers which feed into the CEF Master Risk Register (embedded below), which incorporates those risks across the service board which are >15. Those that are >20 are escalated and included in the corporate risk register.

CEF have made good progress with the conversion of risks from the Excel format to the UHB Amat System and all existing risks with a rating of >20 now complete. As of the 16th January 2026, a total of over 340 have been successfully transferred to Amat with 145 remaining outstanding, albeit, the team are confident that these will be completed within the corporate governance target date, at the end of the current financial year.

The quarterly risk workshops operated by CEF will continually review all risks and where appropriate increase or decrease the risk rating and revise the Amat status.

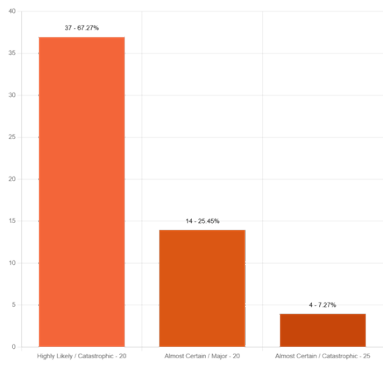
Table 1 provides a summary of the 55, 20 & >20 infrastructure risks. Within the reporting period, 1 risk has been reduced following the completion of the Electrical Substation 2A Replacement Switchgear, an issue which was identified during the UHW 'Operation POET' exercise in 2023.

Table 1

CEF – Infrastructure Risk 20 +

Risk rating	Count	Percentage
Highly Likely / Catastrophic - 20	37	67.27
Almost Certain / Major - 20	14	25.45
Almost Certain / Catastrophic - 25	4	7.27

Closed Risks		
Risk ID	Speciality	Risk title
CEF - Electrical/2024-2505	Speciality	E16 - Electrical sub station 2A - auto changeover fail.
Reduction of 1 Risks since last report		



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The >20 risk register is forwarded to Corporate Governance bi-monthly and any additional >20 risks reported to the Operational, Health and Safety Group meeting quarterly.

UHB Electrical Infrastructure Improvement works and Resilience Testing

UHW ITU Infrastructure & Proposed Phased Expansion

The UHB were successful in receiving Welsh Government slippage funding to install compliant Uninterrupted Power Supply (UPS) systems across the Intensive Care Unit at UHW. Each of the areas, A3, B3 and C3 are now provided with 'N+1' provision which enhances the resilience of the electrical infrastructure supporting the Unit. This issue was previously a significant cause for concern and risk for the HB

Whilst the immediate issues have been addressed, further risks related to obsolete infrastructure has been identified, which as well as non-compliant ventilation systems has increased the level of risk and the need for refurbishment of the ITU department is considered high priority.
The Director of Capital, Estates and Facilities has discussed the situation with WG and NWSSP Specialist Estate Services, including options to accelerate the refurbishment and expansion of the ITU footprint to improve patient safety and the environment in which patients are cared for and staff work.

The HB, WG and NWSSP Specialist Estate services have concluded that a Programme Business Case (PBC) will be developed to include 3 projects, one for each phase of the refurbishment programme, with procurement of the preferred contractor via a recognised construction framework

- Phase 1 – C3 North, C3 South and Stem Corridor
- Phase 2 – B3 North, B3 South and Stem Corridor
- Phase 3 – A3 North, A3 South, Stem Corridor and A3 Link Isolation Suite

The Design is at an advanced atage and tender packages will be issued early March 2026 which will allow the completion of the PBC and the Business Justification Case for Phase 1. It is anticipated that the documents will be completed to enable them to be considered by the UHB Board at the May 2026 meeting and following the endorsement by the appropriate internal groups and committees.

UHW Replacement of Rising Bus Bars in Tower Block 1

Following the successful completion of the replacement of the Substation 2A switchboard, the team are undertaking the final preparation work to enable the transfer of supplies onto the recently installed Non-Essential Rising Main in Tower Block 1. These works include multiple local isolations affecting the non-essential supplies in many departments.

Intrusive testing of all local circuits within each department affected will be undertaken ahead of the isolations to ensure that as much detail as possible is gathered to mitigate any risks to services with the areas.

The work is being overseen by the project team who have overseen operation 'POET' and includes Estates, Capital, Digital Health Intelligence, Clinical Engineering and Clinical Operational colleagues. Engagement with the clinical areas affected, continues, albeit minimal disruption to services is expected as the essential supply remains available throughout. The electrical works will be undertaken while Theatres 3 & 4 and the theatre recovery area are out of commission for refurbishment which will mitigate any further risks in this area.

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UHL Operation 'POET'

This years exercise had been postponed due to the considerable time required to complete the works on the UHW site with the replacement of substation 2A and the subsequent testing, including Operation 'POET' on 21st October 2025.

Since that time the project team have turned their focus to the planning and preparatory works, for the annual test at UHL. Operation 'POET' is scheduled for Friday 13th February 2026 and the programme for the pre-testing of all local generators has been agreed. In addition, a review of the lessons learnt from the previous Operation 'POET' have been reviewed along with a site survey to ensure any temporary supplies are installed.

Capital Funding and Opportunities

Within the reporting period, the UHB has been successful in receiving the following additional capital funding which will address key issues and mitigate risks;

Approved Schemes	**£m**
End of Year Digital Funding	1.550
End of Year Funding (Estates and Equipment)	4.382
End of Year Funding January 2026 (Estates and Equipment)	7.796
End of Year Digital Funding January 2026	0.700
End of Year Funding – *Refurbishment of C1 Cardiology to allow the relocation of C3 to C1 to release capacity for ITU Expansion*	3.100
Demolitions at UHW – *Brecknock House & Sports and Social Club*	1.834

Capital Management Group took the opportunity to rank estates schemes as the highest priority for recent slippage due to the time required to design, tender and deliver associated works, recognising the ability to procure and deliver medical equipment and digital devices in a shorter timeframe. Any further available funding opportunities will be focused on delivering digital, medical equipment and replacement of beds.

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

- Capital Management Group will continue to consider potential funding opportunities to mitigate associated risk across the estate
- Capital Management Group will monitor the development of the schemes and manage the spend profile accordingly to ensure that the UHB meet their statutory obligation to WG and deliver the CRL within the agreed parameters by the end of the financial year.
- The Capital and Estates risk registers are reviewed on a monthly basis by the CEF Assurance, Safety & Compliance team with a Risk workshop held quarterly with department leads to review all risks above 15.

Recommendation:

The Digital & Infrastructure Committee is requested to:

a) **NOTE:** the approach by CEF to manage and review risk across its portfolio
b) **NOTE:** the receipt of additional funding to address schemes from the respective risk registers
c) **NOTE:** the electrical infrastructure works to Tower Block 1 Non-Essential Riser which will provide further resilience to services with new infrastructure

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Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

1.	Putting People First	√	2.	Providing Outstanding Quality	√
Click the objective above to view more detail.			**Click the objective above to view more detail.**		

3.  **Click the objective above to view more detail.**		4.  **Click the objective above to view more detail.**	√

Five Ways of Working (Sustainable Development Principles) considered *Please place an "**X**" in the below boxes as relevant*									
Prevention	√	Long term	√	Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

Impact Assessment: *Please state **yes** or **no** for each category. **If yes please provide further details.***
Risk: Yes
Lack of capital funding to deliver the scheme has implications on clinical service delivery.
Safety: No
Financial: Yes
As above. The UHB will continue engagement with Welsh Government to determine and potential additional funding available
Workforce: No
Legal: Yes
Statutory obligations require investment and the lack thereof can lead to exposure to risk and legal challenge
Reputational: Yes
The UHB's opportunity to satisfy the JACIE recommendations and maintain accreditation. Loss of accreditation will be detrimental to the reputation of CAV UHB
Socio Economic: No
Equality and Health: Yes
Increasing the overall reliability of the electrical infrastructure in ITU will mitigate the risk of further electrical failures and any impact to patient services.
Decarbonisation: Yes
Although not been specifically, new equipment installed will be more energy efficient.

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Capital Management Group	
Senior Leadership Group	
Finance Committee	
UHB Board	

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Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

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Shaping Our Future Wellbeing

Strategic Framework

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

Strategic Framework						
Strategy	**Putting People First**	**Providing Outstanding Quality**			**Delivering in the Right Places**	**Acting for the Future**
Strategic Portfolio	Shaping Our Future People & Culture	Shaping Our Future Population Health & Place Based Partnerships	Shaping Our Future Quality, Value & Sustainability	Shaping Our Future Clinical Services	Shaping Our Future Infrastructure	Shaping Our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	
Committees	People and Culture Committee	Quality Committee			Digital and Infrastructure Committee	Finance and Performance Committee
		Mental Health Committee				
	Audit & Assurance					

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Shaping Our Future Wellbeing

Strategic Objectives

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

Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

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Shaping Our Future Wellbeing

Strategic Risks – Infrastructure

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

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB.
The condition of facilities within our main hospitals and some community facilities are impacting on our ability to continue to provide the full range of services and provide the would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.

Cause	Impact
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • • Medical equipment replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

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Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This is being updated. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2025/26 Capital Plan will be submitted for Board with the IMTP • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This part of the Capital Management Group agenda. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month. • Welsh Government has asked all NHS organisations to provide a prioritised capital programme using a weighting framework developed by the Infrastructure Investment Board. The submission date is 31st March 2024. The Health Board's submission has been scrutinised and approved through the internal governance mechanisms and is coming to the Board on 28th March for oversight. • The outcome of the WG prioritisation process was confirmed and the schemes which they have indicated support include The Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. Following discussions with WG colleagues the UHB are developing options for the delivery of these projects which could include an integrated new build facility. • Discussion with Welsh Government regarding the Shaping Our Future Acute Hospital Programme continues, albeit that there has been somewhat of a hiatus over the last 9 months. The initial focus will be on the delivery of a master planning exercise to determine the most appropriate direction of travel to deliver new facilities to support the delivery of clinical services into the future. The tender documentation and specification is being finalised with the intention to procure a supplier by the end of 2025.	• The estates and capital team is in constant dialogue with WG and continues to present business cases to secure the necessary capital to address the major short/medium term service estates issues. This has proven successful in the closing months of the financial year A significant amount of end of year funding has been secured, as in previous years, and this has enabled capital investment in critical digital infrastructure in particular. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee has been strengthened(1) • The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Finance & Performance Committee (1) (2) •) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Finance and Performance Committee continue to oversee the delivery of the Capital Programme (1) • A way forward in relation to the Shaping Our Future Hospitals Strategic Outline Case is being progressed by the Health Board(3) Risk Register reporting to D&I Committee

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Shaping Our Future Wellbeing

Strategic Risks – Infrastructure

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

Gaps in Controls	Gaps in Assurances
• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the estate and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 4	Net Risk: 20	

Actions			
What	**Lead**	**By**	**Update**
Risks to infrastructure which have been identified are developed into robust plans for mitigation. These are prioritised through our annual planning work and identified	Geoff Walsh	Annual plan	The discretionary capital is prioritised to meet our annual plan. Prioritised plan is signed off by CMG and SLB and Board. Significant risks or financial requirements are raised regularly with Welsh Government to support when necessary. WG Targeted Estates Funding received which will address some of the highest risks identified on the CEF Risk Register. Schemes which received approval have been reported to CMG and SLB
Where estate is no longer required for the provision of care or services a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	Annual plan	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition, along with Brecknock House and the recently vacated Sports and Social club CEF are working with the Specialist Clinical Board on options to re-locate ALAS and deliver a single site option for the service Disposal plans – Rookwood the UHB have identified a preferred bidder following a comprehensive disposal exercise and are working with them to develop the proposal, including Heads of Terms etc.

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Strategic Risks – Infrastructure

A condition survey will be undertaken to understand in detail the status of the Health Board estate with a view to inform a future investment priorities and estate needs.	Geoff Walsh	Initial commission complete	The survey work has been completed and a comprehensive data base including risks cost and a draft 10-year plan is being finalised for completion by the end of the calendar year as planned. An overarching document is being produced to socialise with the wider UHB and a paper is being presented to the C & I committee in February 2026.

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Report Title:	Infrastructure Surveys to Inform Future Capital investment			Agenda Item no.	2.3
Meeting:	Digital & Infrastructure Committee	Public	√	Meeting Date:	10.02.2026
		Private			
Status *(please tick one only):*	Assurance	√	Approval		Information
Lead Executive Title:	Director of Finance				
Report Author (Title):	Director of Captial, Estates and Facilities				

Main Report
Background and current situation:

The purpose of this report is to provide the Digital and Infrastructure Committee with the initial findings of the survey undertaken across the University Hospital of Wales Site to provide a clear, evidenced based view on the estate condition and risk.

A number if reports have been prepared and considered by the Health Board relating to the deteriorating infrastructure across its Estate, with increasing system failures, impacting on patient safety, appropriate clinical environments in which to treat patients, infection prevention and control etc.

Whilst significant work has been undertaken by the Capital, Estates & Facilities Service Board to identify, assess and manage the risks across the estate, it is becoming increasingly difficult to reduce the level of risk and mitigate, without significant and appropriate investment.

The limited capital funding available to address the high level of backlog maintenance increases the risk of infrastructure failure and we therefore have a situation where the approach to ongoing maintenance is reactive as opposed to preventative, which impacts on downtime of key infrastructure affecting clinical services, increased repair costs and safety. Whilst CEF have continued to consider opportunities to reverse the trend, without the capital investment it is difficult to see when the shift in balance will occur.

Recognising, the deterioration of the infrastructure and the need to develop capital investment plans to support investment the Health Board with the financial support of Welsh Government commissioned an extensive survey of its estate, with the primary purpose of the findings to support any future capital investment.

The report would provide a comprehensive database detailing the:

- The condition and risk of all assets
- Priority investment required
- Consequences of continued under-investment

The detailed surveys have now been complete for all sites across the HB portfolio. The findings of the surveys and proposed investment priorities will be presented in 3 reports:

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- University Hospital of Wales
- University Hospital Llandough
- Community and Primary Care Estate

The presentation attached provides a summary of the findings and proposals for the University Hospital of Wales, with the other reports to follow. The intention is to have a comprehensive report delivered by the end of the financial year for consideration both internally and with WG colleagues to determine how we move the agenda forward to ensure we have the appropriate level of investment to provide an estate fit for the delivery of clinical services for the future.

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

- The increased level of backlog maintenance, recognising that the amount indicated in the presentation is related to UHW only
- The Investment required to manage the High and significant risk
- The significant amount of investment that is identified within the first 3 years

Recommendation:

The Digital & Infrastructure Committee is requested to:

a) **NOTE:** the content of the report and presentation

b) **NOTE:** the significant increase in 'backlog' renewal, recognising that over 85% is Essential and Mandatory demonstrating that the investment is needed to sustain safe clinical operation and prevent escalation into statutory non-compliance

c) SUPPORT: the submission of the summary document to WG to inform the earliest discussion to highlight the level of risk that the HB is currently managing on the UHW site

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

1.	Putting People First **Click the objective above to view more detail.**	√	2.	Providing Outstanding Quality **Click the objective above to view more detail.**	√
3.	Delivering in the Right Places **Click the objective above to view more detail.**		4.	Acting for the Future **Click the objective above to view more detail.**	√

Five Ways of Working (Sustainable Development Principles) considered

*Please place an "**X**" in the below boxes as relevant*

Prevention	√	Long term	√	Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?:

*Please place an "**X**" in the below boxes as relevant. Any queries, please contact Alexandra.scott3@wales.nhs.uk*

Yes – ***(please provide completed QIA document)***		No – ***(Please provide reasoning, e.g. not required)***		*Comment here*

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Impact Assessment:

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

Risk: Yes

Lack of capital funding to deliver the scheme has implications on clinical service delivery.

Safety: No

Financial: Yes
As above. The UHB will continue engagement with Welsh Government to determine and potential additional funding available
Workforce: No
Legal: Yes
Statutory obligations require investment and the lack thereof can lead to exposure to risk and legal challenge
Reputational: Yes
The UHB's opportunity to satisfy the JACIE recommendations and maintain accreditation. Loss of accreditation will be detrimental to the reputation of CAV UHB
Socio Economic: No
Equality and Health: Yes
Increasing the overall reliability of the electrical infrastructure in ITU will mitigate the risk of further electrical failures and any impact to patient services.
Decarbonisation: Yes
Although not been specifically, new equipment installed will be more energy efficient.

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Capital Management Group	
Senior Leadership Group	
Finance Committee	
UHB Board	

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CURRIE & BROWN

The Value of Certainty.

University Hospital Wales - Facet Surveys

Executive Summary

Prepared for Cardiff & Vale UHB

December 2025

Purpose of This Report

Purpose

This Executive Summary presents the key findings from the 10-year estate condition, risk and lifecycle modelling for University Hospital Wales.

It has been prepared to:

- Provide a clear, evidence-based view of estate condition and risk
- Identify priority investment needs
- Support Welsh Government funding discussions
- Explain the consequences of continued under-investment compared to targeted intervention

The analysis draws directly from the validated Power BI estate model, using asset-level condition, risk, backlog and lifecycle cost data.

Functional suitability and space utilisation are outside the scope of this summary.

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Estate Overview

University of Wales at a Glance

The University Hospital Wales site supports a wide range of acute, community, mental health and specialist services.

Much of this activity is delivered from ageing infrastructure, placing increasing pressure on asset condition, resilience and maintenance demand.

65
Total Facilities

£472 m
10 Years Renewals

£47 m
Annualised spend

£116.5 m
Total backlog maintenance
***Year 1 Investments*

£94.9 m
Cost to Condition B

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Model Structure

Estate data inputs and baseline assumptions

The estate model is built from validated, asset-level survey data and structured to allow consistent comparison across the estate.

It combines condition, cost, risk and lifecycle information within a single, coherent dataset that underpins all subsequent analysis.

Core data inputs include:

- Condition grades (A–Dx) for fabric and M&E and assets
- Asset replacement costs aligned to standardised cost libraries
- Remaining service life for each asset
- NHS priority categories (Mandatory, Essential, Desirable, Statutory)
- NHS 1–25 risk scoring inputs (likelihood and consequence)
- Gross internal floor area (m^2) for benchmarking and normalisation

Baseline assumptions:

All costs are normalised to a common base year

- Data is aggregated at both building and site level
- Consistent classification and coding is applied across all assets
- Functional suitability and space utilisation are excluded from this model
- This structure provides a single, coherent dataset that underpins all subsequent analysis.

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Modelling Approach

How data is converted into backlog, risk and investment need

Key modelling steps:

The model converts survey data into backlog, risk and investment need through a series of clear steps:

- **Backlog:** the cost to return assets in Condition C–Dx to Condition B
- **Lifecycle:** renewal costs profiled over 10 years based on remaining service life
- **Risk:** costs weighted using NHS 1–25 likelihood and consequence scoring
- **Priority:** works classified as Mandatory, Essential, Statutory or Desirable

This approach allows high-risk, high-cost assets to be identified and enables investment decisions to be prioritised on the basis of risk, cost and impact.

What this enables:

- Identification of high-risk, high-cost assets
- Comparison of alternative investment scenarios
- Clear visibility of how deferred investment escalates risk and cost
- Evidence-based prioritisation of capital and revenue spend

Outputs are presented through site-wide and facility-level dashboards to support decision-making.

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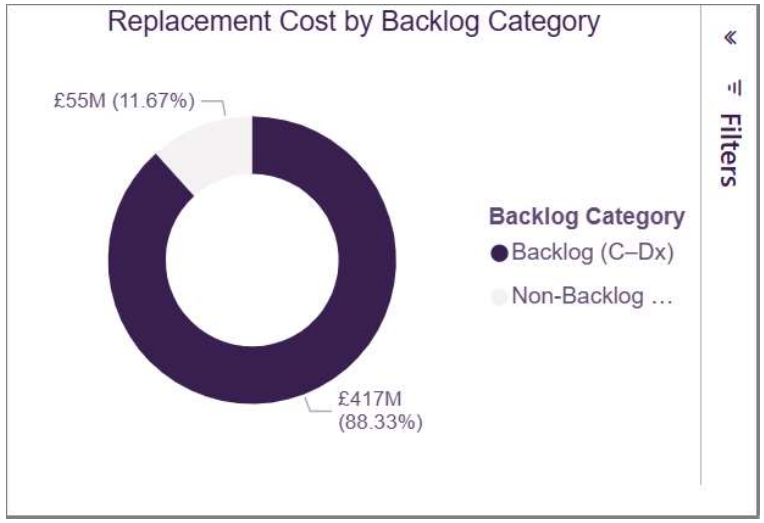
"88% of estate liability relates to backlog — driven primarily by widespread deterioration rather than isolated failures."

Condition Distribution

Grade split

- Grade A / B: ~12% – Generally serviceable
- **Grade C: ~78% – Deterioration evident**
- **Grade D / Dx: ~10% – Significant risk / failure**



Escalating Risk from Deferred Investment

While part of the estate remains serviceable, most lifecycle liability sits within Grade C assets.

This reflects widespread deterioration across the estate rather than isolated failures and is the primary driver of backlog growth.

This position is the primary driver of backlog growth and presents an escalating operational and financial risk if not addressed through sustained investment.

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Backlog Maintenance

Backlog Overview

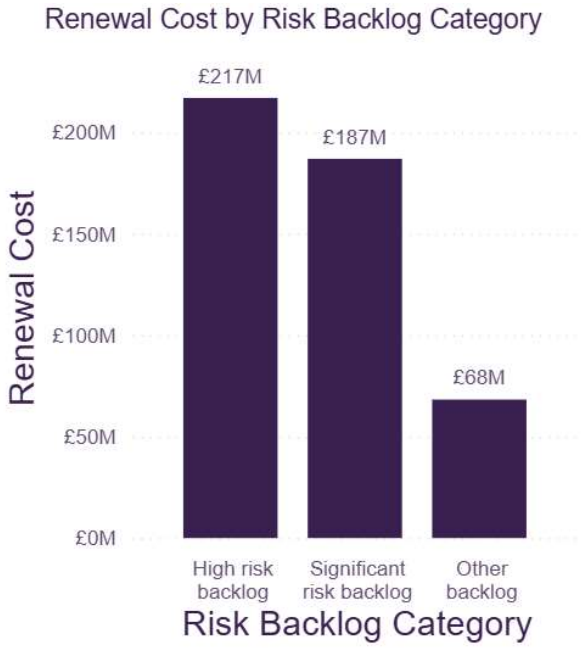
The backlog reflects:

- Historic under-investment
- Ageing infrastructure
- Increasing compliance and resilience demands
- Without intervention, backlog will continue to grow at an accelerating rate rather than stabilising over time.

Note: Backlog = cost to return Condition C–Dx assets to Condition B.

£417 m
Total Backlog

£402 m
High / Significant backlog



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“National Benchmarking Confirms Severe Backlog Position”

Backlog - National Context

How UHW compares nationally

A comparison against the **2023–24 ERIC returns** shows that **University Hospital Wales (UHW) is a clear national outlier**.

£2,086 per m2 performs very poorly against NHS England average of £662 per m2

- Backlog at UHW is £2,086 per m², compared with an NHS England average of £662 per m²→ More than three times the national benchmark
- When ranked against all NHS Trusts, UHW sits within the worst-performing cohort nationally on a backlog per m² basis.
- On a national league table, UHW ranks 6th worst out of 208 Trusts, placing it firmly at the extreme end of national performance.

£2,086 v £662

Backlog per m2 – UHW Vrs NHS England Average

Top 10 Trusts - Backlog M2

Trust Name
AIREDALE NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
BARTS HEALTH NHS TRUST
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY HOSPITAL WALES
THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATIC TRUST
CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST
BOLTON NHS FOUNDATION TRUST

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Note: ERIC benchmarking is indicative and intended for high-level comparison only.

"Over one-third of total estate risk sits in just ten buildings."

Risk Profile (NHS 1–25)

Top 10 Sites - Total Risk Exposure

Site Name	Building Name	Total Risk Exposure (Avg x Count)	Sum of Renewal Cost	% of Total Risk
University Hospital Of Wales	10 - Ward block a	9794	£86,259,096	12.89%
University Hospital Of Wales	11 - Ward block b	8244	£64,678,100	10.85%
University Hospital Of Wales	18 - Tower Block 3	8140	£56,244,290	10.71%
University Hospital Of Wales	09b - Tower block 1b	8132	£18,151,853	10.70%
University Hospital Of Wales	09c - Tower Block 1c	7835	£27,763,093	10.31%
University Hospital Of Wales	12 - Ward block c	7687	£98,234,009	10.12%
University Hospital Of Wales	102 - Car Parks	6851	£9,917,505	9.02%
University Hospital Of Wales	05a - Dental hospital	6707	£35,054,180	8.83%
University Hospital Of Wales	08a - Tower block 2a	5872	£16,774,540	7.73%
University Hospital Of Wales	08b - Tower block 2b	5807	£20,966,785	7.64%

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Drivers of Escalating Estate Risk

Risk is not evenly distributed across the estate. **Around 38% of total estate risk is concentrated within just ten buildings,** primarily critical clinical and ward facilities.

Targeted, risk-led investment in this group would deliver a disproportionate reduction in overall estate risk.

C, CX, D, DX – CONDITION CODES

COST PROFILE

YEAR 1

Row Labels	Sum of Renewal Cost
Alarms and Detection	£29,200
Boilers and Calorifiers	£1,102,300
Drainage and Water Mains	£237,250
Electrical System	£7,117,592
External Fabric	£618,613
Fire Safety	£4,507,036
Fixed Elec Plant and Equipment	£13,433,889
Fuel Storage and Distribution	£32,850,000
Grounds & Gardens	£315,164
Health & Safety	£14,229,179
Heating System	£87,600
Hot & Cold Water Systems	£459,900
Internal Fabric	£465,516
Internal Fixtures & Fittings	£25,545
Lifts and Hoists	£2,757,434
Lighting	£1,751,974
Roof	£102,746
Structure	£31,603
Telecomms	£18,250
Ventilation System	£36,414,225
Grand Total	£116,555,016

YEAR 1 & 2 COMBINED

Row Labels	Sum of Renewal Cost
Alarms and Detection	£29,200
Boilers and Calorifiers	£1,102,300
Drainage and Water Mains	£248,121
Electrical System	£7,117,592
External Fabric	£3,578,249
Fire Safety	£4,507,036
Fixed Elec Plant and Equipment	£13,433,889
Fuel Storage and Distribution	£32,850,000
Grounds & Gardens	£363,070
Health & Safety	£14,229,179
Heating System	£87,600
Hot & Cold Water Systems	£459,900
Internal Fabric	£533,027
Internal Fixtures & Fittings	£169,247
Lifts and Hoists	£2,757,434
Lighting	£1,751,974
Roof	£10,857,971
Structure	£3,920,919
Telecomms	£18,250
Ventilation System	£36,414,225
Grand Total	£134,429,184

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What Investment Buys You

Translating investment into measurable risk reduction

Targeted, risk-led investment delivers far greater benefit than spreading funding evenly across the estate.

Focused intervention enables:

- **Meaningful risk reduction** – addressing a small number of high-risk facilities removes a disproportionately large share of total estate risk
- **Protection of core clinical services** – prioritising Mandatory and Essential works reduces immediate safety, statutory and operational exposure
- **Better value for money** – early intervention avoids escalation into reactive maintenance, emergency replacement and unplanned disruption
- **Greater certainty over future investment** – tackling front-loaded lifecycle demand stabilises longer-term funding requirements

Regan, Nikki
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"Over 85% of the 10-year £472m renewal requirement is driven by Mandatory and Essential works, demonstrating that the estate's investment need is primarily to sustain safe clinical operation and prevent escalation into statutory non-compliance, rather than discretionary improvement."

Priority Categorisation

10-Year Priority Spend Profile

Investment requirements over the 10-year period are categorised in line with NHS priority definitions:

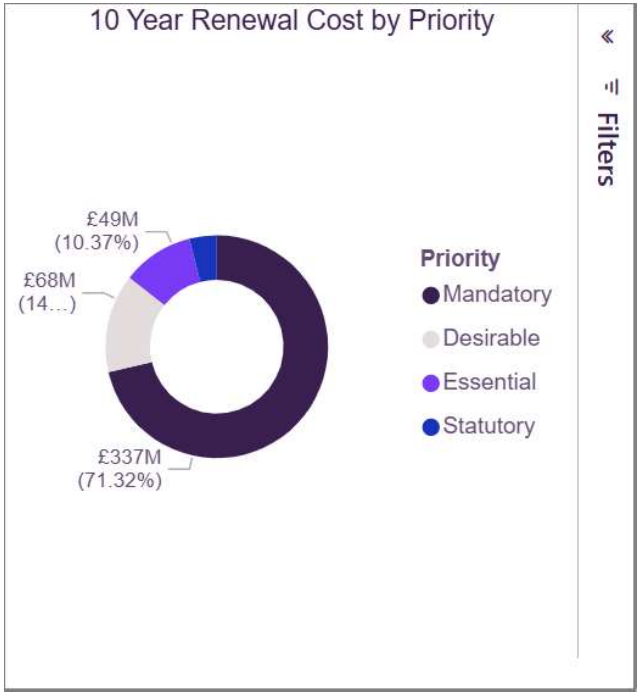
Mandatory: £336.6m (71.3%)
Works essential to maintain safe and continuous clinical operation, where failure would result in service disruption or unacceptable operational risk.

Essential: £49.0m (10.4%)
Works required to prevent further deterioration and escalating risk, protecting asset integrity and avoiding higher future costs.

Desirable: £67.7m (14.3%)
Longer-term lifecycle and optimisation works that support estate performance but do not present immediate safety or operational risk.

Statutory: £18.7m (4.0%)
Works required to meet existing legal or regulatory obligations, including life safety, fire safety and statutory compliance.

Priority categories defined in line with NHS Estates guidance.



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"A limited number of high-cost, high-risk facilities drive the majority of the estate's long-term maintenance liability, reinforcing the need for **prioritised, risk-led capital investment**.

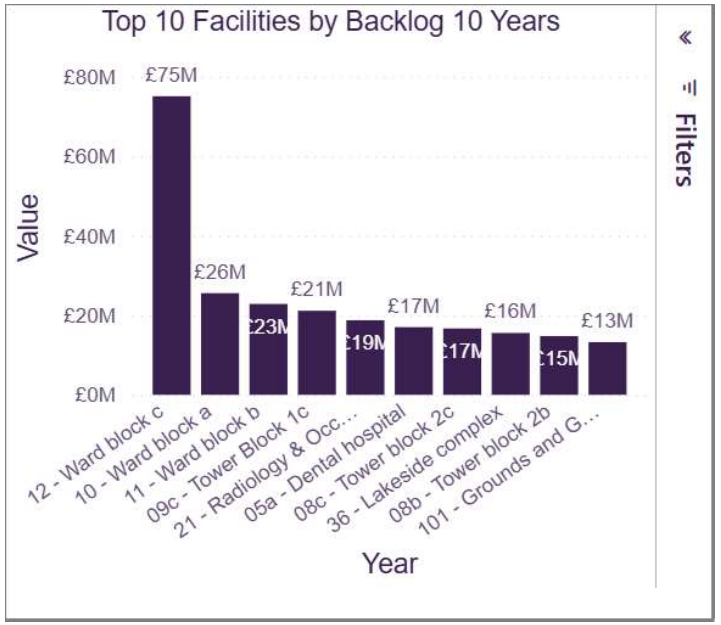
Facility-Level Cost Concentration

Backlog Cost Concentration

Backlog maintenance cost is highly concentrated within a small number of facilities rather than spread evenly across the estate.

The top ten facilities alone account for around £245m — more than half of the total 10-year renewal requirement.

This creates a clear opportunity to target investment where it will have the greatest impact on risk and service resilience.



Backlog maintenance costs are disproportionately concentrated within the top 10 facilities, accounting for over half of the total 10-year renewal requirement.

Regan, Nikki
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"Severe Front-Loaded Renewal Replacement Indicates Estate in Very Poor Condition

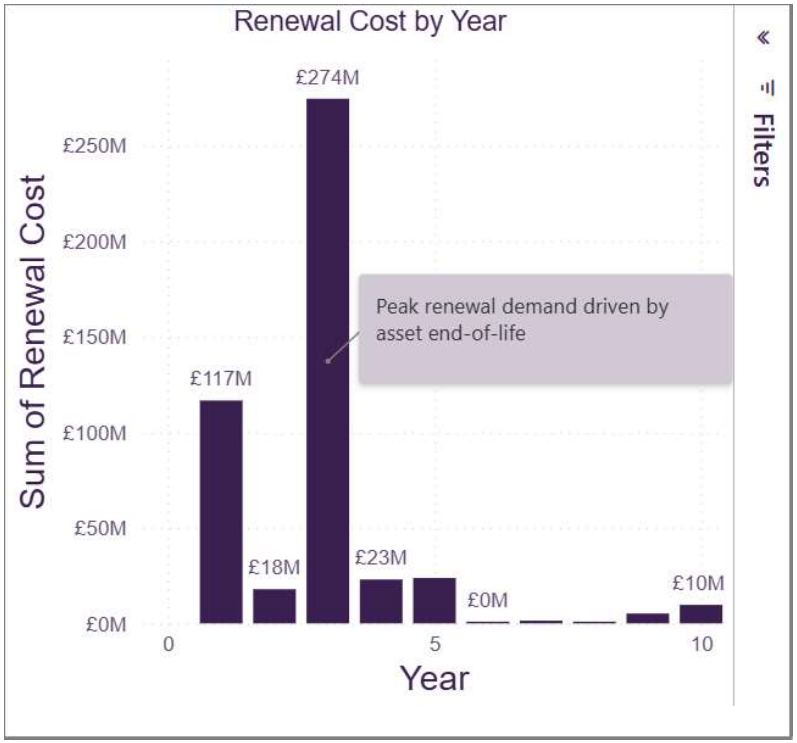
10-Year Renewal Profile

Lifecycle Demand Over Time

The 10-year lifecycle profile shows that renewal demand is heavily front-loaded, driven by ageing assets and historic construction cohorts reaching end of service life at the same time.

Over 70% of the total 10-year renewal requirement falls within the first three years, with a pronounced peak in Year 3. This is a timing issue arising from asset age, not a discretionary investment decision.

The apparent reduction in later years does not indicate reduced risk; rather, it highlights that failure to intervene early would result in asset failure, service disruption, or emergency replacement.



Renewal costs are heavily front-loaded, with the majority of lifecycle investment required in the early years of the programme.

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Consequences of Under-Investment

What Happens If Investment Is Deferred

Without targeted intervention, the estate will experience:

- Escalating clinical and operational risk
- Increased statutory and safety exposure
- Greater reliance on reactive maintenance
- Poorer value for money and higher whole-life cost

These impacts affect both patient safety and the reliability of clinical services.

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Conclusions & Recommendations

Strategic Implications for Investment

The 10-year condition, risk and lifecycle model demonstrates that:

1. Estate risk and cost are highly concentrated, not evenly distributed
2. Investment need is driven by Mandatory and Essential requirements
3. Renewal demand is front-loaded and unavoidable
4. Targeted investment will deliver disproportionate risk reduction

Recommendations next steps

- Prioritise funding toward highest-risk, highest-cost facilities
- Focus early investment on Mandatory and Essential works
- Use the model as a live decision-support tool for capital planning
- Deploy outputs to support Welsh Government funding discussions

Digitally signed by Nikki Green
Date: 2026.02.09 11:27:07 GMT

Appendix 1 – Photo Schedule – Critical Asset End of Life

Item	System/Asset	Photo	Photo	Photo	Building/Location	Notes
1	HV Generator				Site	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. The system and redundancy of the system does not comply with the latest WHTMs. Critical failure would result in closure of large sections of the hospital.
2	HV Load Control				Site	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. The system and redundancy of the system does not comply with the latest WHTMs. Critical failure would result in closure of large sections of the hospital.
3	LV Generator				Site	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. The system and redundancy of the system does not comply with the latest WHTMs. Critical failure would result in closure of large sections of the hospital.

Regan, Nikki
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Appendix 1 – Photo Schedule – Critical Asset End of Life

Item	System/Asset	Photo	Photo	Photo	Building/Location	Notes
4	LTHW Plant and Controls				Boiler House	Large sections of the asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. Critical failure would result in closure of large sections of the hospital.
5	Main Steam Header and Valves				Boiler House	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. Critical failure would result in closure of large sections of the hospital.
6	HV Intake distribution board				Main HV Switch room	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. The system and redundancy of the system does not comply with the latest WHTMs. Critical failure would result in closure of large sections of the hospital.

Regan, Nikki
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Appendix 1 – Photo Schedule – Critical Asset End of Life

Item	System/Asset	Photo	Photo	Photo	Building/Location	Notes
7	Main LV distribution board				Boiler House	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. The system and redundancy of the system does not comply with the latest WHTMs. Critical failure would result in closure of large sections of the hospital.
8	Electrical Infrastructure				Site	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. The system and redundancy of the system does not comply with the latest WHTMs. Critical failure would result in closure of large sections of the hospital.
9	Pipework infrastructure				Site	The pipework infrastructure is largely the original, 1970s, installation and struggles to satisfy the hospitals requirements. Leaks and emergency remedial works effects large amount of the hospital.

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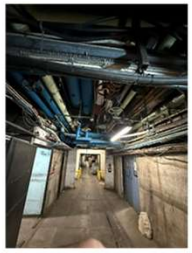
Appendix 1 – Photo Schedule – Critical Asset End of Life

Item	System/Asset	Photo	Photo	Photo	Building/Location	Notes
10	Ventilation System				Site	The asset is beyond its expected life expectancy, lack of spare parts will result in long and costly downtimes. There areas of the hospital where air changes do not meet WHTMs.
11	Drainage				Site	The drainage infrastructure is largely the original, 1970s, installation and struggles to satisfy the hospitals requirements. Leaks and remedial works effects large amount of the hospital.
12	Lifts				Site	The majority of these assets are beyond their expected life expectancy, lack of spare parts will result in long and costly downtimes. This causes major disruption to day to day running and use of the hospital.

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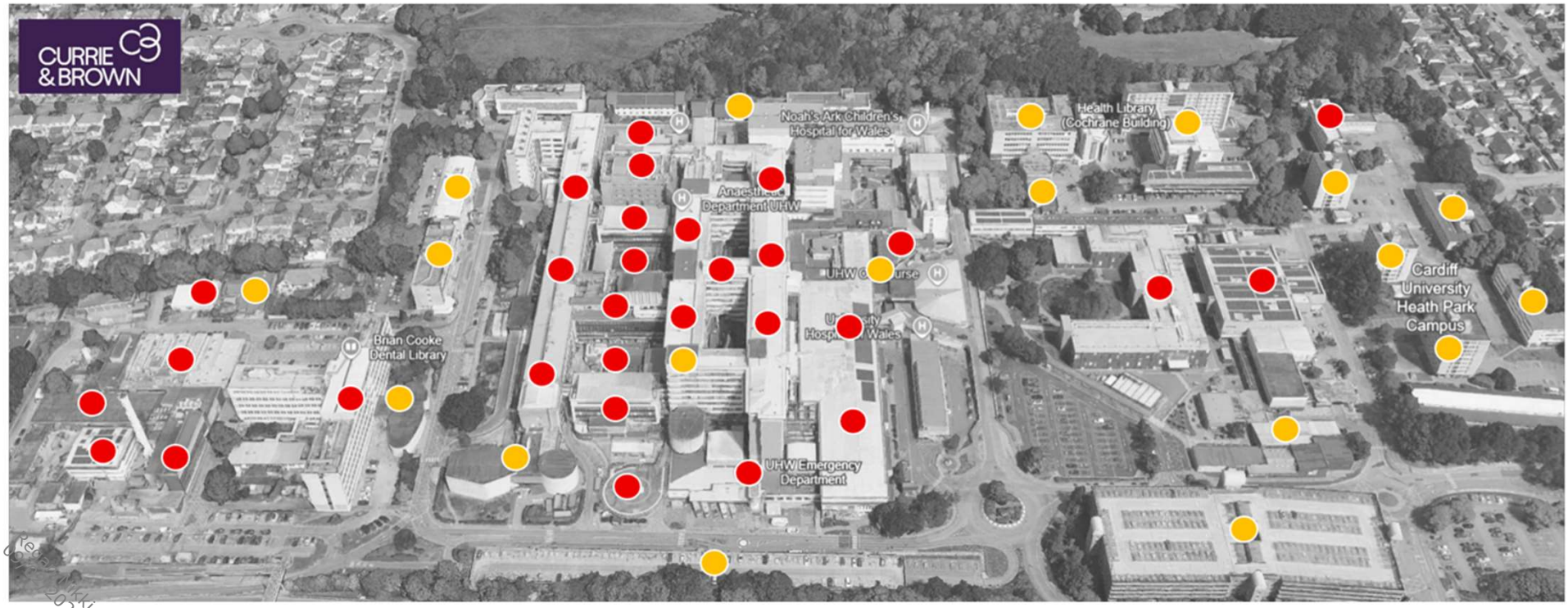
Appendix 2 – Heat Map - NHS Risk Banding by Building

NHS RISK BAND – EXTREME

NHS RISK BAND – VERY HIGH



Received 05 May 2026 11:27:07

This report provides a clear, evidence-based platform to support informed decisions on capital prioritisation, risk management and long-term estate planning.

CURRIE & BROWN

Regan,Nikki
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Report Title:	Digital Roadmap and work programme update			Agenda Item no.		3.1
Meeting:	Digital & Infrastructure Committee		Public Meeting	X	Meeting Date:	10th February 2026
			Private Meeting			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Director of Digital Transformation					

Background and current situation:

Shaping our Future Digital Services

1.1 Digital Foundations Programme Business Case

The Digital Foundations (DF) Programme Business Case (PBC) was completed in its first iteration as reported to the committee meeting in November 2025.

1.2 Funding the PBC

Also as reported November 2025, we have been undertaking a review with Clinical Board senior representatives, and Finance colleagues to identify sufficient revenue benefit to make the case self-funding. It is apparent however that some sort of additional revenue requirement is inevitable. This work has not concluded and, as these are enterprise solutions that benefit the whole system, it is difficult to determine precisely where a benefit may land for example in an individual benefit or clinical board. We are also discussing with expert colleagues which cost elements could be capital and which remain as revenue. This may require remodelling of the costs but doesn't change what we need to do.

Further, we have consistently reported that DF is not about technology for its own sake, it is about creating the conditions for safe, sustainable, person-centred care and a way forward. The programme directly supports critical enablers of population health improvement, reduction of inequalities and enhanced service quality.

The benefits therefore need to be considered in the context of how they support new care models that solutions can facilitate. Completion of the Clinical Services Plan will help with this. A paper was published 11 December 2025 by NHS Confederation reinforces this view, as shown at **Appendix 1.**

The current plan is to present the case to Board for approval at the May 2026 meeting. If approved, the case will then go to Welsh Government for consideration.

In the meantime, senior colleagues continue their dialogue with Welsh Government colleagues in capital and digital to ensure awareness the case is still progressing. As Wales will enter a General Election in May, it is possible there may not be a funding decision until later in 2026.

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Background reported November 2025 includes that:

CAVUHB's ambition is to become data-driven and digitally enabled to support safer and smarter care. This ambition is grounded in CAVUHB Shaping our Future Wellbeing Strategy

(https://shapingourfuturewellbeing.com/) which describes 4 strategic objectives, all of which rely upon good quality data and information.

Current digital capability and infrastructure is no longer fit for purpose, leading to inefficiencies, safety risks, and operational challenges. Without decisive investment in foundational digital capabilities, the Health Board risks falling behind in its ability to protect patients, support staff, and deliver on its strategic commitments. Continuing as we are, is not considered a sustainable option.

CAVUHB need of an Electronic Health (Patient) Record System (EHR/EPR) remains.

Digital leaders in Welsh Government began discussing commissioning an all Wales EHR in 2024/25. A national solution will be most welcome however the project is in its infancy and unlikely to be material for CAV for 5 or more years.

Meantime, CAV staff continue to experience issues through a lack of digitisation and data capability.

The DF programme brings forward proposed solutions and requests investment to improve CAVUHB digital capability (until such time as national solutions materialise) in support of pressures today, to support the achievement of SOFW, and quality improvement.

Digital Foundations is central to the Health Board's ability to meet its statutory obligations, improve day to day efficiency, effectiveness, improve quality, deliver its Annual Plan, the Shaping our Wellbeing Future Strategy and to participate meaningfully in the national digital health agenda. It is a strategic and operational necessity and is complementary to national Welsh Government commissioned solutions.

DF is not about technology for its own sake, it is about creating the conditions for safe, sustainable, person-centred care and a way forward. The programme directly supports critical enablers of population health improvement, reduction of inequalities and enhanced service quality.

1.3 About the PBC

The 5-year programme comprises 5 annual phases. Each phase has a series of projects attached to it. The Year 1 business justification cases were validated as priorities in a 2025 resident doctor survey. Digital Foundations describes a digital roadmap that improves CAV digital maturity over 5 years from HIMSS level 1 to at least HIMSS level 3 by improving infrastructure and introducing basic, core clinical and operational digital capabilities. Year 1 priorities comprise:

- Electronic observations
- Clinical notes
- Order communications (electronic test requesting and referrals especially where we have gaps i.e. paper processing)
- Replacement of EU workstation and digitising patient letters
- Infrastructure to support these priorities

The 5 year roadmap developed absorbs the previous roadmap shared at the Digital and Infrastructure Committee in May 2025 and adds detail. This new roadmap was the output of numerous workshops with clinical and non-clinical colleagues and is designed to meet clinical need, thus delivering improvements for patients by introducing solutions that will support improvement in patient outcomes.

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1.3.1 Completed

- First draft of the Programme Business Case and Year 1 Business Justification Cases

1.3.2 In progress

- Further iteration of the PBC document and BJC drafts focussing on the benefits realisation
- Refresh Digital Strategic Plan with a Target Operating Model (TOM) for the Digital & Health Intelligence directorate and a TOM for Digital Foundations implementation

1.3.3 High level risks/opportunities

- Welsh Government plans for a national Electronic Health Record (EHR) (our Digital Foundations plans are complementary)
- CAV digital maturity is low including culture and digital literacy as well as technology
- Cost estimates are pre-procurement
- Time before we can submit to Board and WG
- Welsh Government being unable to fund the BJC cases

1.3.4 Plan

To be revisited following cost and benefit review with Clinical Boards.

1.4 Welsh Emergency Care Dataset (WECDS) compliance and Emergency Unit workstation (EUWS) replacement

CAV and DHCW reviewed the new Urgent and Emergency Care App, under development by DHCW. A gap analysis is being commissioned to review the current functionality CAV has in use and the MVP. Currently the existing internal application has greater functionality than the minimal viable product (MVP).

CAV UHB continues dialogue with the National 6 Goals programme team at Welsh Government.

1.5 Digital roadmap progress

As part of Digital Foundations, a five-year roadmap was developed. As funding is not certain, lower cost (and lower functionality) alternatives are being explored for some options to potentially derive some benefit and improve our digital maturity until the Digital Foundations case is agreed.

2 Update on IMTP priorities with status

Appendix 2 contains the digital priorities shared at the last meeting updated to show the main IMTP (Annual Plan) priorities and their current status.

Both RISP and LIMS implementation windows have slipped into 2026/27.

3 Tactical Service Delivery Activity Update

An update on tactical activity relating to the Digital & Health Intelligence directorate's work programme since the last meeting in November 2025 is shown in **Appendix 3** (below).

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

Reganmkt 09/01/2026 11:21:

Progressing the digital maturity of the organisation is fundamental to delivering our strategy (delivering in the right places) and is a key enabler to all our future plans and ambitions.

Appendices *(Please list any appendices that will accompany this report, please do **not** embed)*

- Appendix 1 – Extract from Digital transformation in the NHS: a reference guide, Unpacking the fundamentals of digital transformation in the NHS to support the shift from analogue to

digital published 11 December 2025 by NHS Confederation. If the link above does not work, please copy and paste the following URL into your web browser: https://www.nhsconfed.org/publications/digital-transformation-nhs-reference-guide#:~:text=The%20British%20Medical%20Association%20estimates,outcomes%20and%20plan%20services%20effectively

- Appendix 2 – Local update on National Programme implementations
- Appendix 3 – Digital & Health Intelligence operational Updates

Recommendation:

The Committee is requested to:

a) **Note** the progress and updates contained within this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.** Digital Foundations and the digital roadmap are core to the achievement of this strategic objective		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

Yes		No –		

Megan Nikki 09/02/26 21:27:07

Impact Assessment:

Risk: na

Safety: na

Financial: na
Workforce: na
Legal: na
Reputational: na
Socio Economic: Yes/No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES]***
Equality and Health: na
Decarbonisation: na
Welsh Language: na

Approval/Scrutiny Route *(**please note anywhere else this paper has been before**):*	
Committee/Group/ Exec	Date:

Regan,Nikki
09/02/2026 11:27:07

APPENDIX 1

Extract from Digital transformation in the NHS: a reference guide, Unpacking the fundamentals of digital transformation in the NHS to support the shift from analogue to digital published 11 December 2025 by NHS Confederation.

• *… (digital) is expected to be embedded across all roles and functions… creating a more distributed model of leadership.*
• *Building a shared understanding of digital concepts and their relevance to everyday roles will be key to unlocking the full potential of transformation*
• *It is not only making services digital, but completely reimagining care models to make them more productive, patient-focused and sustainable. True digital transformation harnesses innovative technologies to reimagine how care is delivered, how systems operate and how patients engage with the NHS*

The British Medical Association estimates that clinicians lose more than 13.5 million hours a year due to inadequate or malfunctioning IT. Analysis shows that trusts that are highly digitised have a 13 per cent lower cost per admitted patient episode and a 4.5 per cent reduction in inpatient length of stay.
Previous digital ambitions have been undermined by inconsistent and insufficient funding. As cloud-based subscription models become more prevalent, the balance between capital and revenue funding must also adapt, with greater emphasis on sustained revenue to unlock the full value of procured technologies. To achieve transformation that supports the shift to a preventative neighbourhood health service, funding must be rebalanced and comprehensive across the system.
Crucially, successful digital transformation depends not only on technology, but on thoughtful implementation. Business cases for new technologies must include robust plans to realise the benefits of the investment, including staff training and financial support for change programmes.

The paper Tech to save time: how the NHS can realise the benefits - The Health Foundation referenced in the report goes on to say

- Our analysis challenges the assumption that the procurement of technology will automatically lead to benefits such as freeing up staff time or improving care. It highlights that programmes to rollout technologies instead require greater focus on implementation and optimisation
- Successful technology implementation requires funding and support. … It is critical that policymakers and system leaders fund the change, not just the tech.
- Successful implementation requires designing new uses of technology in consultation with staff and patients – avoid a one-size-fits-all approach
- Realising the benefits can take time – give greater priority to the optimisation of existing technologies

And in Tech to save time: how the NHS can realise the benefits - The Health Foundation, they note

- *As highlighted in The Strategy Unit's recent report, Digital Downsides, 'a hunger for solutions within resource-starved services creates ideal conditions for digital enthusiasm'. But it is important this enthusiasm comes with a dose of realism about the challenges involved, particularly with regard to saving staff time. As this analysis has shown, there are many instances where technologies have failed to have a positive impact on staff time due to problems with implementation and use.*

Rosen,Nikki 06/02/2026 11:11:07

APPENDIX 2 Local update on National Programme implementations

Key	CAV perspective on local implementation
Red	Off track
Amber	Going or slightly off track
Green	On track
Blue	National programme

			STATUS				
Project/programme	**Description**	**Update**	**Feb 2025**	**May 2025**	**Aug 2025**	**Oct 2025**	**Feb 2026**
Regional shared care record (for the purposes of direct care)	A regional partnership board programme To support the delivery of integrated care in integrated multi-agency teams between Cardiff and The Vale Councils and CAVUHB. Relevant information shared via a summary care view	• Adult Safeguarding made Live on 7th Nov. • All development and IG complete. Awaiting Regional Digital Board Approval to Go-Live in Feb'26 for the following: • Sharing uHB urgent care and child at risk data between HB and LA's; CRT and Integrated Discharge Service; Future Care Plans being shared between regional GP practices and NHSWAST. • Core Team funding agreed for 2026/27					
Connecting Care (previously WCCIS2)	A national programme managed by DHCW To replace the Welsh Community Care Information System (WCCIS). In relation to community and mental health services. This national DHCW led programme has submitted a revised business case for Welsh Government. CAV with all other UHB has contributed to this work	CAV remains fully supportive of the intention for all HB's to procure new systems with the support of DHCW and WG 2025/26 WG funding in place and deployed to map existing services. This will assure a 2026/27 procurement identifies a fit for purpose replacement for PARIS. National funding support is pending decision from DHCW/WG. UHB unlikely to be able to fund Paris replacement without WG funding which remains unidentified within WG					

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		2025/26 WG funding in place and deployed for the procurement of replacement 'community devices' (4G laptops for clinical staff). These will be handed out through Q1 and Q2 2026.					
WRAPPER (Welsh referral, activity and patient pathway enterprise repository) MDT management	A joint CAV and DHCW project as part of the Canisc replacement programme. This project delivers functionality to WRAPPER that enables cross-organisational booking and data sharing between health Boards for Cancer MDT management purposes	Phase 2 (outbound) – work continues in partnership with DHCW. Completion expected Q4 following re-prioritisation					
Scan4Safety	A national NWSSP patient safety initiative that supports inventory and stock management as well as compliance with the medical device bill for implantable devices It will trace NHS patients and their treatments, manage medical devices and monitor products used in procedures	Reconfiguring governance to better engage with operational and clinical leads and some delays due to resource constraints Temporary pause as this is established including consideration of this as part of our quality improvement programme					
PROMS (patient reported outcome measures)	PROMs are part of the CAV and National Value in Health Programmes. PROMs support improved quality, safety and experience of care for patients and promote health equality to patients by reducing unwarranted variation in care.	Onboarded 27 services to date 39,925 patients onboarded 157,578 PROMs completed 3,232 PREMs completed 48% PROM completeness rate Work continues to migrate T&O PROMS including the migration of historical data saving c£50,000 per annum c83 services listed to onboard in 2026/2027					
Electronic prescribing and medicine administration	This programme is in collaboration with NerveCentre (supplier) and DHCW for use in all patient	Currently live across 40% inpatient settings (64 wards - 1450 beds): • The go lives in January have increased to 70% coverage. This includes wards in UHL, St Davids and Barry Hospitals					

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	settings across the UHB and will improve patient safety. Business case agreed by Welsh Government in Q1 2024	• Activity Summary to date: Administrations – 404.675 Prescriptions – 145,943 • Some services, including outpatients will need to be undertaken within 2026/27, through uHB funded business as usual activity.					
NHS Wales app (DSPP)	A national programme, all development goes through the National Digital Services to patients and public (DSPP) programme managed by DHCW. CAV is live with the NHS App in all GP practices with feature sets varying by practice.	Successfully deployed the initial phase of the Planned Care Feature Set. This includes new accepted waiting list entries from GP referrals into services that are managed through PMS, and also new first appointments that are made in PMS where the referral type is from GP. Iterative improvements to the current feature set are being developed by the national DSPP programme, and the onward phases of development for the expansion of this (and other) Planned Care features are being discussed likewise by the national programme team along with Health Board colleagues. National funding for 2026/27 rollouts to be agreed.					
Welsh Intensive Care Information System (WICIS)	A national programme managed by DHCW, to be implemented locally Introduces electronic observations at the bedside in intensive care	WG have agreed to implement the WICIS solution with preparatory work to be done in Qtr 4 2025/26					
National laboratory systems replacement (LIMS)	A national programme managed by DHCW, implemented locally	This is progressing and is being managed by the relevant clinical board (CD&T via their internal teams) with some support from the D&HI directorate. The implementation timetable has slipped with the focus now on service by service go-live rather than by individual organisation. Go Live for CAV was planned for September 2025. Now Q4 2025.					
National radiology system replacement (RISP)	A national programme managed by DHCW, implemented locally	The RISP business case has been approved; the programme is led by DHCW with an expected implementation date for Cardiff & Vale UHB at 30/03/26 is likely6 to slip due to the reliance on an					

Regan, Nikki
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	Go Live for CAV is planned 2026	additional link to UHL not being in place in sufficient time..					
Digital Cellular Pathology	A national programme to fully digitise and improve laboratory workflow, creating digital slides	A national business case is in the process of being considered by individual health boards.					

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09/02/2026 11:27:07

Appendix 3 Digital & Health Intelligence operational Updates

Digital Service Management Team

- NHS Wales App – Following connectivity work to link our data feed to the national NHS App NHS integration repository, this went live for GP referrals and first out-patient appointments on 8th January 2026.
- Scoping work is underway for further improvements and enhancements to the NHS App, through our engagement with DHCW. A governance function for development and support of the functionality within the App is being identified locally.
- Connecting Care (i.e. PARIS our existing Community and Mental Health EPR system) – Following the allocation of national funding for foundational works in 2025/26, external support has been commissioned to undertake detailed business analysis and develop a data migration strategy during Q4 2025/26.
- Capital funding from both the Connecting Care programme and WG end of year capital is being used to refresh and replace the mobile devices for community-based mobile staff.
- The Theatreman AQUA system upgrade was done on 13th Jan 2026. This provides numerous functional and operational improvements including the availability of operational notes in other clinical systems to support improved communication and efficiency.
- The Digital Care Region (DCR) programme - Adult Safeguarding rollout is live in December 2025. Children's Safeguarding project is also advancing, with a target go-live in late January. Additionally, engagement has begun with Mental Health, Learning Disability and MDT services to explore use of the Summary Care Viewer to support clinical practice.

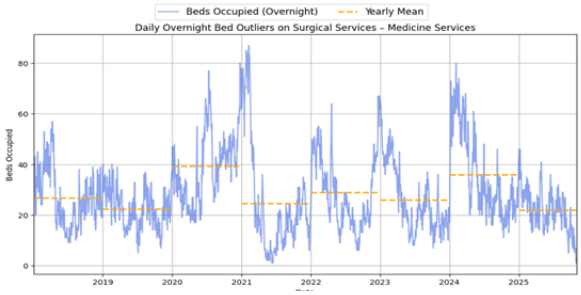
Business Intelligence (BI) Information

- The Business Intelligence Team have been busy supporting PRISM involving a numbers of measures and short turn around timescales. The BI team has developed a comprehensive Length of Stay dashboard for user-acceptance testing by the Ops team prior to wider release.

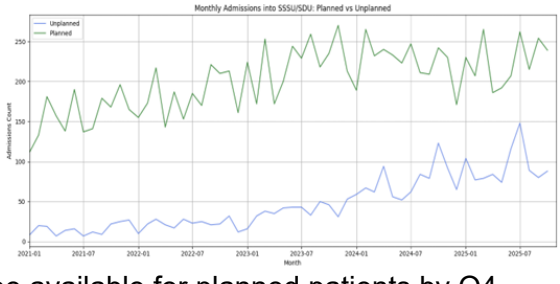
Analytics Team

The team were asked for 'Future Bed Modelling' forecasts for the Surgery Clinical Board. Below are the results shared with the Clinical Board -

Medicine outliers in surgery accounted for an average of 22 overnight bed occupancies per day in 2025.



Unplanned admissions to SSSU/SDU show a gradual upward trend.



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- Average monthly occupancy since 2024 is 302 beds.
- If bed availability remains at 302 and unplanned admissions increase as forecasted, only 130 beds will be available for planned patients by Q4 2026.

Digital Eyecare

- Our Digital Eye Care Team continue to support our ophthalmology services and those at Swansea Bay and CwmTaf Morgannwg for live service. The team remains in position to support AB UHB go live during February and to support HDD UHB who are looking to deploy in March 2026.

- DHCW's interim referral system, Opera, is scheduled for rollout before 31/03/26, though integration between the OpenEyes eye care electronic patient record and Opera has not been fully agreed and requires more discussion with DHCW.

Digital Operations

- The Networks team priorities include completing the replacement of core network equipment, finalising the implementation of the new perimeter firewalls and expanding Wi-Fi coverage for clinical (ePMA) and non clinical areas.

- The server team are in the process of procuring replacement virtual host servers to update our virtualisation environment, ensuring robust and scalable server capabilities.

- The Cyber and Server teams have worked together to implement scheduled vulnerability scanning. The INFRAM 2025 assessment has been completed and submitted for HIMSS validation. An incident escalation framework is under review. Cloud adoption is advancing through the AWS Landing Zone workshops, and a governance model for OpenStack is being defined.

- National programme support includes WAN link installations and security devices for RISP, with major diagnostic system replacements for LIMS2 and RISP scheduled for February/March. The ePMA hardware deployment and testing are complete, with rollout percentage currently at 40%, with completion expected in Qtr2 2026.

- The Windows 11 migration project has delivered 90% of the work already. To ensure comprehensive coverage and maintain security, we have procured additional extended security update licences. These licences will be utilised to support the remaining devices, ensuring they stay protected and updated during the final stages of the migration process.

Digital Transformation

- The PMS (PAS) system was successfully upgraded which supports the core health board applications and manages the full acute patient workflow from referral to discharge.

- Handling over 5,000 users with integration across 30+ internal and hundreds of external systems.

- Patching required a long downtime, but the migration followed four years of detailed planning with Oracle and internal teams and has ensured compliance, security and improved resilience. The system also includes redundancy and database replication for continuity.

- Updated 30+ applications and 300 interfaces to modern technologies.

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- A robust exit/rollback strategy was developed to mitigate risk.

- Downtime was kept to a minimum of less than 2 hours whilst the upgrade took place on Monday, 19th January 2026.

Report Title:	Corporate Digital Risk Register			Agenda Item no.	3.2	
Meeting:	Digital & Infrastructure Committee Meeting	Public	X	Meeting Date:	10th February 2026	
		Private				
Status:	Assurance		Approval		Information	X
Lead Executive:	**Director of Digital and Health Intelligence**					
Report Author:	**Director of Digital and Health Intelligence**					

Background and current situation:

The joint IMT Risk register is a combined register consisting of digital / Information Governance and Information / Performance risks.

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

There are currently 9 joint IMT/IG risks identified on the report:

1 x Risk remains in red status with a score of 20 which is:

- Cyber Security

1 x Risks changed from yellow status to amber (going from 8 to 12)

- Insufficient Resource – Capital & Revenue

4 x Risks remain in yellow status with scores between 8 and 9 and these are:

- WCCIS replacement procurement programme
- Data Quality *
- Clinical Records
- Non-Compliance with data protection legislation

1 x Risks are proposed to be closed and these are:

- Governance framework (IG policies and procedures)

2 x Risks are proposed to be amalgamated with Data Quality

- UHB Standard Data Processing *
- Data availability (Accessibility of Data) *

Recommendation:

The Board/Committee are requested to:

NOTE progress and updates to the Risk Register report.

Kegan Lewis 09/02/2026 11:12:12

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	x	Long term		Integration		Collaboration	x	Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: Yes
Safety: Yes
Financial: Yes
Workforce: Yes
Legal: Yes
Compliance with regulatory requirements
Reputational: Yes
Equality and Health: Yes/No
Decarbonisation: Yes
Green UT and digital solution that support greater virtual working
Welsh Language: Yes/No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

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Format of the Workbook	**MPLETING THE RISK REGISTER** **sk assessment prior to them being added to the Risk Register**
	Risk
	Strategic
	Date Risk Added: Please enter in the format dd/mm/yyyy.
	Risk Descriptio
Accepted or Closed Risks Once risks are removed or accepted they should be	**Executive**
	Initial Risk
	Controls:
	Assurance
	Current
	Gaps In Control: These are controls which are required to reduce the risk but which are curr
	Actions: This is a bulleted list of the actions needed to provide/increase/improve controls or
	Who is leading on these actions and **When** are they expected to be achieved?
	Target
	Review Date: The Risk Management and Board Assurance Framework Strategy (UHB 470) d
	Assurance Committee: For assurance purposes a UHB Board Committee should be assigned

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rently absent or only partially effective.
r to provide assurance of control effectiveness.

escribed the required review periods.
l for any risks escalated to the Corporate Risk Register.

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RISK REGISTER TEMPLATE

CLINICAL BOARD/CORPORATE DIR CORPORATE

SPECIALITY/DEPARTMENT: Digital & Health Intelligence

Strategic Objective	Date risk added dd/mm/yyyy	Risk	Exec Lead	Initial Risk Rating			Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who	When	Target Risk rating			Date of next review	Assurance Committee
				Consequence	Likelihood	Total			Consequence	Likelihood	Total						Consequence	Likelihood	Total		
8	06.08.2011	**Cyber Security** - Due to prevailing national and international Cyber Security threats there is a risk that the Health Board's IT infrastructure could be compromised resulting in prolonged service interruption and potential impacts on the safety	Director of Digital and Health Intelligence	5	4	20	The UHB has in place a number of Cyber security precautions. These include the following: - The implementation of additional VLAN's and/or firewalls/ACL's - Segmenting and an increased level of device patching. - The use of Monitoring and Vulnerability Software - Health Board wide Mandatory Cyber Security Training and Phishing Campaigns.	Regular Cyber Security updates that review the Health Board's preparedness for a cyber attack and the controls in place are undertaken in the following forums: - at fortnightly Operational Cyber Group Meetings - at monthly Cyber Security Meetings - at each private and public Digital Health and Intelligence Committee An Assessment of the Health Board's Cyber Assessment Framework was undertaken in January 2022 with 4 Critical Priority Areas and 6 Significant/Moderate Priority Areas recommended.	5	4	20	Additional resources is required to fully implement recommended areas of best practice. Completion of mandatory Cyber Security training is below the required level.		January 2024 update: Cyber Security Manager now re-banded and currently being advertised. This new post will operational lead the Cyber team strengthen the UHB's cyber security posture. A further phishing simulation was launched in October to continue raising cyber security awareness. In February, we also promoted 'vishing' training to all staff. May 2024 update: New Cyber Security Lead appointed and due to start 14th May 2024. Priorities include further deployment of CAV assessment to assist with NISD compliance. July 2024 update: Progress made with developing a combined Information Asset Register and Business Impact Assessment to be sent out to all services. This will be used to centrally log all assets and identify and assess critical systems. The DR plan is also under review. Oct '24: Cyber team fully recruited and focused on updating the cyber action plan Jan'25: New Secure Web Gate Way currently being deployed across the organisation to further secure our internet interface and provide the UHB better control. Mar 2025: New Secure Web Gateway has been fully deployed across the organisation, with all capable devices now using the new gateway, with few exceptions. This has provided much greater control over permitted websites, which can be used to manage/reduce website related security risks. It also works to prevent unauthorised users from installing systems without the knowledge of Cyber Security and/or the Service Desk teams. May 25: Two further phishing simulations performed. 97 users with very weak passwords reset. Gen AI guidance to be accepted by users before visiting AI sites. July 2025: Annual review of local admin accounts performed - 26 accounts disabled. High risks moved from Cyber Risk Register transferred to AMaT to provide a better risk management solution. Old RDS de-commissioned removing a large number of legacy servers. Oct '25: Cyber risks transferred to AMAT, work is in train to capture Clinical Boards cyber risks through direct engagement with CB management teams. **Jan'26: Clinical Boards tasked with identifying leeds and provide information on Information Assets and owners to ensure full capture of all UHB Cyber risks**	Head of IG & Cyber Security	August 2022 Ongoing	5	3	15	01.07.2022	Digital Health Intelligence Committee
8	13.12.2013	**Insufficient Resource:** The delivery of the IM&T Strategic Work plan is based on the UHB being able to ensure that the IM&T Department is appropriatel	DT			0	The UHB continues to address priority areas in relation to its infrastructure management and strategic programme.		3	4	12			Jan'24: Proposal developed and presented to CMG in December 2023. 'Case for Investment' setting out the request for capital monies in 2024/25 to develop the business case for longer term investment. Being reviewed at February 2024 CMG meeting. May '24: Internal case developed for consideration at the Investment Group in early summer which supports the Digital Foundation OBC in accessing capital funds through the All Wales Capital Programme for 2025/25. Oct'24: Investment case successful in funding short term roles to develop the programme business case and make the case for achieving the digital foundations priorities. Jan 2025: Digital Foundations business case works has commenced with non-recurrent investment for back-filling the Director of Transformation and a solutions/enterprise architect in place to progress this work. Mar '25: External support procured to support development of the Programme Business Case. Interim internal resources all in place May '25: Digital Foundations PBC being progressed with engagement from all Clinical Boards July '25: Digital Foundations Programme Business Case being developed. Review of plan share with WG's major capital lead. Oct '25: DF PBC shared with Digital Leads at WG. Local revenue implications being worked through with Clinical Boards before progressing to local governance route. **Jan'26: The PBC required Board approval prior to submission to WG but associated revenue costs are unfunded leading to further internal work. The risks are therefore increased.**	Director of D&HI				0		
8	10.07.1905	**WCCIS2 (Connected Care):** The National procurement has now splintered into 'Social Care' (being undertaken directly by LAs across Wales), 'Mental Health' (being undertaken directly by HBs, with a funding model via DHCW to WG), and 'Community Health' which W.G are favouring a	DT	4	3	12	DT has engaged with WG to assure this risk of delay/slowness of a National framework procurement is understood. The PARIS programme team are engaged with NWSSP to understand alternate/direct procurement routes if the National route is delayed.	Limited assurance can be offered as Connecting Care timelines are dictated by W.G decisions.	3	3	9	uHB Chair level involvement to bring assurance to CaV concerns is required.		Mar'25: CaV engaged with DHCW on an updated National Business Case. A CaV Business Case is drafted for pushing through CaV capital and revenue agreement groups in Q2 2025/26 May '25: National Outline Business Case submitted to Welsh Government for consideration. Discussions on a local CAV business case to replace the PARIS system taking place with Welsh Government July '25: CAV's strategic requirements fed into the National Connectivity Care case submitted to ~WG. In the meantime an alternative plan is being developed to extend the current contract by a further 1 year. Oct'25: CaV have received 25/26 funding to progress 'pre-procurement' and 'data migration' activities. These are currently being planned and procurements progressed to bring in data migration expertise. **Jan'26: Channel 3 consults supporting a massive 'service mapping' and 'data migration planning' exercise in Dec'25 to March'26. CaV continue to await news on 2026/27 funding of Connecting Care from WG.**	Head of Digital Services Management					0	

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8	19.02.2018	**Data Quality** High level risk - core business activities potentially compromised as a result of weaknesses in assurance framework in areas listed below: Absence of Standard	DT			0	Further re-invigoration of the role out of COM2 will increase clinically validated data. Updates and training programme scheduled for mental health and our partners in order to address issues identified in recording and reporting compliance with parts 2 and 3 of the mental health measures. New dashboard release will expose greater amount of data to users, in a more user friendly way, enabling validation by relevant clinicians. Data quality group has established a work plan to improve quality and completeness of data and how it is presented.		3	3	9			Jan 2024: This work is being absorbed into the Data Insights development work looking at current and future data insights provision with work to produce a data strategy by Qtr 2 24/25. May '24: Data Insights Programme Board established to review and oversee the Data Improvements and data strategies work which supports data requirements. Jul '24: The newly established Data Insights Programme Board will review this risk at the next board meeting on 24-Jul-2024 2pm Oct '24: Data strategy being developed to capture the data quality requirements . Jan '25: Data strategy development being led by CCIO and will be reviewed via digital governance structures in Q1 FY 25/26 Mar '25: No further update May '25: Draft Data Strategy on track for review by end of Qtr 2, 25/26 July '25: No further update. Oct '25: Data strategy being shared at SLT meeting in December '25 for review and approval. **Jan'26: Clinical Board reps invited to develop and implement a strategy via Steering Group established to oversee this work following SLT presentation.**	Head of Architecture and Analytics				0		
8	28.09.2015	Risk: **Accessibility of data**: UHB does not have an ability to access and use the data it requires to carry out its full range of statutory obligations and enable delivery of our strategy and IMTP. . Specific risks - lack of access to	DT			0	Approach identified to work with C&V GPs to share data across care sectors to inform improvement and to gain a better understanding of need, demand and the capacity available to meet it. National data repository programme will provide access to tools and expertise		3	3	9		Merge with Data Quality risk	Jan 2024: We have started work with DHCW API management team to understand the WRRS API so that we can help Richard Davies (Cardiff and Vale UHB - Anaesthetics) with yearly lab bloods data and Robert McLeod (Cardiff and Vale UHB - ENT) to check if MRI skull scans have been carried out. Jul '24: The newly established Data Insights Programme Board will review this risk at the next board meeting on 24-Jul-2024 2pm.May '24: DHCW has recently updated that the WRRS API release will now be pushed back 9 months to Jan 2025, therefore pausing the previous project updates Oct '24: Data Insights Programme Board recommended the risk be reviewed and updated to reflect the digital roadmap plans Jan '25: Work continues to increase the accessibility of data to enable the service to make data driven decisions. The Information Team are developing Power BI dashboard replicas of the Lighfoot dashboards as part of the Lighfoot transition plan. Using a modern technology such as Power BI enables the service to securely access their dashboards anywhere in the world using any network. As part of the five year digital strategy work progresses to ingest data from many existing and new systems into the LDR, with the latest ingest of data being EPMA, which will take several weeks Mar '25 - Dashboards to replace Lightfoot viewers and associated data products are on track to be delivered according to plan. May '25: Dashboards developed and demonstrated to users - on track for rollout by Summer 2025. July '25: No further update Oct '25: CAV signed a Joint Data Controller Agreement document with DHCW. **Jan'26: The data accessibility risk will be addressed via the emerging plan coming out of the Data Strategy work. It is therefore proposed to make this a component of the Data Quality risk and to close this risk.**	Head of Architecture and Analytics				0		
8	28.09.2015	**Clinical Records Risk**: Clinical records are not joined up across disciplines, care settings or geographical boundaries resulting in incomplete and out of date patient information. Summary information is not routinely shared across systems. Differing	DT			0	UHB architectural design to be reviewed to consider local data repository for bringing together in a usable way clinical information held in numerous clinical systems. UHB working through a programme to implement once for Wales requirements for data and technical interoperability standards.		3	3	9			Jan 2024: The data quality working group have conducted several interviews with various parts of the organisation to determine how they use data and in what systems. The group will meet on 12-feb-2024 to review these findings and set the next objectives. The Digital Care Region demonstrated at the 1st regional board meeting, a proof of concept website combining health and social care data into a single record, which was well received, next steps are to introduce more data, this time for looked after children. May '24: work continues with Digital Care Region with go live imminent once a decision his made where to service will be hosted. DHCW update two weeks ago, the WRRS API has been pushed 9 months to Jan 2025 since what they developed did not perform well when tested.. Jul '24: The newly established Data Insights Programme Board will review this risk at the next board meeting on 24-Jul-2024 2pm Oct '24: Data Insights Programme Board recommended the risk be reviewed and updated to reflect the digital roadmap plans Jan '25: Local Data Repository plans are being developed to support the data insights requirements of the organisation, for sign off at Data Insight Programme Board in Q2 FY 25/26 Mar '25: No further Update May '25: Internal audit review of LDR developments made specific recommendations regarding the governance and documentation requirements, which are being addressed. July '25: LDR action plan to address agreed recommendations from Audit Review in process. Oct '25: LDR Programme Board established, chaired by CCIO to oversee Action plan to fully implement this. **Jan'26: LDR Programme Board oversees the LDR Audit Action Plan.**	Head of Architecture and Analytics				0		
8	16.02.2018	**UHB Standard Data Processing** Risk: obligations and accountabilities relating to the way data is handled are not formalised Consequence: the UHB could suffer detriment and/or have difficulties applying remedies against a	DT			0	Library of outline documents for sharing data available, with completion of these supported by corporate information governance department. Requirements to use and refer to are being emphasised within the training.		4	2	8		Merge with Data Quality risk	Jan '24: work progressing in developing a data strategy to support the Data Insights plan to address completeness and quality of data in our clinical systems. July '24: Data Strategy is being developed and has been shared at the Data Insights Programme Board in June, led by the CCIO. Oct'24: A roadmap to develop data insights reporting, modelling and analysis, is being produced to support the data strategy ambitions. Jan 2025: Procurement continue to make IG aware of new projects. However, suppliers are now more commonly exploiting a loophole in this process by offering services for free. By targeting UHB staff directly, suppliers are able to bypass Procurement and IG. This has led to staff disclosing identifiable health data without UHB awareness or governance and outside of any legal contract. This has been confirmed as a deliberate approach by at least one private supplier, who has then sought to exploit this loophole by creating a UHB dependency on their product, from which point it will be possible to monetise any dependency. Mar 2025: No changes to the level of risk. IG and Procurement continue to work closely to identify all new flows of data via suppliers. May '25: No further update July '25: No further update. Oct '25: Data strategy with support standardisation and reduce variation (quality and completeness of data also) **Jan'26: This risk will be addressed through the Data Strategy development work, with the Clinical Boards' input. It is proposed to amalgamate with the other data risk**	Director of D&HI				0		

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8	28.09.2015	Risk:- **Non compliance with Data Protectio**n & **Confidentiality Legislation** - the UHB's progress in taking forward the action plan to reduce the risk of non compliance following the ICO's assessment of our 'reasonable assurance'	DT			0	Clinical Board assurance and co-ordinated mitigation of risk being developed via quality and safety meetings. Ownership and community of practice anticipated to develop across IAOs/IAAs from this. GDPR awareness being used to ensure Leaders and asset owners are reminded of existing requirements and mandatory nature of the asset register. Options for enabling messaging in compliance with legislation has been considered by clinical and executives on a number of occasions, and UHB close to agreement.		4	2	8			Restructuring of IG department will increase amount of expert resource. Resolution of long term absence will also increase available expertise and resource to support GDPR plan, and manage the operational requirements on the corporate department. Ongoing implementation of GDPR/ICO action plan. The Information Governance team have developed a work plan to review and update all outstanding policy and procedure documents in the CDF and these are scheduled to be complete by December 2020. Implementing the action plan will reduce the risk, May 2021: policies are being reviewed and an update will be reported to DHIC in May 2023 update: Ongoing work tackling inappropriate access to clinical systems with access to own and family records reduced by 76% and 85%. July '23: IG Mandatory training for Cardiff and Vale staff continues to increase. NIAS compliance has improved as a result of awareness raising September 2023 update: IG Mandatory training now at 76% across the workforce. NIIAS monitoring continues with over >750 letters sent to staff on behalf of the Caldicott Guardian regarding inappropriate access. January 2024 update: The Information Governance Dept is focusing on a number of proactive tasks that are outstanding. Once in place, the risk of GDPR non-compliance will reduce. These will be completed by Qtr 22 24/25. May 2024 update: Work commenced to identify appropriate IAO & IG champions. July 2024 update: Progress made with developing a combined Information Asset Register and Business Impact Assessment to be sent out to all services. This will be used to centrally log all assets and identify and assess critical systems. Oct '24: No update Jan'25: No update Mar '25: No update May 25: No update July '25: No update Oct '25: IG mandatory training compliance tracked at Clinical Board review meetings to improve rates. Share at D & I Committee. **Jan'26: IG Mandatory training continues to be raised at CB Reviews and routinely reported at D & I Committee.**	Head of IG & Cyber Security				0		
8	16.02.2018	Risk: **IG policies and procedures** are not up to date/do not cover all relevant areas. Procedures are not aligned to	DT			0	Update: Controlled document framework requirements delayed due to resource constraints - Integrated IG policy is live and covers a number of existing policies.		3	2	6		CLOSE	January 2024 update: Overarching Information Governance Policy being presented to DHIC (February 2024) with proposed changes. May 2024 update: Information Governance Policy approved and available to staff. Oct '24: Review of all policies and procedures being led by the Corporate team to determine which require updating, deletion or re-writing. Jan'25: No update Mar '25: No update. IG Policy remains in-date. May 25: No update July '25: Records Management Policy and retention schedule updated for October '25 review. Oct '25: Policy being taken to D & I Committee in November 2025 Jan'26: Policy was approved at D & I Committee in November 2025. This action can be closed.	Head of IG & Cyber Security				0		

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Accepted or Closed Risks

Risk Ref.	Strategic Objective	Date risk added (to original risk register)	Risk	Exec Lead	Initial Risk Rating		
					Consequence	Likelihood	Total

Risk Ref.	Strategic Objective	Date risk added dd/mm/yyyy	Risk	Exec Lead	Ini
					Consequence
A5/0013	8	13.12.2013	**Software End of Life Implications** The UHB is at risk because its PCs require upgrading to Windows 10 due to support ending for Windows 7 in January 2020. There are potentially significant issues with compatibility with applications systems in use both Nationally and within the HB specifically. The UHB has circa 11,000 devices (laptops and PCs) that require operating systems upgrade; of these, 5,500 will additionally require either replacement or physical hardware upgrade.	DT	

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A3/0104	8	13.12.2013	**End of Life Infrastructure (access devices)** Each year a number of access devices (PC's , laptops, netbooks etc.) fall in to the category of being end of life. The Health Board's clinical and business needs requires continued and expanding use access devices. This infrastructure has a maximum lifespan of typically 5 years and then requires replacement.	DT	
	8	02.02.2018	**Governance arrangements** for overseeing and challenging NWIS are weak. There is insufficient transparency, blurred lines of accountability and they lack a clear set of priorities Consequences: The significant resource we provide to NWIS is not optimally used to support the UHB in delivering its statutory	DT	

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			Risk of CAVUHB Video Consultation Programme The attend Anywhere (AA) contract ends on 30th September 2024, with no safe video consultation option available for Clincial Services by the cut-off date. The risks associated with this programme and its status have been elevated to WG and a bridging gap has been requested. An exit strategy for all eventualities is being drafted with the input of clinical representatives from Services who	DT	4
	8	01.10.2018	**Effective Resource utilisation** :With an increasingly restricted resource, the UHB requires assurance that digital effort is expended in the most benefits laden workload. Benefits based prioritisation requires robust and matured benefits tracking and a matured reprioritisation	DT	

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A3/0110	8			13/12/201	**Server Infrastructure** The IM&T Department is actively implementing a vFarm infrastructure that significantly reduces costs whilst dramatically increasing resilience of Server Systems. However, the cost savings are to the Health Board as a whole and Service Departments in particular and come at an increased cost to IM&T specifically. This infrastructure requires core investment to complete and revenue based support to	DT	
				01.10.2018	**Effective Resource utilisation** :With an increasingly restricted resource, the UHB requires assurance that digital effort is expended in the most benefits laden workload. Benefits based prioritisation	DT	

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Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who
		Consequence	Likelihood	Total				

tial Risk Rating		Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance
Likelihood	Total			Consequence	Likelihood	Total		
	0	update 02/08/19: Microsoft will offer extended support on Windows 7 as part of the all Wales MS 065 contract recently negotiated and in place for all NHS organisations in Wales. This will provide support for Windows 7 PCs, beyond 2020.		4	0	0		

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	0	There is an impact to Business and Clinical Systems because of the age of the hardware and clinical/business application software - replacement relates to the availability of resources and departmental agreement /priorities.		3	0	0		
	0	UHB is engaged with WG and NHS peers to take forward the recommendations of the WAO review of NWIS with a view to addressing the		3	1	3		

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2	8	T. A clinical/corporate risk assessment has been drafted with input from all services that utilise VC and would be negatively affected by 01 eventuality, with the intention to elevate this to the COO once		0	0	0		COMPLETED
0		Establishment of a formalised corporate prioritisation mechanism based on benefits and corporate drivers for change:		4	1	4		

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	0	The UHB continues to address priority areas in relation to its infrastructure management and strategic programme.		4	2	8		
		Establishment of a formalised corporate prioritisation mechanism based on benefits and		4	1	4		

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When	Target Risk rating			Accepted or Closed?	Date accepted/closed	Rationale	Review date (If applicable)
	Consequence	Likelihood	Total				

Actions	Who	When	Target Risk rating			Date of next review	Assurance Committee
			Consequence	Likelihood	Total		
Jan 2022 update: The UHB Device estate has increased significantly to 14000 partly as a result of home working. There now remain less than 900 devices to upgrade or replace. Completion target is March 2022. May 2022 - The CAV UHB workstation estate (11,000+ devices) have been replaced,	Head of Digital Operations				0		

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May 2022: The CAV UHB workstation estate (11,000+ devices) have been replaced, upgraded or removed as part of the Windows 10 Programme. **Sept 2022: This item can be marked as completed /closed. The CAV workstation estate has been replaced and therefore will not**	Head of Digital Operations				0		
CAV involvement in National programme activities and Governance review. Opportunity to influence the new SHA replacing NWIS via	Director of D & HI				0		

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May '24: 1. Collaboration with Clinical Services to further assess impact of no VC after 30th September 2024. 2. Finalise with sign off on exit strategy document for all possible eventualities, including process maps for VC team and CB actions.	Head of Digital Services Management							
Jan 2024: After a successful pilot and test within the Server Team, other Digital Operations teams are using the new Change	Head of Digital Operations				0			

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. Jan 2024: Electrical work has been completed and A/C units installed. Servers and Services will be moved in a phased approach to UHL and Woodland House Q2/3 2024/25	Head of Digital Operations				0		
May '25: LBAUs for D&HI teams are now 30% entered to the departments MSPa tracking	Head of Digital Services Management						

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Report Title:	Information Governance Data Compliance			Agenda Item no.	3.3	
Meeting:	Digital & Infrastructure Committee	Public	×	Meeting Date:	10th February 2026	
		Private				
Status:	Assurance	×	Approval		Information	
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Head of Information Governance & Cyber Security					

Background and current situation:

This report considers key information governance issues considered by the responsible Executive Director, Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO). Specifically, it provides information on the following areas of Information Governance within Cardiff and Vale University Health Board (the UHB).

- Information Governance (IG) Staffing levels and capacity
- Data Protection Act - Serious Incident Summary and Report
- Freedom of Information Act - Activity and Compliance
- Data Protection Act (DPA) - Subject access requests (SAR)
- Compliance monitoring/National Integrated Intelligent Auditing Solution (NIIAS)

Each individual report contains specific details relevant to the subject area, and includes updated information since the previous report to the Digital & Infrastructure Committee (D&IC). on how the UHB has complied with the obligations of each piece of legislation that satisfy the information governance requirements.

The UHB is required to ensure that it complies with all the legislative requirements placed upon it. In respect of Information Governance, the relevant legislation which largely impacts on this work are the Data Protection Act 2018 (DPA), UK General Data Protection Regulation (UK GDPR) and the Freedom of Information Act 2000 (FOIA).

Quarterly reports are produced for the D&IC to receive assurance that the UHB continues to monitor and action breaches of the UK GDPR/DPA 2018, FOI requests and that subject access requests (SAR) are actively processed within the legislative time frame that applies and, that any areas causing concern or issues are identified and addressed.

ASSESSMENT

1. **Information Governance Staffing Levels and Capacity**

Information Governance staffing levels have reduced following a departure in the middle of January 2026.

The staffing structure is as follows:

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- David Thomas, Director of Digital and Health Intelligence is the Senior Information Risk Owner
- Dr Richard Skone is the Caldicott Guardian
- James Webb is the Data Protection Officer
- The Information Governance Department is currently resourced at 4 WTE.

2. Data Protection Act – Serious Incident Report

Date reported: October 2025 to December 2025

Between October 2025 and December 2025, the Information Governance Department have reviewed a total of 146 (49 per month) information governance related incidents, which were reported via the UHB's Datix reporting solution. On average, for the last 12 months, the Information Governance Department has reviewed approximately 47 incidents per month, which is a slight increase compared to the previous report.

Of these breaches reviewed during this recent period, one breach met the threshold to be reported to the Information Commissioner's Office (ICO).

3. Freedom of Information Act

FOI compliance percentage for the last rolling 12 months against the 20-working day deadline is demonstrated as follows:

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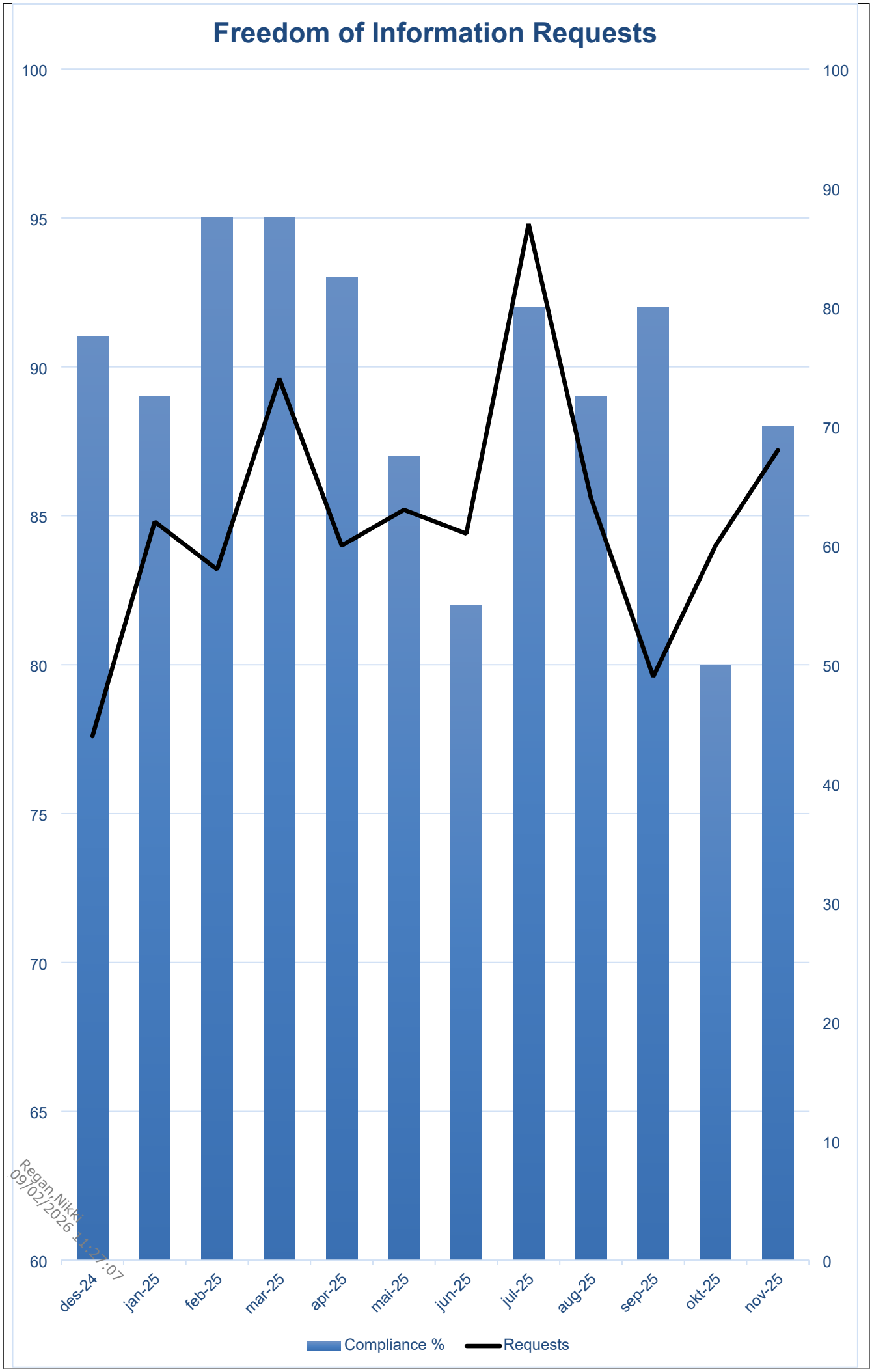
Freedom of Information Requests
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jun-25
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okt-25
nov-25
Compliance %
Requests
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The average number of FOIs received during the last 12 months remains unchanged at 63 requests per month, and average compliance has marginally dropped slightly to 89%.

A link to the UHBs FOI disclosure log can be found below. This provides a link to every FOI the UHB publishes online. In the event that requests are made for the same information, the UHB is able to signpost requestors to this log.

https://cavuhb.nhs.wales/about-us/governance-and-assurance/freedom-of-information/disclosure-log/

4. Subject Access Requests Processed

4.1 Health Records requests

Medical Records SAR compliance percentage for the last rolling 12 months against the one-month deadline is demonstrated as follows:

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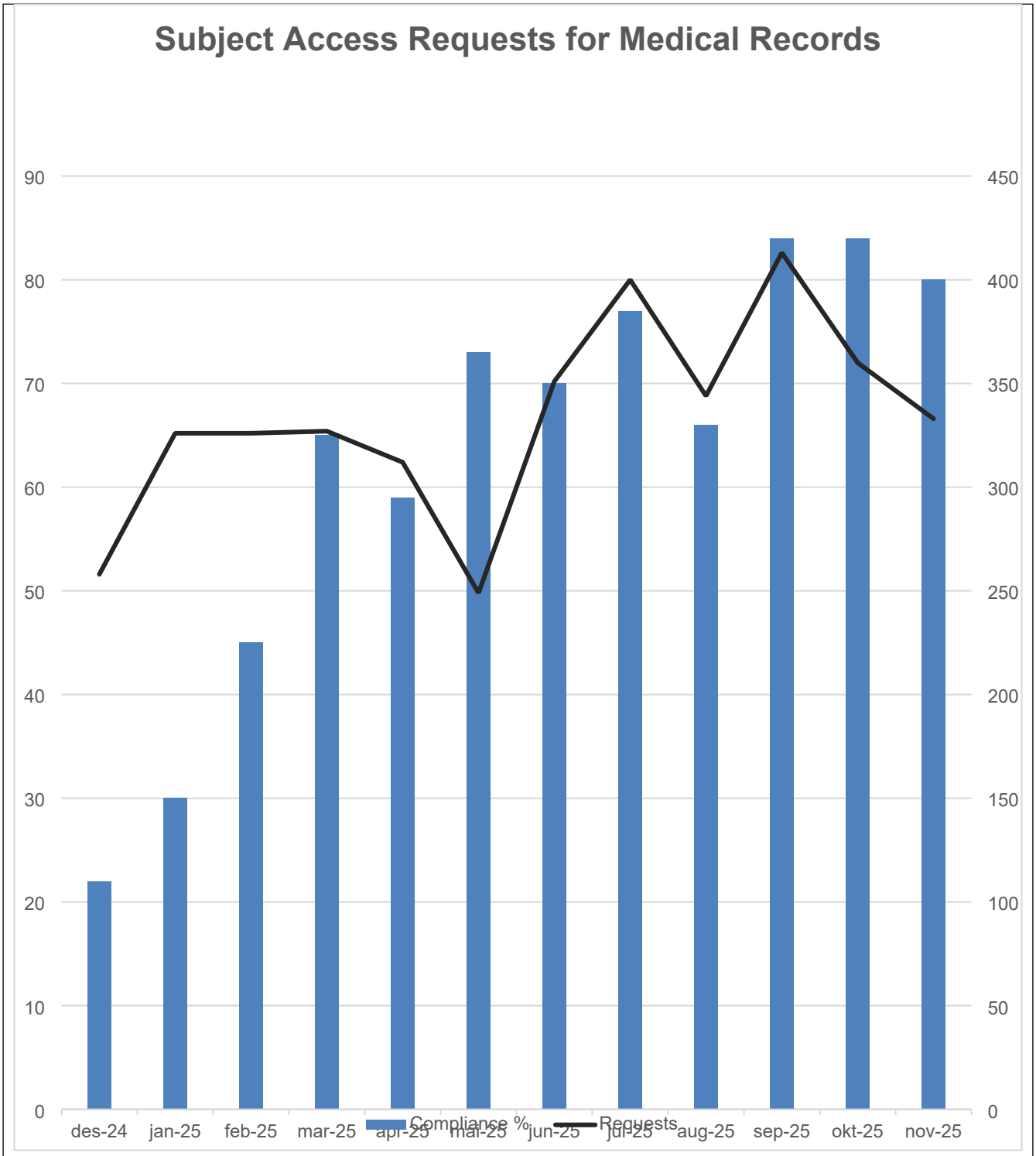

The ongoing improvements seen over the last 12 months, continue to be made with average compliance now averaging 64% per month (an increase from 48% since the last committee). During this time, an average of 333 requests have been submitted each month, up from 318.

Additionally, the average request was responded to within 20 days, against a deadline of 28 days. Only 7 requests remain open for September to November.

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4.2 Non-Health Records requests

A total of 55 subject access requests submitted for non-health records were received between September 2025 & November 2025. 48 requests (87%) have been complied with within the legislated timeframe.

5. Compliance Monitoring/NIIAS

Since January 2022, the UHB has sent out a total of 1305 letters to staff who have been identified by the UHB's instance of the National Intelligent Integrated Audit Solution (NIIAS), based on a process approved by Management Executive.

These letters form part of an approach which also includes a wide-reaching and targeted comms program of work. Further detail is provided in the private committee agenda.

6. Information Governance Mandatory Training

Overall UHB Information Governance training compliance is currently 74% and is broken down by Clinical Boards as follows.

Clinical Board	Assignment Count	Achieved	Compliance
All Wales Genomics Service	369	332	90%
Capital, Estates & Facilities	1415	1203	85%
Children & Women Clinical Board	2316	1772	77%
Clinical Diagnostics & Therapeutics Clinical Board	2808	2226	79%
Corporate Executives	1049	803	77%
Medicine Clinical Board	2058	1438	70%
Mental Health Clinical Board	1573	1077	68%
Primary, Community Intermediate Care Clinical Board	1197	885	74%
Specialist Services Clinical Board	2240	1626	73%
Surgical Services Clinical Board	2514	1688	67%
UHB	**17539**	**13050**	**74%**

The figure represents no change in overall completeness since figures were provided to the last Committee.

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

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- Information Governance resource has reduced to 4 WTE.
- 146 information governance related incidents reviewed between October 2025 & December 2025.
- 1 data breach since the last committee has been reported to the Information Commissioner's Office.

- Freedom of Information compliance remains largely unchanged since the last committee – 89% for last 12 rolling months.
- Access to Health Records compliance continues to increases to 64%. The number of requests over the last 12 months has increased to 333 per month.
- Letters to staff regarding inappropriate access to clinical systems remain in place.
- Information Governance mandatory training across the UHB remains at 74%.

Recommendation:

The Board/Committee are requested to:

a) RECEIVE and NOTE a series of updates relating to significant Information Governance issues

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:

Risk: Yes/No (delete as appropriate)

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

Safety: Yes/No

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

Financial: Yes/No

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

Workforce: Yes/No

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

Legal: Yes/No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: Yes/No

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

Socio Economic: Yes/No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. (If this has been addressed in the main body of the report, please confirm)

Equality and Health: Yes/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. (If this has been addressed in the main body of the report, please confirm)

Decarbonisation: Yes/No

There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB.
These include:

- *A focus upon preventing ill health in our population*
- *Saving energy or increasing throughput.*
- *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary outpatient appointments.*
- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

Does the subject matter of your paper risk any of the above not being achieved?

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Welsh Language: Yes/No	
Consideration should be given to potential impact on the Welsh language, including the following key aspects: *• More than just words: Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language, and supporting active offer and bilingual care?* *• Accessibility and compliance: Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.* *• Patient understanding and safety: Could English-only content impact Welsh speakers' comprehension in critical areas like consent and medication instructions, potentially affecting safety?* *• Staffing and resources: Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?* *Does the subject matter of your paper risk any of the above not being achieved?*	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

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<table>
<tr><td>Report Title:</td><td colspan="3">Data Strategy</td><td colspan="2">Agenda Item no.</td><td colspan="2">3.4</td></tr>
<tr><td rowspan="2">Meeting:</td><td rowspan="2" colspan="2">Digital & Infrastructure Committee Meeting</td><td>Public</td><td>X</td><td rowspan="2">Meeting Date:</td><td rowspan="2" colspan="2">10th February 2026</td></tr>
<tr><td>Private</td><td></td></tr>
<tr><td>Status:</td><td>Assurance</td><td></td><td>Approval</td><td></td><td colspan="2">Information</td><td>x</td></tr>
<tr><td>Lead Executive:</td><td colspan="7">Director of Digital & Health Intelligence</td></tr>
<tr><td>Report Author:</td><td colspan="7">Chief Clinical Information Officer</td></tr>
</table>

Background and current situation:

The strategy articulates how Cardiff & Vale UHB will transition to a system where practice generates data (P2D), data becomes knowledge (D2K), and knowledge informs practice (K2P). It embeds a standards-based, interoperable, and transparent data ecosystem, aligned with national and regional digital expectations.

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

Key Points:

- Establishes a *learning health and care system* driven by real-time digital data capture.
- Embeds core principles: persistent/reusable data, co-design, agile delivery, and democratised access to data and insight.
- Proposes adoption of a common data model, based on the data standard used worldwide known as OMPO (Observational Medical Outcomes Partnership to reduce duplication and support operations, analytics, and research.
- Defines seven essential organisational requirements:

    1. Internal data governance
    2. Standardised vocabularies
    3. Openness and transparency
    4. Coordination with partners
    5. Investment in data fabric
    6. Reusable tools
    7. Education and training

- Details progress to date, including the establishment of Technical Design Authority (TDA), Clinical Design Authority (CDA), Change Advisory Board (CAB), and adoption of SNOMED CT (clinical codes) and HL7 FHIR (an Interoperability standard).
- Outlines near-term developments such as creation of the Data Steering Group (DSG), improved data quality oversight, and integration of siloed systems.

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Assessment / Impact:
The strategy provides a coherent, long-term framework for ensuring data is captured, standardised, governed, and reused across the organisation. It supports improved clinical outcomes, operational efficiency, and research capability while reducing duplication and technical debt.

No adverse patient impact anticipated; expected benefits include better data quality, improved safety through consistent data reuse, and richer insight to inform decision-making.

Recommendation:

The Committee are requested to:

1. **Note** the strategic direction and foundations described.
2. **Endorse** the establishment and resourcing of the Data Steering Group and associated governance structures.
3. **Support** continued development in data infrastructure, standards adoption, and workforce capability

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:

Risk: No

Safety: Yes

Financial: No

Workforce: Yes

Legal: No

Reputational: Yes

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Socio Economic: Yes
Equality and Health: Yes
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

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Delivering data

Building a learning health and care system

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D2K

- By analysing the data we collect it turns into information and knowledge. We can only change and improve our system if we understand it.

K2P

- We must then use the understanding we gain to inform , improve and transform practice. This is the most important step, and the hardest to achieve.

P2D

- To collect our data, we will need to enable clinicians and patients to record their activities digitally without interfering with the processes of care. Data must be collected and used in 'real-time' to maximise its usefulness in operational as well as planning services

Persistence and re-use of data

- Whenever digital information is collected, it will be stored in a form that enables it to be re-used by other appropriate applications. For example, if a patient has had an allergy recorded in a hospital clinic, that information will then be updated and re-used by another application used by a pharmacist, GP or other care provider. This will greatly enhance efficiency and safety.

Co-production through user-centered design

- The introduction of a digital process requires and understanding of what it means to the service users – both patients and clinicians. When introducing new digital solutions, patients and clinicians will therefore be involved in deciding what it should look like, where it fits in to their view of the service, and what benefits it might bring.

Digital as the enabler, not digital as a goal in itself

- Simply digitising a process seldom brings any benefits. It should instead provide an opportunity to review and change the care process, which will have been established around paper-based processes.

Iterative, agile design

- It is tempting to try and do everything at once, and to sponsor large-scale centrally controlled projects to achieve this. The so-called 'waterfall' approach does not generally work in digital health care. By the time the required governance and procurement cycles have been worked through, the digital landscape has often changed, and the solution acquired (and committed to) has been superseded. Instead, it is better to break projects down into smaller chunks using small, focused teams working in 'sprints' to achieve digital solutions which will be 'good enough' (although safe) rather than perfect initially, but which will then be changed in response to user-feedback in an iterative manner.

Innovation aligned to strategy

- CAV will continue to foster and encourage innovation, but will ensure that it is aligned with the digital strategy, and that any digital elements of innovation projects fit in with the digital architecture, and are capable of being scaled-up if they prove successful.

Democratise data, democratize knowledge

- The data collected by the organisation will produce large pools of 'big data' which is the foundation for the learning health system. With appropriate safeguards, this data will be made available to clinicians, managers and analysts across the organization. There are myriad ways of using, visualizing and interpreting data, and even in 5 years we will still only be beginning to understand how to do this. We need therefore to permit multiple stakeholders to innovate in making use of this data and turning it into knowledge. We will not constrain ourselves by assuming there is only one way of interpreting data – there are many mays to the truth!

Regan Nikki
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What underpins a data strategy for a learning health and care system?

- Cross boundary data capture and management
- Analytics and knowledge generation
- Research
- Governance and ethics
- Culture and workforce
- Communities

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Key principles

- **Patient centricity**: respecting data privacy and prioritising patient consent and control
- **Interoperability**: data standardisation and supporting best-of-breed integration independent from but informed by specific requirements
- **Vendor-neutrality**: favour lifelong meaningful data over ephemeral applications
- **Secure**: mapping of existing and new data flows and uses, maintaining cybersecurity standards including finely-grained access controls
- **Transparency**: Fostering trust through clear communication about data use, and outcomes
- **Evidence-based**: Using data to inform clinical practice, service planning, improvement and population health interventions

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Operational clinical systems

Intermediary ("pluripotent") representations

Analytics
Research
Reporting
Dynamic registries

HL7 FHIR
HL7 v2 (ADTs)
SNOMED CT

Interoperability
User experience
Granular

Simpler ETL →

OMOP CDM-like and extensions

Standardised

Transform →

Tailored and bespoke

Rectangular projections

Multiple perspectives

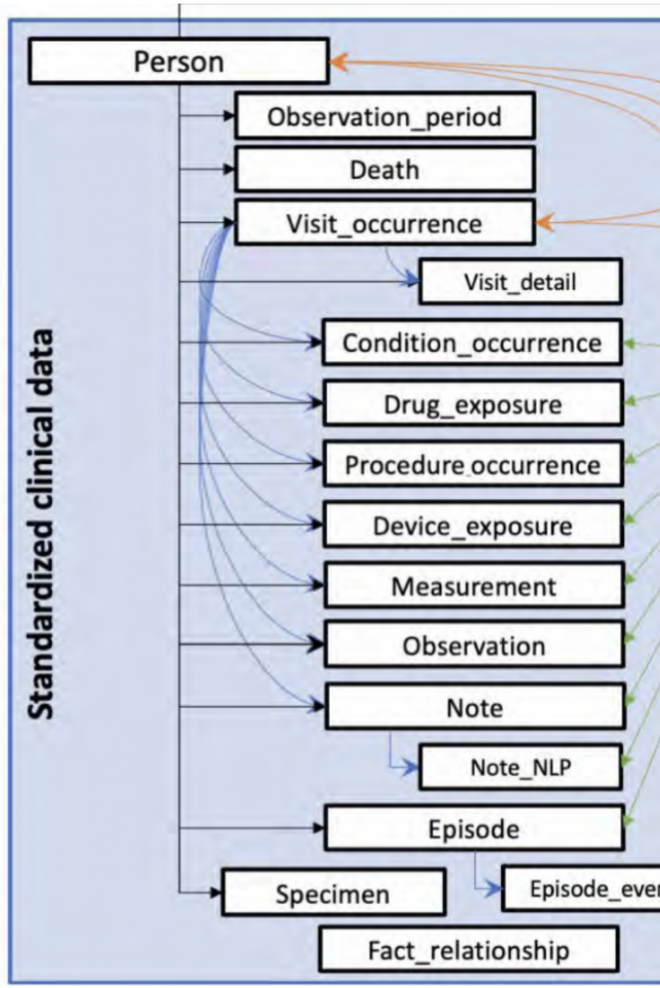
Bespoke ETL →

Legacy (non-standardised) silo

Requirements

Internal data governance
Standardised vocabularies
Openness and transparency
Coordination with partners (WG/HBs/DHCW)
Investment in our data fabric
Re-usable tools
Education and training

Observational Medical Outcomes Partnership (OMOP): Common Data Model (CDM)



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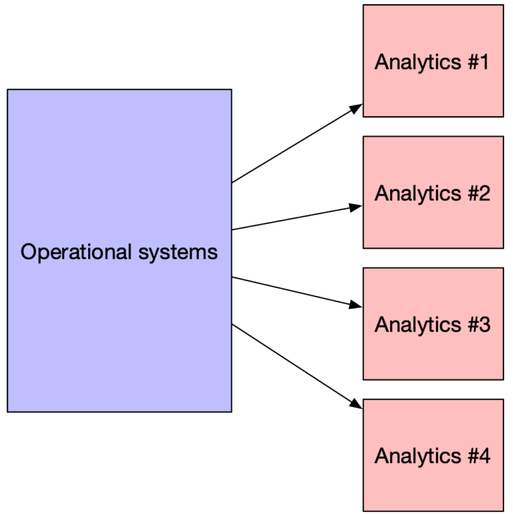
Common data models

What do we need from data?

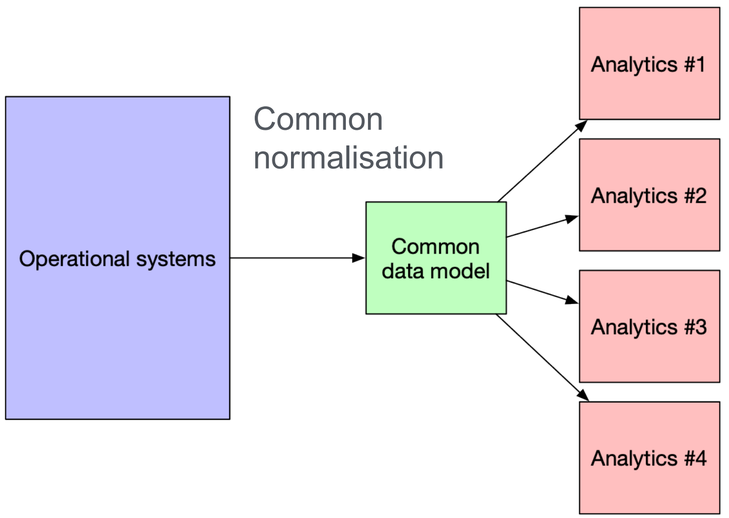
- Satisfy operational requirements - both management and clinical
- Support secondary uses
- Audit, research
- e.g. which drugs, which conditions, which devices?
- Aggregation / composability across boundaries
- Reduce duplication of effort (errors, non-standard, duplicate work) in making sense of data for different purposes
- Nothing here solved by buying an EPR or multiple EPRs



Duplicate effort

Variation

See artefacts of analytics requirements in operational systems



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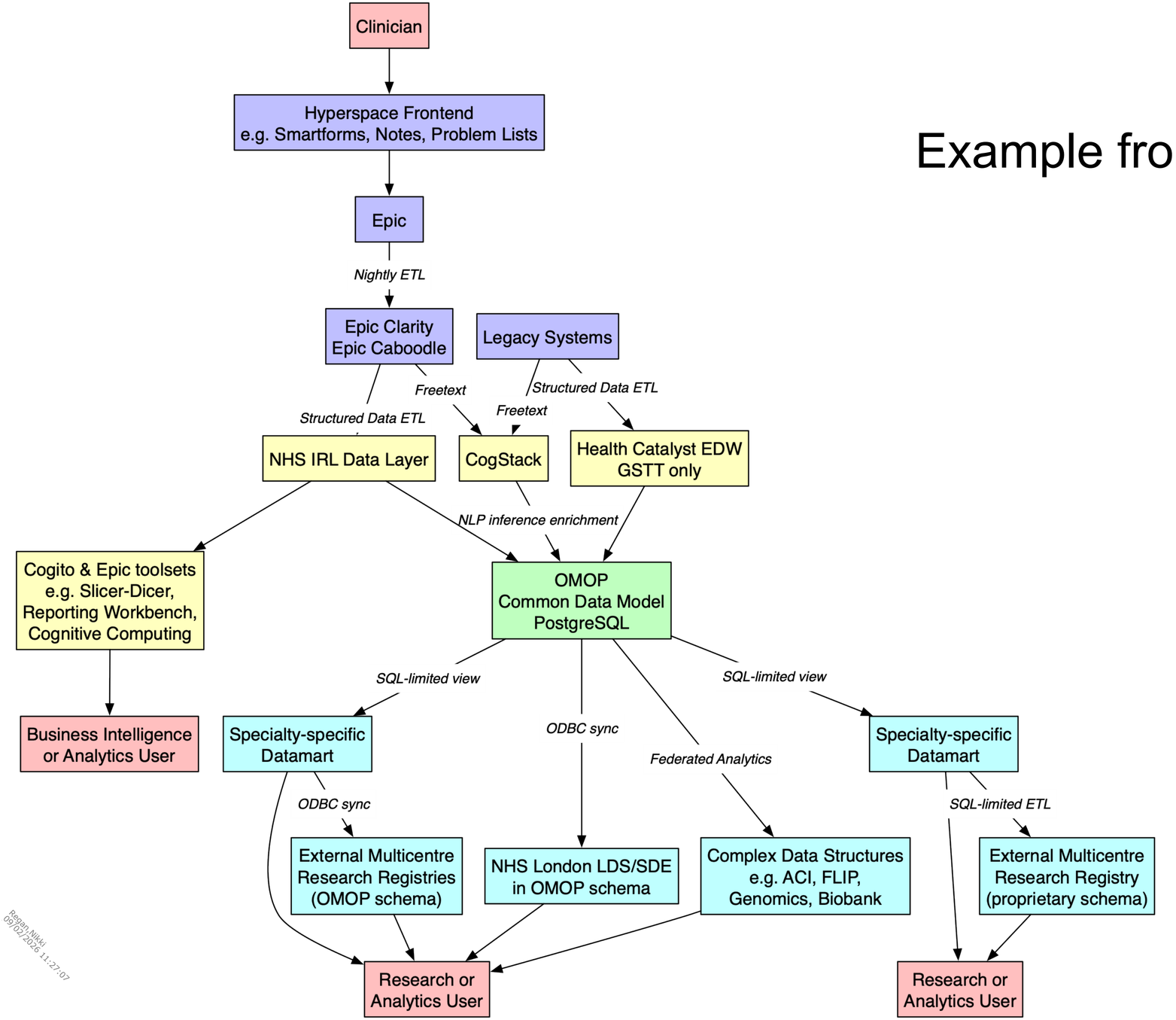
Example from KCL



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Requirements

- Internal data governance
- Standardised vocabularies
- Openness and transparency
- Coordination with partners (WG/HBs/DHCW)
- Investment in our data fabric
- Re-usable tools
- Education and training

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Requirements

- **Internal data governance**
- *Standardised vocabularies*
- *Openness and transparency*
- *Coordination with partners (WG/HL*
- *Investment in our data fabric*
- *Re-usable tools*
- *Education and training*

Registration and monitoring of data flows (information governance, feral apps, o365)

Standardisation of data across uses

Harmonisation / data quality

Understand common foundations

Maintenance and publication of common data model

-> Clinical and technical design authorities

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Requirements

- *Internal data governance*
- **Standardised vocabularies**
- *Openness and transparency*
- *Coordination with partners (WG/HL*
- *Investment in our data fabric*
- *Re-usable tools*
- *Education and training*

Essential for *semantic* interoperability

Match to regional, national and international standards

First-class mapping and transformation

To satisfy myriad *potential* requirements - operational clinical systems, analytics, reporting and research

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Requirements

- *Internal data governance*
- *Standardised vocabularies*
- **Openness and transparency**
- *Coordination with partners (WG/HL*
- *Investment in our data fabric*
- *Re-usable tools*
- *Education and training*

Radical transparency and visibility

Publication of standards used, for all purposes. Openly available and managed and updated

Versioning and registration of use

Avoid breaking changes; additive change: *you don't care if your delivery truck bringing your parcel also has other parcels on it.*

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Requirements

- *Internal data governance*
- *Standardised vocabularies*
- *Openness and transparency*
- **Coordination with partners (WG/**
- *Investment in our data fabric*
- *Re-usable tools*
- *Education and training*

We must work across region, across Wales and across UK

Our collaborative efforts must be prioritised and supported

Some of what we need can and should be delivered by our partners

Regan,Nikki
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Requirements

- *Internal data governance*
- *Standardised vocabularies*
- *Openness and transparency*
- *Coordination with partners (WG/HE*
- **Investment in our data fabric**
- *Re-usable tools*
- *Education and training*

Raise the visibility of our data infrastructure

Balance short-term delivery goals with longer-term standardisation, harmonisation and documentation

Avoiding technical debt and ‘big ball of mud’ architectures; Infrastructure on demand and as infrastructure as code. Declarative.

Focus on interoperability, principled approach based on re-use, understand commonalities/foundational data structures

Regan,Nikki
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Requirements

- *Internal data governance*
- *Standardised vocabularies*
- *Openness and transparency*
- *Coordination with partners (WG/HL*
- *Investment in our data fabric*
- **Re-usable tools**
- *Education and training*

Investment in tooling, and pipelines, that are ‘invisible’ and yet vital. “Our plumbing”

Investment in our ability to extract, transform and load data; “internal interoperability”

Could and should be shared across Wales

Open standards, and open-source at foundations

Regan,Nikki
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Requirements

- *Internal data governance*
- *Standardised vocabularies*
- *Openness and transparency*
- *Coordination with partners (WG/HE*
- *Investment in our data fabric*
- *Re-usable tools*
- **Education and training**

Health and social care

Regional partnerships

Inculcate *art-of-the-possible*, data skills, across organisations

Workshops, investment in training, workforce and digital skills, peer support

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Progress so far

- Established technical design authority (TDA) and clinical design authority (CDA)
- Tracking links and representation with regional and national partners (Internal Audit/2025/995/MD3/1)
  - *including links with revised DDaT structures in NHS*
- Established change advisory board (CAB) for internal change control
- Review of all existing and proposed internal and external data flows, albeit at high level
- Adoption of SNOMED CT, HL7 FHIR as foundational standards

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In progress: DSG

- A new ‘Data Steering Group’ (DSG) to provide clinical and operational leadership for data flows, processing, quality and prioritisation, strengthening organisation-wide data governance
(Corporate Governance - Internal Audit/2025/995/MD4/1)

- DSG to set data quality targets, enabling benchmarking across clinical boards - clinical boards will appoint senior representatives responsible for digital and data
(Corporate Governance - Internal Audit/2025/995/MD4/2)

- Commission to document existing local and national reporting requirements and set quality metrics / commission automated reporting of poor quality data, and to identify data quality gaps [e.g. clinical coding]
(Corporate Governance - Internal Audit/2025/995/MD4/3)

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In progress / pending

- Better integration of siloed data systems via LDR investment and better prioritisation and oversight
  - *making data available*

- Better meaningful data; clinical outcomes > measures of process
  - *making meaningful data*

- Better feedback mechanisms for boards and directorates to understand their data quality problems. (Corporate Governance - Internal Audit/2025/995/MD8)
  - *using quality data*

Regan,Nikki
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Report Title:	CAR PARKING POLICY WITH EHIA			Agenda Item no.	4.1	
Meeting:	Digital & Infrastructure Committee	Public Meeting		Meeting Date:	10.02.2026	
		Private Meeting	x			
Status:	Assurance		Approval	x	Information	
Lead Executive:	Director of Capital, Estates & Facilities					
Report Author:	Head of Transport and Sustainable Travel					

Background and current situation:

This paper seeks Committee approval for the Car Parking Management Policy, which has been developed in response to ongoing operational challenges and evolving strategic priorities. The policy is required to ensure that car parking across all University Health Board (UHB) sites is managed in a fair, transparent, and sustainable manner, in line with Welsh Government guidance (WHC 2018/010), the Equality Act 2010, and the Welsh Language Act 1993. The updated policy introduces a structured approach to prioritising access for patients, disabled users, and essential staff, while promoting sustainable travel options such as Park & Ride and car sharing. This policy will benefit the UHB by supporting site accessibility, reducing congestion, and enhancing patient experience. For staff, the policy supports equitable permit allocation and provides administrative support through a staffed parking office. Visitors will benefit from clearer signage, safer traffic flow, and designated drop-off zones. Overall, the policy contributes to the UHB's strategic goals of delivering outstanding quality, acting for the future, and putting people first.

Background

Effective car parking management is essential for ensuring safe, accessible, and equitable access to healthcare services across University Health Board (UHB) sites. Historically, car parking at NHS facilities has faced challenges including congestion, unauthorised use, limited availability for disabled users and patients, and inconsistent enforcement practices. In response to these issues, the Welsh Government issued guidance (WHC 2018/010) to support NHS Wales organisations in developing transparent, fair, and sustainable car parking policies.

The UHB recognises the importance of aligning its car parking practices with national guidance, legal obligations under the Equality Act 2010 and Welsh Language Act 1993, and its own strategic goals for sustainability and service quality. This policy has been developed to formalise car parking arrangements, improve patient experience, and support operational efficiency across all UHB sites.

Current Situation

Currently, car parking at UHB sites is provided free of charge, in line with Welsh Government policy. However, demand for parking often exceeds supply, particularly at major hospital sites, leading to challenges in accessibility, traffic flow, and enforcement. The UHB has implemented several measures to address these issues, including:

- A points-based permit system for staff, prioritising essential users such as those with medical conditions, caring responsibilities, or multi-site duties.
- Segregated parking zones for disabled users, staff, and time-limited drop-off/pick-up areas.
- Use of a British Parking Association (BPA) approved enforcement provider to manage unauthorised parking and ensure compliance with site regulations.
- Bilingual signage and road markings to support clear communication and legal compliance.
- A staffed parking office to provide administrative support and assist users with queries or concerns.
- Promotion of sustainable travel options, including Park & Ride services, car sharing, and cycling facilities.

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Despite these efforts, challenges remain, particularly in ensuring equitable access for staff working anti-social hours, managing permit expectations, and maintaining safe traffic flow. The policy aims to address these issues through ongoing monitoring, stakeholder engagement, and continuous improvement.

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

The implementation of a comprehensive car parking policy is a critical step in addressing longstanding operational challenges across UHB sites. The policy reflects a proactive approach to balancing accessibility, equity, and sustainability, and aligns with Welsh Government guidance and statutory obligations. The introduction of a structured permit system, enhanced enforcement, and promotion of sustainable travel options demonstrates a commitment to improving patient and staff experience.

A key issue for Committee consideration is the implementation of the new parking management contract. This contract introduces new mechanisms for enforcement and monitoring, which must be underpinned by a robust policy framework to ensure consistency, transparency, and legal compliance. The Committee should also note the importance of ongoing stakeholder engagement and feedback mechanisms to support continuous improvement and responsiveness to emerging needs.

Appendices *(Please list any appendices that will accompany this report)*

Car Parking Management Policy
Equality Impact Assessment
Quality Impact Assessment
Health Impact Assessment

Recommendation:

The Committee is requested to:

Acknowledge the requirement for a formalised policy framework to support the implementation and governance of the new parking management contract, ensuring alignment with strategic objectives and legal obligations.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

1. Putting People First **Click the objective above to view more detail.**	x	2. Providing Outstanding Quality **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	x

Five Ways of Working (Sustainable Development Principles) considered:

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Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	

Quality Impact Assessment Completed?

Yes – (***please provide completed QIA document***)	X – in main policy	No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:

Risk: No

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

Safety: No

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

Financial: No

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

Workforce: No

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

Legal: No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: No

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

Socio Economic: No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. (If this has been addressed in the main body of the report, please confirm)

Equality and Health: Yes – within policy document

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. (If this has been addressed in the main body of the report, please confirm)

Decarbonisation: No
There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB. *These include:* • *A focus upon preventing ill health in our population* • *Saving energy or increasing throughput.* • *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions* • *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated follow ups to reduce unnecessary outpatient appointments.* • *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.* • *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.* *Does the subject matter of your paper risk any of the above not being achieved?*
Welsh Language: No
Consideration should be given to potential impact on the Welsh language, including the following key aspects: *• More than just words: Does the report align with the More than just words strategy, ensuring Welsh-speaking patients can access services in their preferred language, and supporting active offer and bilingual care?* *• Accessibility and compliance: Ensure key information is bilingual and that the report meets the Welsh Language Standards for communication, signage, and patient materials.* *• Patient understanding and safety: Could English-only content impact Welsh speakers' comprehension in critical areas like consent and medication instructions, potentially affecting safety?* *• Staffing and resources: Does the report address the need for Welsh-speaking staff or bilingual resources to deliver equitable care?* *Does the subject matter of your paper risk any of the above not being achieved?*

Approval/Scrutiny Route (***please note anywhere else this paper has been before***):	
Committee/Group/Exec	Date:

Regan,Nikki
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Reference Number: UHB 546 **Version Number:** 1 *unless document for review*	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number: UHB 546**

Car Parking Management

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will, in accordance with WHC *Car Parking Management – guidance for NHS Wales* (2018) 010: implement a parking policy that will:

.

- Provide help and advice on car parking matters within the UHB site and at its Park & Ride facilitie(s).
- Protect disabled parking spaces, maintaining a safe traffic flow around sites and ensure clear and safe access routes for emergency vehicles are maintained;
- Encourage and outline some provided means to people to use alternative means of travel, reducing greenhouse gas emissions e.g Park & Ride service;
- Encourage the development of sustainable travel hubs; and
- To prevent unauthorised parking and encourage people to only park on hospital sites for hospital related business.
- To prevent unauthorised use of the hospital grounds.

Policy Commitment

Parking at UHB sites will remain free of charge (unless Welsh Government advice changes) and the UHB will maintain proportionate enforcement measures to address illegal parking and access issues. Car parking management will recognise that each site can have different parking issues relating to their location, the footprint of their estate, the number of spaces etc., and will enable car parking facilities to be managed to ensure patients, visitors, staff, emergency services, public transport operators and authorised contractors can safely access Health Board premises.

This will be achieved through the appointment a British Parking Association approved external parking enforcement supplier that meets the UHB specification embodying the UHB's expectations and values. The UHB will also maintain a staffed parking office to provide an internal administrative function as well as offering advice and help in addressing concerns for site users.

This policy will commit to the following main principles:

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- Where it is safe and reasonably practical to do so, priority parking in proximity of the health care premises main entrances will be given to our patients, and disabled patients and staff drivers who display a valid disabled driver badge.

- The UHB does not provide designated individual staff or departmental parking areas, other than the segregation of staff parking from that for patients and visitors. The Health Board will provide and operate a hospital permit parking scheme providing prioritised access for certain key staff at the main hospital sites. Discussion RE general v multisite at UHW and UHL]

- Parking management for staff parking will operate in accordance with the hospital permit scheme set criteria. Site parking capacity and the number of permit parking spaces available to be allocated is limited. Once allocated a permit, a space will not be guaranteed.

- Site parking areas will be clearly segregated into disabled patient/visitor, staff permit area, and where required, fleet and contractor parking areas. Suitable time limited drop off and pick up zones will be provided at the main entrances to all hospital sites. Parking enforcement will be used to manage and protect these parking areas.

- Parking enforcement will be deployed at all sites, roadways and pathways where parking management activity, and inconsiderate and unsafe parking is deemed to impact on safe traffic and pedestrian management and where parking is problematic.

- Whilst the management of traffic on Health Board sites has compliant Highways Agency signage and road markings to indicate parking restrictions, parking enforcement is also carried out using British Parking Association (BPA) Code of Practice bilingual approved signage to indicate to motorists that a parking enforcement scheme is in operation and takes precedence in respect of the issue of civil penalty notices.

Supporting Procedures and Written Control Documents

This Policy describes the following with regard to Car Parking Management.

- **Provision of Guidance and Support**: Offers help and advice on car parking matters across all Cardiff and Vale University Health Board (UHB) sites, including Park & Ride facilities.
- **Accessibility and Safety**: Ensures the protection of disabled parking spaces, maintains safe traffic flow, and guarantees clear access routes for emergency vehicles, and pedestrians.
- **Sustainable Travel Promotion**: Encourages the use of alternative travel methods such as Park & Ride services and supports the development of sustainable travel ideas to reduce greenhouse gas emissions.

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- **Parking Enforcement and Regulation**: Implements proportionate enforcement measures to prevent unauthorised parking and ensure that parking is used solely for hospital-related purposes.
- **Permit-Based Staff Parking**: Operates a points-based hospital permit parking scheme for staff, prioritising essential users while acknowledging that a permit does not guarantee a space.
- **Designated Parking Areas**: Clearly segregates parking zones for disabled users, staff, fleet vehicles, contractors, and includes time-limited drop-off/pick-up zones at main entrances.
- **Use of Approved Enforcement Providers**: Employs a British Parking Association (BPA) approved external enforcement supplier and uses bilingual signage in line with the BPA Code of Practice.
- **Internal Administrative Support**: Maintains a staffed parking office to manage administrative functions and assistance to site users.
- **Compliance with Legislation**: Aligns with the Welsh Government's WHC (2018) 010 guidance, the Equality Act 2010, and the Welsh Language Act 1993.

Other supporting documents are:

- WHC (2018) 010
- Welsh Language Act 1993

Scope

This policy applies to all of our staff in all locations including those with honorary contracts, and to all users of car parking bays and the roads on UHB sites.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact. *Please see appendix A*

Health Impact Assessment	A Health Impact Assessment (HIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found incorporated within this policy. Please see appendix B.
Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how	For example: Health System Management Board

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this policy will be implemented	
Accountable Executive or Clinical Board Director	Geoff Walsh, Director of Capital, Estates & Facilities

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New Document*

Appendix A

Equality Impact Assessment (EqIA)

Reference Number: TBA
Version Number: 1
Date of Next Review: To be included when document approved
Previous Trust/LHB Reference Number: Not Applicable

Policy Title: Car Parking Management

1. Aim of Policy

To implement a car parking management policy that ensures fair and transparent access to parking facilities, supports sustainable travel, and prevents unauthorised parking while addressing site-specific issues at University Health Board (UHB) premises.

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2. Objectives

- Provide advice on car parking matters across UHB sites.
- Protect disabled parking spaces and ensure emergency vehicle access.
- Promote alternative means of travel to reduce greenhouse gas emissions.
- Develop sustainable travel initiatives.
- Prevent unauthorised parking and ensure parking is used for hospital-related purposes only.

3. Data and Evidence Used

- **WHC (2018) 010**: Welsh Government guidance on car parking management.
- **Equality Act 2010**: Ensures compliance with obligations to prevent discrimination.
- **Welsh Language Act 1993**: Compliance with bilingual requirements for signage and communications.
- Points-based eligibility criteria for permit allocation.

4. Groups Affected by the Policy

This policy applies to all UHB staff, patients, visitors, and contractors using car parking facilities. It includes specific considerations for:

- **Disabled users**: Blue Badge holders and those requiring reasonable adjustments.
- **Staff with medical conditions**: Priority permit access based on need.
- **Essential car users**: Staff requiring cars for multi-site work or on-call duties.
- **Parents and carers**: Those with documented caring responsibilities.
- **Staff working anti-social hours**: Early morning or late-night shifts with limited public transport options.
- **Car sharers and sustainable transport users**: Incentivised through the permit system.
- **Park and Ride users:** Incentivised through the permit system.

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5. Assessment of Impact

Positive Impacts:

1. **Disabled Access:**
   - Protects disabled parking spaces and prioritises permits for staff with disabilities.
   - Ensures compliance with the Equality Act 2010.
2. **Sustainability:**
   - Encourages use of Park & Ride services and car-sharing.
   - Supports UHB's commitment to reducing carbon footprint such as providing cycling facilities.
3. **Fairness and Transparency:**
   - Points-based permit allocation ensures equitable access based on need.

Potential Negative Impacts:

1. **Permit Limitations:**
   - Staff living close to sites or with viable public transport options may have limited access to permits, potentially disadvantaging those without reliable transport alternatives.
2. **Anti-social Hours Staff:**
   - Limited public transport availability for early/late shifts may create difficulties for some staff.

Mitigations:

- Ensure public transport information and car-sharing schemes are well-promoted and accessible.
- Regular reviews of permit allocation criteria to address unforeseen issues or emerging needs.
- Parking office to assist site users with concerns or queries.

6. Actions Identified

- **Bilingual Signage:** Ensure all parking-related signage and communications comply with the Welsh Language Act 1993.
- **Monitoring and Feedback:** Regularly review policy implementation and adjust as needed based on stakeholder input.
- **Reasonable Adjustments:** Prioritise and clearly communicate options for reasonable adjustments for staff with disabilities or medical conditions.

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7. Decision-Making

The EqIA concludes that the Car Parking Management Policy will have a predominantly positive impact, promoting equitable and sustainable practices. Identified negative impacts have been mitigated through targeted actions. The policy should proceed to implementation with ongoing monitoring.

8. Governance and Approval

Policy Approved by: [Insert Committee/Board Name]
Date Approved: [Insert Date]
Accountable Executive: [Insert Post Title]

9. Monitoring and Review

- **Review Period:** Annually or as required based on stakeholder feedback or legislative changes.
- **Responsible Department:** Transport and Sustainable Travel

10. Contact Information

For further information or to provide feedback on this policy, please contact the Head of Transport and Sustainable Travel

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Appendix B

Health Impact Assessment (HIA) for Car Parking Management Policy

Introduction

This Health Impact Assessment (HIA) evaluates the potential health effects of the Car Parking Management Policy implemented by the University Health Board (UHB). The policy aims to ensure equitable access to parking, promote sustainable travel, and maintain safety and accessibility across UHB sites.

Policy Overview

The Car Parking Management Policy outlines a framework for managing parking facilities across UHB premises. Key components include:
- Free parking (subject to Welsh Government guidance)
- Prioritisation of disabled and patient parking
- Promotion of sustainable transport (e.g., Park & Ride, car sharing)
- Enforcement of parking regulations to ensure safety and access

Population Groups Affected

- Patients and Visitors
- Staff (including those with disabilities or medical conditions)
- Contractors and Emergency Services
- Public Transport Users and Car Sharers

Potential Health Impacts

Positive Impacts

- Improved Accessibility: Prioritised parking for disabled users and patients enhances access to healthcare services.
- Environmental Health: Promotion of sustainable travel options (e.g., Park & Ride, cycling) contributes to reduced air pollution and greenhouse gas emissions.
- Physical Activity: Encouragement of walking and cycling supports physical health.
- Mental Wellbeing: Clear signage, fair permit allocation, and a staffed parking office reduce stress and confusion for users.

Negative Impacts

- Transport Inequity: Staff without access to reliable public transport, especially during anti-social hours, may face challenges.

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- Permit Allocation Stress: Limited permits and no guaranteed spaces may cause anxiety among staff.

Mitigation Measures

- Enhanced Communication: Promote awareness of public transport options and car-sharing schemes.
- Flexible Permit Criteria: Regularly review and adapt permit allocation to reflect changing needs.
- Support Services: Maintain a responsive parking office to address user concerns and provide assistance.

Recommendations

- Ongoing Monitoring: Collect feedback from users and adjust policy implementation accordingly.
- Stakeholder Engagement: Involve staff, patients, and community representatives in future reviews.
- Health Metrics: Track indicators such as air quality, staff satisfaction, and accessibility complaints to measure health outcomes.

Conclusion

The Car Parking Management Policy is likely to have a positive overall health impact, particularly in promoting accessibility, sustainability, and fairness. Identified risks are manageable through proactive mitigation and continuous policy evaluation.

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Report Title:	Counter Fraud Procedure				Agenda Item No:	4.2
Meeting:	Digital & Infrastructure Committee	Public			Meeting Date:	10/02/2026
		Private				
Status **(please only tick one)**	Assurance		Approval	x	Information/Noting	
Lead Executive Title:	Catherine Phillips – Executive Director of Finance					
Report Author Title:	Henry Bales – Counter Fraud Manager					

Main Report
Background and Current Situation:

The organisation has a counter fraud procedure in place, since its previous approval there have been changes in legislation, staffing within counter fraud and ways of working within counter fraud. The policy has been updated to reflect these changes to ensure accuracy and compliance.

Executive Director Opinion & Key Issues to bring to the attention of the Board/Committee/SLT (delete as appropriate)

Updated procedure supported for approval.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Counter Fraud Procedure

Recommendations:

a) The committee are requested to approve the procedure.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention	X	Long Term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the*	x	No *(please provide reasoning e.g. not required*		

complete QIA document)				

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes/~~No~~
Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Safety: ~~Yes~~/No
Financial: Yes/~~No~~
All fraud occurring in the organization has a financial loss to the organization.
Workforce: Yes/~~No~~
Policy links with workforce/disciplinary policies and procedure.
Legal: ~~Yes~~ /No
There are legal obligations for the organisation in relation to the requirement for s provision of counter fraud. Investigations are conducted in line with legal requirements.
Reputational: Yes/~~No~~
Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No
Welsh Language: ~~Yes~~ /No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Catherine Phillips	

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Reference Number: UHB 054 **Version Number: 4**	**Next Review Date: TBC** **Previous Trust/LHB Reference Number: T129**

Counter Fraud Bribery and Corruption Procedure

Introduction and Aim

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will be committed to reducing the level of fraud and/or corruption within the NHS to an absolute minimum and keeping it at that level, thereby this will free up public money that can be put to providing better patient care. As one of the basic principles of Public Sector organisations is the proper use of public funds, the Health Board must ensure that its employees act with absolute integrity and honesty as expected and detailed under the various Codes of Conduct.

Objectives

The objective is to ensure that all assets and public funds entrusted to the Health Board are protected against Fraud and/or Loss. The Counter Fraud and Corruption Procedure describes the mechanisms and process that the Health Board will implement and then use to investigate allegations of fraud and fraud related offences, and to develop an Anti-Fraud Culture in accordance with the NHS Counter Fraud Authority's / Cabinet Office required standards.

Scope

This policy relates to all forms of fraud and corruption and is intended to provide direction and help to members of staff who may identify suspected fraud.

It is intended to provide a framework for responding to suspicions of fraud, advice and information on various aspects of fraud and implications of an investigation.

This policy applies to all CAVUHB staff, including secondees, those engaged via the bank, volunteers, those with honorary contracts, Independent Members, those working in bodies hosted by CAVUHB and other parties who may have a business relationship with CAVUHB e.g. consultants, vendors or contractors.

Equality Impact Assessment	An Equality and Health Impact Assessment (EHIA) **has** been completed and this found there to be no impact. This procedure relies on the generic EHIA for admin type policies.
Documents to read alongside this Procedure	This procedure should be read in conjunction with the UHB Counter Fraud and Corruption Policy, the All Wales Raising Concerns Policy and the All Wales Disciplinary Policy.
Approved by	Audit Committee

Regan,Nikki 09/02/2026

Accountable Executive or Clinical Board Director	Executive Director of Finance
Author(s)	Henry Bales – Counter Fraud Manager
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the mos to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	24/05/2011	24/05/2011	None
2	03/12/2019	05/12/2019	Updated
3	11/05/2023	16/05/2023	Procedure amended and updated to reflect changes to NHS CFA requirements and to maintain accuracy.
4	TBC	TBC	Updated to account for staffing change within the Counter Fraud Department, introduction on new offence/legislation and maintain accuracy.

Table of Contents

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1. Introduction

1.1. One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and means of enforcing the rules against fraud and other illegal acts involving dishonesty or damage to property. For simplicity all such offences are hereafter referred to as “fraud”, except where the context indicates otherwise. This document sets out the Cardiff and Vale University Health Board policy and response plan for detected or suspected fraud.

1.2. It is essential that all staff are aware of, and are able to access up-to-date, accurate Cardiff and Vale University Health Board (CAVUHB) policies to ensure they are aware of current approved practices to help reduce risk.

1.3. CAVUHB already has procedures in place that reduces the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, documented procedures and a system of internal control and a system of risk assessment. In addition, CAVUHB tries to ensure that a risk (and fraud) awareness culture exists throughout the organisation.

1.4. This document is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation.

1.5. The three crucial public service values which must underpin the work of the health service: accountability, probity, and openness. CAVUHB is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is therefore committed to the reduction of any fraud occurring within CAVUHB, and to the rigorous investigation of any such cases that do occur.

1.6. CAVUHB wishes to encourage anyone having reasonable concern that a fraud has or may be occurring to contact the Counter Fraud service. It is CAVUHB policy that no employee will suffer in any way as a result of reporting reasonably their concerns.

1.7. The flowcharts in section 8.2 describe CAVUHB response when a referral is made to the Counter Fraud service. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions.

1.8. The Counter Fraud Manager will report directly to the Director of Finance and will produce an agreed work plan to follow, to fulfil the requirements of the role.

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2. What is Fraud?

2.1. **Fraud**:

The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of a suspect and the intent to make a gain or cause a loss. It includes the following offences that could be committed against the NHS:

- Fraud by false representation (s.2) – dishonestly misrepresenting something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (s.3) – not saying something where there is a legal duty to do so.
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

Areas where fraud may occur include but are not limited to:

- *Travel and expense claims*
- *Petty cash vouchers*
- *Items of Service claims from independent contractors*
- *Time sheets*
- *Fraudulent use of authorised leave*
- *Overpayment of salary/wages*
- *Fraudulent use of CAVUHB resources*
- *Working whilst on the sick*
- *Handling of cash*
- *Misappropriation of equipment*

This is covered in more detail at section 9.3.

2.2. **Bribery and Corruption**:

"The offering, giving, soliciting of an inducement or reward that may influence the actions taken by a body, its members or officers."

Source: The Code of Audit Practice – Audit Commission

Corruption does not always result in a loss. The corrupt person does not have to benefit directly from their deeds, they may unreasonably use their position to give some advantage to another.

It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

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Corruption prosecutions tend to be most commonly brought using

specific pieces of legislation dealing with corruption, i.e. under the The Bribery Act 2010.

2.3. Bribery Act 2010

The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011. The Bribery Act 2010 will abolish all existing UK Anti-Bribery Laws and replace them with a suite of new offences markedly different to what has gone before. The Bribery Act 2010 makes it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". It will increase the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine. In addition, the Act introduces a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

3. Public Service Values

Source: WHC (2006) 090 'The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006'.

3.1. The codes reinforce the seven principles of public life (The Nolan Principles) and focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity, and openness.

- Accountability: Everything done by those who work in the NHS in Wales must be able to stand the test of scrutiny by the Welsh Government, public judgments on propriety and professional codes of conduct.
- Probity: There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of the NHS in Wales's duties.
- Openness: There should be sufficient transparency about the NHS in Wales's activities to promote confidence between the NHS body and its staff patients and the public.

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4. Economic Crime and Corporate Transparency Act 2023 – Failure to Prevent Fraud Offence

The Economic Crime and Corporate Transparency Act 2023 (ECCTA) introduces a new corporate criminal offence: Failure to Prevent Fraud. This offence applies to all organisations, including NHS bodies, and creates a legal obligation to implement reasonable procedures to prevent fraud.

Under this legislation, the organisation may be held criminally liable if an employee, agent, or associated person commits fraud intending to benefit the organisation. Liability arises even if senior management were unaware of the fraudulent act. The only defence is to demonstrate that the organisation had reasonable fraud prevention measures in place.

Our Commitment

- We recognise that fraud costs the NHS significant resources that should be directed to patient care. Preventing fraud is therefore a core organisational priority.
- The organisation will maintain robust anti-fraud processes, controls, and governance arrangements to comply with ECCTA requirements.

Reasonable Procedures

To meet the statutory defence, the organisation will:

- Conduct regular fraud risk assessments and update controls accordingly.
- Implement proportionate, risk-based prevention procedures aligned with NHS Counter Fraud Standards.
- Ensure top-level commitment, with Board-level accountability for fraud prevention and a nominated Fraud Champion.
- Apply due diligence to staff, contractors, and suppliers to mitigate fraud risks.
- Maintain clear reporting routes for staff and third parties to raise concerns confidentially.
- Deliver mandatory counter fraud training to all staff to raise awareness of responsibilities under ECCTA.
- Keep accurate records and evidence of fraud prevention activities, policies, and decisions.

Staff Responsibilities

Fraud prevention is everyone's responsibility. All staff must:

- Follow organisational policies and procedures.
- Report suspected fraud promptly through the designated reporting channels.
- Complete required training and remain vigilant for fraud indicators.

Failure to comply with these requirements may expose the organisation to criminal liability and reputational damage.

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5. CAVUHB Policy Statement

5.1. CAVUHB is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is also committed to the elimination of any fraud within CAVUHB, and to the rigorous investigation of any such cases.

5.2. CAVUHB wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also CAVUHB policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting reasonably held suspicions.

5.3. All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes "reasonably held suspicions" shall mean any suspicions other than those which are raised maliciously and found to be groundless.

6. Provisions of Government Functional Standard GovS 013 Counter Fraud

From April 2021, all NHS funded services nationally, were required to provide assurance of compliance with the requirements of the Functional Standard. This included NHS bodies in Wales.

The purpose of the Functional Standard is to set the expectations for the management of fraud, bribery and corruption risk in government organisations and wider public services, while reinforcing the government's commitment to fighting fraud against the public sector.

Complying with the Government Functional Standard - 013: Counter Fraud requires a three-stage framework to Counter Fraud work as outlined below:

- Strategic governance – This sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that counter fraud measures are embedded at all levels across the organisation.

- Proactive response – This sets out the requirements in relation to raising awareness of NHS fraud across the organisation and working with NHS staff, stakeholders and the public to highlight the risks and consequences of economic crime against the NHS. This response also sets out the requirement in relation to fraud risk assessment and proactive initiatives with the aim of providing remedy and fraud proofing by ensuring that opportunities for fraud to occur is minimised/mitigated/disrupted.

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- Reactive response – This sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed such crimes and seeking financial redress where appropriate.

7. Roles and Responsibilities

7.1. Executive Director of Finance

The Director of Finance, in conjunction with the Chief Executive, monitors and ensures compliance with the Counter Fraud Directions for the organisation.

The Director of Finance will, depending on the outcome of investigations and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The Director of Finance and Local Counter Fraud Specialist (LCFS) will be responsible for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.

The Director of Finance will inform and consult the Chief Executive in cases where the loss may be above the agreed limit or where the incident may lead to adverse publicity.

If an investigation is deemed to be appropriate, the Director of Finance will delegate to the LCFS, who has responsibility for leading the investigation, whilst retaining overall responsibility themself.

The Director of Finance or the LCFS will consult with the Executive Director of People and Culture or delegated representative, if a member of staff is to be interviewed or disciplined.

The Director of Finance or LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation as part of a disciplinary process.

7.2. Local Counter Fraud Specialist

Local Counter Fraud Specialists (LCFS) are located in each NHS organisation. The Lead LCFS is appointed by the Executive Director of Finance and will be responsible for investigating cases of fraud up to a value of £15,000. All investigations involving more than £15,000 and/or Corruption must be referred to the NHS Counter Fraud Service (Wales) Regional Team. Only individuals who are accredited as Counter Fraud Specialists will be responsible for investigating cases of fraud. The LCFS will be responsible for notifying all cases of fraud to NHS Counter Fraud Service Wales in the

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appropriate manner and via the CLUE Case Management System. The LCFS shall:

- Report to Executive Director of Finance.
- Provide a written report at least annually to CAVUHB on counter fraud work within the organisation.
- Be entitled to attend Audit Committee meetings and have a right of access to all Audit Committee members and the Chair and Chief Officer of CAVUHB.
- Undertake, as agreed with CAVUHB Executive Director of Finance, proactive work to detect cases of fraud and corruption, particularly where systems weaknesses have been identified. This work shall be carried out so as to complement the detection of potential fraud and/or corruption by auditors in the course of routine audits.
- Proactively seek and report to CFS (Wales) opportunities where details of counter fraud work (involving action on prevention, detection, investigation, sanctions or redress) can be used within presentation or publicity in order to deter fraud and corruption.
- Investigate cases of suspected fraud in accordance with the division of work specified in the Directions as amended and replaced from time to time. Refer to CFS (Wales) all cases appropriate to them.
- Inform CFS (Wales) of all cases of suspected fraud investigated by CAVUHB.
- Investigate, report and effect remedy in relation to identified system weaknesses within the organisation that can allow the opportunity for fraud to occur.

7.3. NHS Counter Fraud Service (Wales)

The NHS Counter Fraud Service (CFS) (Wales) will investigate all cases that do not fall within the responsibility of the Local Counter Fraud Specialist.

NHS CFS (Wales) will be responsible for the investigation of cases above £15,000, all corruption cases, and any case at the request of the LCFS, where the CFS (Wales) specialist knowledge and resources could assist with the investigation.

Counter Fraud Service Wales will act as the point of contact for the LCFS in relation to liaison with the Crown Prosecution Service.

7.4. NHS Counter Fraud Authority

On the 1st November 2017, an independent special health authority was implemented in England entitled the NHS Counter Fraud Authority (NHSCFA). This was achieved under amendment from the UK Government Secretary of State for Health.

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As a result of this, the previous arrangements which Welsh Ministers entered into with the predecessor organisation of the NHSCFA i.e. NHSBSA/NHS Protect, which was pursuant to section 83 of the Government of Wales Act 2006, which deals with the discharge of certain counter fraud functions in relation to the health service in Wales were reviewed and remained effective with the NHSCFA.

NHSCFA has responsibility for all policy, operational and training matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS.

NHSCFA also provides advice, guidance and risk measurement to NHS Bodies in Wales on all aspects of fraud, bribery and corruption. All instance where fraud is suspected are properly investigated, until their conclusion, by staff who are fully trained and accredited and who are duly nominated by NHSCFA.

7.5. CAVUHB Management

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are followed.

They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated LCFS.

Managers must instil and encourage an anti-fraud, and anti-bribery and corruption culture within their team and ensure that information on procedures is made available to all employees. The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported immediately to the lead LCFS. If formal investigation is undertaken by the LCFS/CFS managers have a duty to produce any documents or evidence that is required by the investigation team in a timely manner.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively.

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The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees.

7.6. Employees

CAVUHB's Standing Orders, Standing Financial Instructions, policies and procedures place an obligation on all employees and Independent Members of the Board to act in accordance with best practice.

Employees are expected to act in accordance with the standards laid down by their professional bodies, where applicable, and have a personal responsibility to ensure that they are familiar with them.

Employees also have a duty to protect the assets of the organisation including information, goodwill and property.

In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality.

All employees have a duty to ensure that public funds are safeguarded, whether they are involved with cash or payment systems, receipts or dealing with contractors or suppliers. If an employee suspects that there has been fraud, bribery or corruption, or has seen any suspicious acts or events, they must report the matter to the nominated LCFS.

7.7. Internal and External Audit

Any incident or suspicion of fraud that is brought to the attention of internal or external audit will be passed immediately to the nominated LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems or processes. Internal Audit will liaise with the LCFS in accordance with the agreed liaison protocol.

7.8. People and Culture (P&C)

P&C will liaise closely with managers and the LCFS from the outset if an employee is suspected of being involved in fraud and/or bribery and/or corruption. P&C staff are responsible for ensuring the appropriate use of CAVUHB's disciplinary procedure. P&C will advise those involved in the investigation on matters of employment law and other employment procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LCFS and P&C will be essential to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a co-ordinated manner, and to ensure the welfare of any employees involved in an investigation.

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8. The Response Plan

8.1. Introduction

The flowcharts in section 8.2 describe CAVUHB intended response to reported suspicion of fraud. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions. Each situation is different; therefore, the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

Further details on the processes in the flowchart are provided in section 8.3 (Commentary on Flowchart Items).

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8.2. Flowcharts

Chart 1

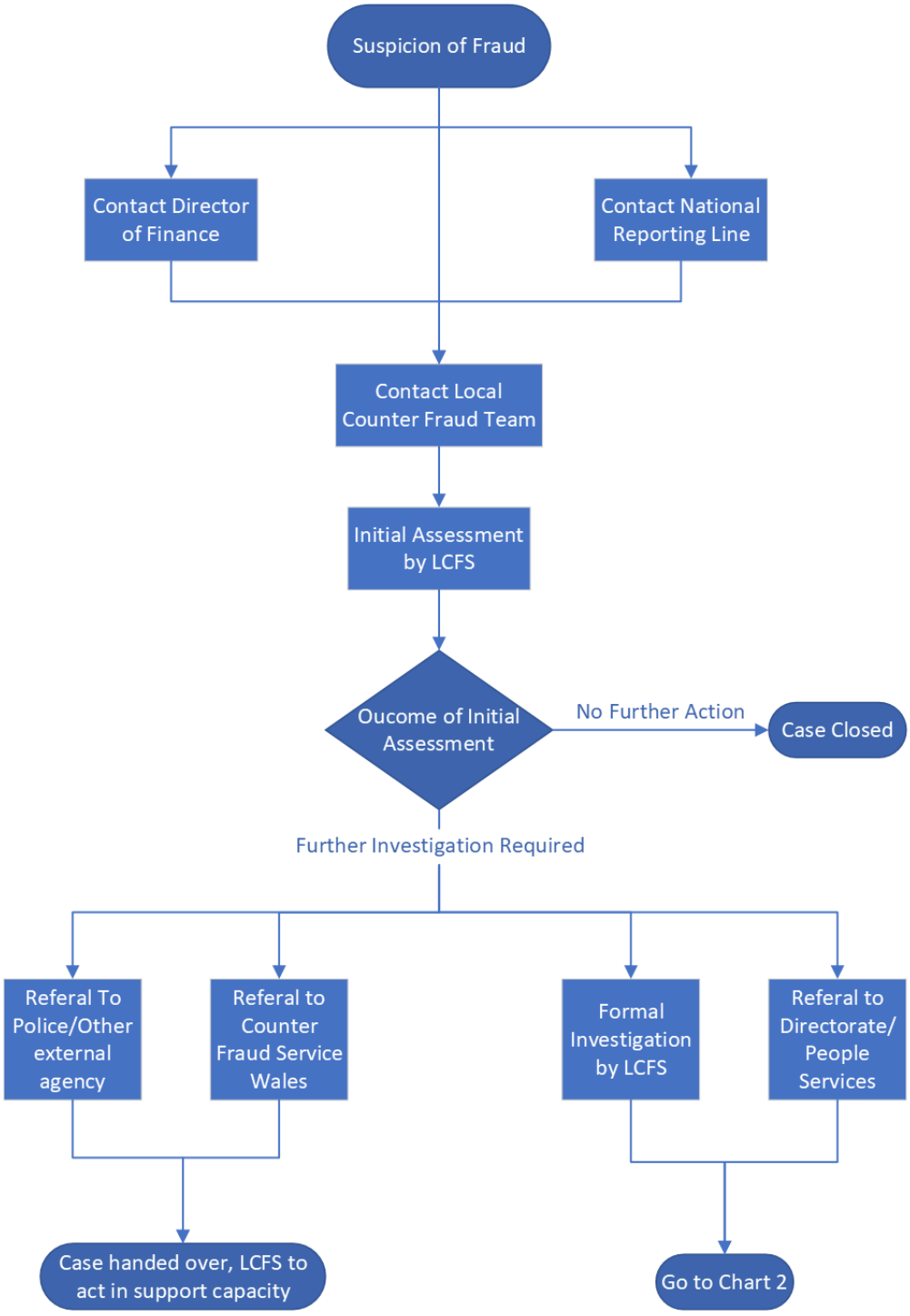

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Chart 2 – Local Counter Fraud Investigation

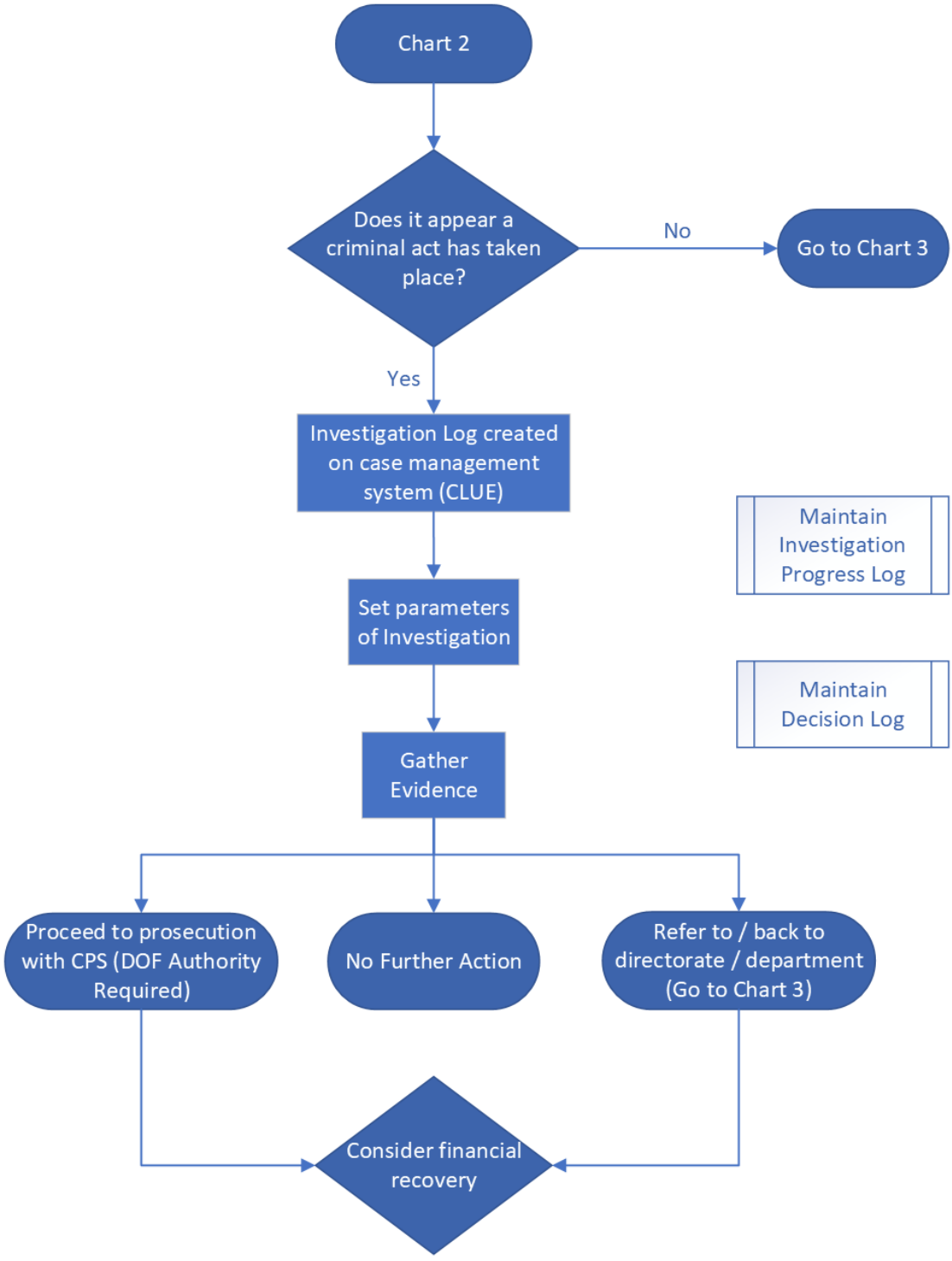

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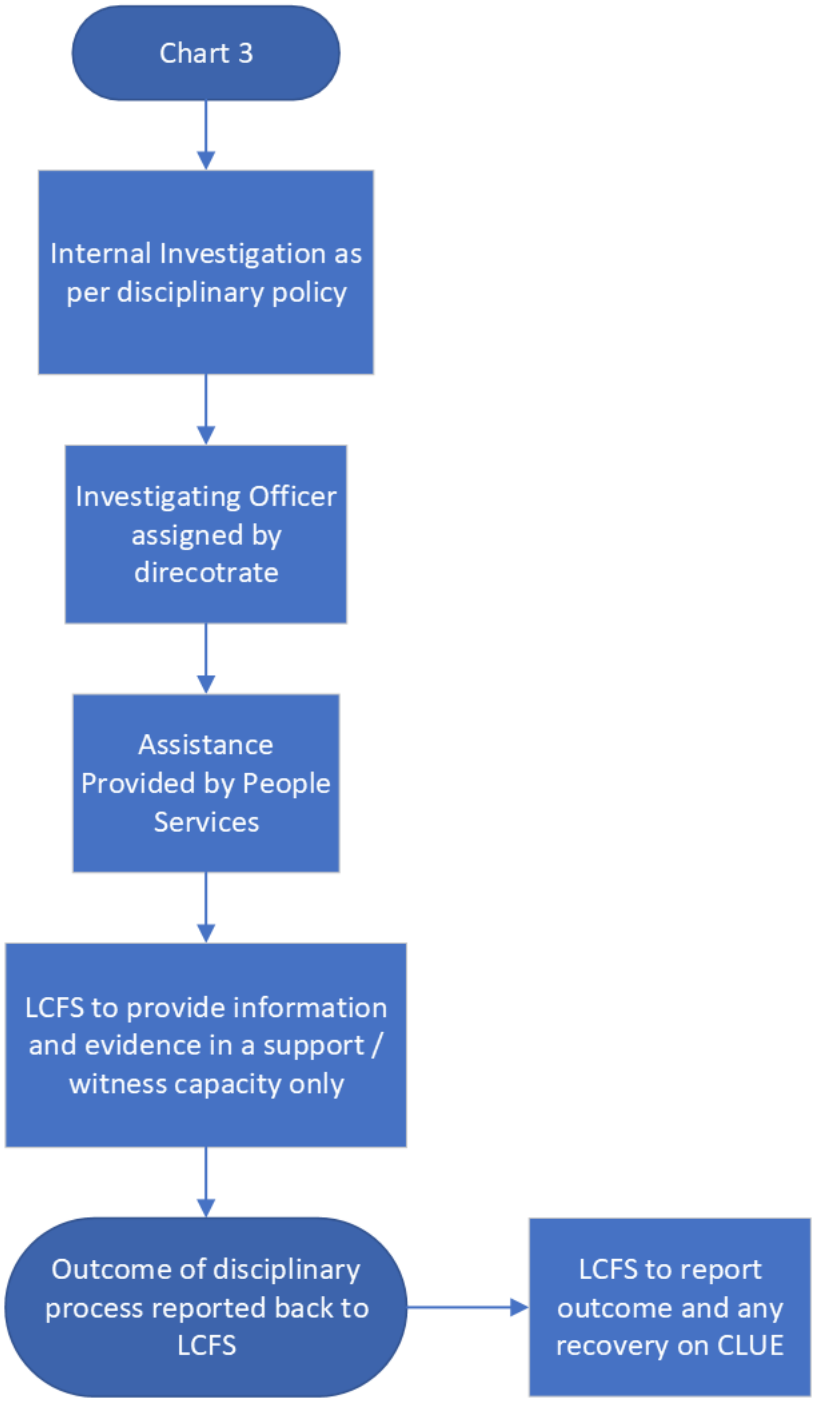
Chart 3 – Disciplinary Process



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8.3. Commentary on Flowchart Items

Further explanation of many items is also given elsewhere in this document.

8.3.1. Chart 1 – Suspicion of Fraud

The Local Counter Fraud Specialist (LCFS)

The Lead LCFS will be authorised to treat inquiries confidentially and anonymously if so requested by the individual making the referral.

The LCFS will receive appropriate skill-based training leading to professional accreditation and will be able to respond tactfully and appropriately to concerns raised by staff.

Suspicion of Fraud or Any Irregularities/Anomalies

If any CAVUHB employee has any concerns that a fraud has or is taking place, then they should discuss any suspicions in the first instance with the Nominated Lead LCFS on 02921 836265.

However, an employee may choose instead to contact the “NHS Fraud & Corruption Reporting Line” on 0800 028 4060.

This contact can be made anonymously.

Time may be of the utmost importance to prevent further loss to CAVUHB

Upon receipt of a referral LCFS will carry out an initial assessment to understand and identify whether there are reasonable grounds to suspect whether criminal offences have been committed. If not, the case will be concluded with no further action taken. Should there be issues of managerial concern evident then LCFS will liaise with appropriate departmental management and People Services department.

LCFS will consider and decide whether the case needs to be referred on to other agencies e.g. Police and Counter Fraud Service Wales. If this is appropriate then LCFS will make the appropriate arrangements. In some instances, a joint investigation may take place.

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8.3.2. CHART 2 – Local Counter Fraud Investigation

8.3.2.1. Progress of investigation

All investigations carried out by the Counter Fraud Department, will be led by an accredited LCFS and will be overseen by the Head of Counter Fraud. All investigations into fraud will be compliant with the Criminal Procedures and Investigations Act 1990 and the Police and Criminal Evidence Act 1984.

The Local Counter Fraud Specialist in charge of the investigation (OIC) will keep a log of events to record the progress of the investigation. This will commence immediately following referral. If a criminal offence is suspected then the referral will be promoted to formal investigation and recorded upon the NHS CFA case management system (CLUE).

8.3.2.2. Does it appear a Criminal Act Has Taken Place?

In some cases, this question may be asked more than once during an investigation. The answer to the question determines if there is to be a criminal investigation. In practice it may not be obvious if a criminal act has taken place. If a criminal act is believed to have occurred, the matter will be dealt with by the LCFS/CFS (Wales) as appropriate. If other criminal offences are involved e.g. theft, criminal damage, consideration should be given to reporting the matter, after consultation with the LCFS, to the police

8.3.2.3. Evidence

For the purposes of criminal proceedings, the admissibility of evidence is governed by the Police and Criminal Evidence Act (PACE). For non-criminal (i.e. civil or disciplinary) proceedings, PACE does not apply, but should nevertheless be regarded as best practice.

It is imperative that the collection of evidence must be coordinated if several parties are involved in an investigation, e.g. LCFS and internal audit, police and solicitors. The LCFS will take the lead on this. Evidence gathering requires skill and experience and professional guidance should be sought where necessary. There is a considerable amount of case law concerning the admissibility of evidence and incorrect procedure can lead to a prosecution collapsing.

8.3.2.4. Witnesses

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If a witness to the event is identified, then they will need to give a written statement. The LCFS will take a chronological record using the witness's

own words. (The witness should be prepared to sign the document as a true record) and advised that the statement may be used as evidence should the matter proceed to court. All witness statements will be completed in accordance with Section 9 Criminal Justice Act 1967 and on the witness statement document provided for this purpose. All witnesses will be provided with ongoing guidance and support throughout the process.

8.3.2.5. Physical Evidence

Upon taking control of any physical evidence, it is very important that a record is made of the time, date, and place it is taken from and by whom, continuity is essential. If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record. It is the responsibility of the LCFS to manage the retrieval, documentation and storage of physical evidence collected during the course of an investigation.

Documentary evidence should be properly recorded, it will need to be numbered and include accurate descriptions of when and where it was obtained and who it was obtained by and from. In criminal actions evidence on or obtained from electronic media needs a document confirming its accuracy.

8.3.2.6. Interviews

Any interviews carried out with a suspect during the course of a fraud investigation will be carried out only by an accredited LCFS, and will be compliant with the relevant codes and sections of the Police and Criminal Evidence Act 1984.

The subject of the investigation will be written to and advised of the reason for the interview and that they are entitled to have a person present at the interview who can act in a legal capacity (i.e. solicitor), but they are not entitled to have a friend, work colleague and/or union representative present at the interview.

The person being interviewed is also to be informed that whilst their attendance at the interview is voluntary, should they not attend, then the matter may be referred to the police which could then result in their subsequent arrest.

Prior to the start of an interview, the interviewee will be assessed with regard to their wellbeing and a decision will be made whether or not it is appropriate to continue with it. If it is not appropriate, then an alternative date in the future will be sought.

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The interview under caution will be tape recorded and once the interview has concluded the interviewee and their legal representative will be provided with a notice informing them of their entitlement to a copy of the recording made. All recordings must be made on a recording device authorised for the purpose.

8.3.2.7. Investigate Internally

If, after discussion with the LCFS, it appears a criminal act has not taken place, or that the act/s are of a minor nature and it would not be proportionate nor in the public interest to proceed criminally, the next step should be an internal review to determine the facts. The review may recommend various courses of action; instigate an investigation under CAVUHB Disciplinary Policy and Procedure; establish what can be done to recover a loss and what may need to be done to improve internal control to prevent the event happening again. Internal disciplinary investigations are the responsibility of the Directorate/Departmental management in conjunction with the People Services team.

8.3.2.8. Recovering a Loss

The seeking of financial redress or recovery of losses should always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Service (Wales) where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case. Redress allows resources that are lost to fraud, bribery and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

Where recovering a loss is likely to require a civil action, in the absence of established procedures for this recovery, e.g overpayments policy and debt collection agencies, it will be necessary to seek legal advice. Where external legal advisors are required, due to the possible high cost implications, the investigation manager must ensure that the Director of Finance is consulted. The decision of whether to proceed with any civil action will rest with the Director of Finance.

8.3.2.9. Court Action, Adverse Publicity and/or Police Involvement

Where the investigation reaches a stage where the case is likely to end up in a criminal prosecution via the criminal justice system, then the LCFS must liaise with the Finance Director. Should the investigation or prosecution be likely to lead to adverse publicity then LCFS should also liaise with CAVUHB Communications/Press relations Department. Where a fraud is suspected

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and the need to use the police to carry out an arrest and/or search, then lead LCFS will make the appropriate arrangements and liaise with the relevant organisation directly. The Director of Finance will be appraised accordingly.

No member of staff should contact members of the press without the authority of the Director of Finance and or the Communications/Press Relations team.

8.3.2.10. Risk Management

At the conclusion/during the course of an investigation it may become clear that system or process weaknesses or failings have provided the opportunity for fraud or loss to occur. In these circumstances LCFS will conduct a risk assessment into the target area and report accordingly upon any weaknesses identified. The CLUE case management system will be used for this purpose. Any weaknesses and recommendation for remedial action will be reported to the relevant directorate or department. Any risks identified during the course of an investigation will be recorded on the local risk register by departmental management in conjunction with the LCFS. This may give rise to future proactive work such as Local Proactive Exercises that will be conducted by the LCFS to test that remedial actions have been undertaken. Where fraud risk assessment/fraud proofing work is required, departmental management must assist in providing all necessary information requested by the LCFS or Internal Audit in relation to the processes or systems under review.

8.3.3. CHART 3 – Disciplinary Process

8.3.3.1. Disciplinary Procedure

CAVUHB Disciplinary Policy and Procedure has to be followed in any disciplinary action taken by CAVUHB towards an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, the results of the investigation (a formal report) and take appropriate action against the employee.

In the event of a disciplinary investigation taking place where a suspicion of fraud exists, then the appointed investigating officer must liaise with the LCFS to agree a way forward. A decision will be made whether the investigations can run concurrently or whether the internal investigation will need to be put on hold until the completion of the criminal investigation or part of it.

In some cases where a fraud is suspected it may be deemed by the Lead LCFS that the matter is of a minor nature, or that it would not pass the relevant evidential or public interest threshold tests, and therefore a formal

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criminal investigation will not progress. In these instances' the LCFS will keep departmental management and People Services appraised that no further action will be taken. A disciplinary investigation can still take place in these circumstances. If a disciplinary investigation only ensues following the report of a fraud or fraud related offence, the internal investigating officer and People Services representative will ensure that the LCFS is kept appraised of the process and any resulting action that takes place. The LCFS will act in support of any disciplinary only investigation in the position of a witness only. Any evidence gathered by the LCFS will be shared with management if it assists with the case.

As per national requirements LCFS will report any outcome on the CLUE case management system.

9. The Law and its Remedies

9.1. Introduction

Section 6 of the NHS Counter Fraud Manual provides in-depth details of how sanctions can be applied where fraud and corruption is proven and how redress can be sought.

To summarise, local action can be taken to recover money by using the administrative procedures of the organisation or civil law. In cases of serious fraud, bribery and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s) and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate. This is known as the triple track approach.

Actions which may be taken when considering seeking redress include:

- no further action
- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under the Proceeds of Crime Act 2002 (POCA)
- recovery sought from ongoing salary payments

In some cases (taking into consideration all the facts of a case), it may be that CAVUHB under guidance from the LCFS and with the approval of the Director of Finance, decides that no further recovery action is taken.

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Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring

this activity to the attention of the criminal courts (Magistrates' Court and Crown Court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

9.2. Proceeds of Crime Act

The NHS Counter Fraud Service (Wales) can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

9.3. Fraud Act 2006

The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss. It includes the following offences that could be committed against the NHS:

- Fraud by false representation (s.2) – dishonestly misrepresenting something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (s.3) – not saying something where there is a legal duty to do so.
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.
- Possession of articles for use in fraud (s.6) – Having possession or control over a document or item, intended for use in the commission of fraud.
- Making or supplying articles for use in fraud (s.7) – Making, adapting, or supplying a document or item in the knowledge it is to be used to commit fraud.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, the mere exposure to the risk of loss is sufficient, so long as the intent is there.

9.4. Other Offences

Outside of the Fraud Act 2006, the following offences could be committed against the NHS: (this is not an exhaustive list)

- False accounting (s.17 Theft Act 1968) – Dishonestly altering a record kept for accounting purposes in order to make a gain or loss.

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- Possession of false identity documents (s.25 – Identity Cards Act 2006) Having possession or control over an identity document that is false, has been improperly obtained or relates to someone else.
- Unauthorised access to computer material (s.1 – Computer Misuse Act 1990) to secure access to a program or data that is unauthorised.
- Unauthorised access with intent to commit or facilitate commission of further offences (s.2 – Computer Misuse Act 1990) to carry out s1 with intent to commit an offence or facilitate to commission of an offence.
- Theft (s.1 – Theft Act 1968) to dishonestly appropriate, property that belongs to another with the intention of permanently depriving the other person of that property.
- Forgery and Counterfeiting Act 1981 (s.1 to s.4) making, copying, using or using a copy of a false instrument with the intention of inducing somebody to accept it as genuine.

9.5. Bribery and Corruption

Corruption can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment, or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another. It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.
The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011. The Bribery Act 2010 provided a suite of new offences markedly different to what has gone before. The Bribery Act 2010 made it a criminal offence to “give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad”. It increased the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine. In addition, the Act introduced a ‘corporate offence’ of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The ‘corporate offence’ is not a standalone offence but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

10. References

This policy should be read in conjunction with:

- Standing Orders
- Standing Financial Instructions
- Disciplinary Policy and Procedure

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- Standards of Business Conduct
- I.T Security Policy
- Public Relations and Communications Strategy
- Procedure for NHS Staff to raise concerns
- Respect and Resolution Policy
- CAVUHB policies relating to:
  - Gifts
  - Hospitality
  - Conflicts of Interest
  - Procurement
  - Capital/PFI Contracts
- Directions to NHS Bodies on Counter Fraud Measures (National Assembly Wales)
- NHS Counter Fraud Manual
- NHS Counter Fraud Strategy
- Public Interest Disclosure Act 1998
- The Fraud Act 2006
- Bribery Act 2010
- Government Functional Standard GovS 013 Counter Fraud
- Economic Crime and Corporate Transparency Act
- Information Governance Policy

11. Further Information

Further information and a copy of the fraud policy and response plan may be obtained from the LCFS or CAVUHB intranet.

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12. NHS Fraud and Corruption: Dos and Don'ts
A desktop guide for CAVUHB

FRAUD is the deliberate or reckless intent to permanently deprive an employer of money or goods through false representation, failing to disclose information or abuse of position.

CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

DO	DO NOT
• **Note your concerns** **Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.**	• **Confront the suspect or convey concerns to anyone other than those authorised, as listed below** **Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.**
• **Retain evidence** **Retain any evidence that may be destroyed, or make a note and advise your LCFS.**	• **Try to investigate, or contact the police directly** **Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.**
• **Report your suspicion** **Confidentiality and anonymity will be respected – delays may lead to further financial loss.**	• **Be afraid of raising your concerns** **The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.**

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If you suspect that fraud against the NHS has taken place, you must report it immediately, by:

- directly contacting the Local Counter Fraud Specialist, or
- telephoning the free phone NHS Fraud and Corruption Reporting Line, or
- contacting the Director of Finance, or
- Using the organisations Speaking Up Safely procedure.

Do you have concerns about a fraud taking place in the NHS?

If so, any information can be passed to the NHS Fraud and Corruption Reporting Line:

0800 028 40 60

All calls will be treated in confidence and investigated by professionally trained staff

Your nominated Local Counter Fraud Specialist are:

Henry Bales – Counter Fraud Manager – Henry.Bales@nhs.wales.uk – 02921836265

Steve Betty – Deputy Counter Fraud Manager – Steve.Betty@wales.nhs.uk - 029218 362642

Jacob Parkinson – Local Counter Fraud Specialist – Jacob.Parkinson@wales.nhs.uk - 029218 362642

Rhidian McCann – Local Counter Fraud Specialist – Rhidian.McCann@wales.nhs.uk - 029218 36262

If you would like further information about the NHS Counter Fraud Service, please visit **www.nhscfa.co.uk** **or** **Counter Fraud - Home (sharepoint.com)**

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Report Title:	Waste Management Procedure				Agenda Item No:	4.3
Meeting:	Public Digital & Infrastructure Committee	Public	x		Meeting Date:	10/02/2026
		Private				
Status **(please only tick one)**	Assurance		Approval	x	Information/Noting	
Lead Executive Title:	Geoff Walsh, Director of Capital Estates and Facilities					
Report Author Title:	James Randall-Bromley, Head of Waste Compliance & Recycling					

Main Report
Background and Current Situation:

The Waste Management Procedure has been fully revised to align with NRW recommendations, updated legislation, including the Waste Recycling (Wales) Regulations 2023, and guidance from WHTM 07-01: Safe Management of Healthcare Waste.

The updated procedure provides clear guidance on:

- Waste segregation and classification for all streams (clinical, hazardous, recyclable, confidential, etc.).
- Compliance with environmental, health and safety, and transport legislation.
- Training and auditing requirements for staff.
- Responsibilities across all levels of the organisation.

Executive Director Opinion & Key Issues to bring to the attention of the Committee

Approval of this procedure is critical to:

- Ensure compliance with statutory obligations and Welsh Government recycling targets.
- Mitigate risks associated with non-compliance, including financial penalties and reputational damage.
- Support sustainable development principles and reduce carbon emissions.
- Provide clarity and consistency for staff in managing waste safely and effectively.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

1. WHTM 07-01 – Safe Management of Healthcare Waste
2. NRW Audit Report

Recommendations:

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a) Consider the implementation of Health Board-wide training on waste compliance and recycling to reduce financial risks, enhance regulatory adherence, and drive sustainability improvements.
b) Approve the updated Waste Management Policy to ensure alignment with current legislation and Health Board sustainability objectives.

Link to Strategic Objectives of Shaping our Future Wellbeing: Please place an "x" in the below boxes where relevant – *Click each item for further information.*			
1. Putting People First	x	2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. Acting for the Future	x

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention	x	Long Term	x	Integration		Collaboration		Involvement	

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: No
Safety: No
Financial: Yes
Resource allocation required for compliance.
Workforce: Yes
Training and awareness essential for successful implementation.
Legal: Yes
Aligns with Environmental Protection Act, Health and Safety at Work Act, and Waste Recycling (Wales) Regulations.
Reputational: Yes
Failure to comply could damage public confidence
Socio Economic: No
Equality & Health: No
EHIA completed; no significant negative impacts identified.
Decarbonisation: Yes
Procedure underpins carbon reduction and circular economy principles.
Welsh Language: No
Public Information will include Welsh language.

Approval/Scrutiny Route ***(please list all other Committees/Groups this report has been to)***	
Name of Committee/Group/Exec	Date:

Reference Number: UHB038 **Version Number:** 5	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *109*

WASTE MANAGEMENT POLICY AND PROCEDURE

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that all waste is managed in accordance with the Welsh Health Technical Memorandum (WHTM) 07-01, the waste hierarchy, and all relevant environmental, health and safety, and transport legislation. Our aim is to protect patients, staff, the public, and the environment by minimising waste generation, ensuring effective segregation, and promoting best practice in waste handling and disposal.

This document and supporting Procedure Document aims to describe in an easy to navigate, user friendly and concise manner, the policy, and correct procedures for managing all waste streams produced as a result of the activities and services of Cardiff and Vale University Health Board.

The Health Board is committed to managing waste in line with Welsh Government strategy, current legal obligations, and other applicable requirements. Wherever reasonably and economically practicable, we will apply the principles of the Waste Management Hierarchy to drive continual improvement in our environmental performance. Our approach to sustainable waste management focuses on using resources efficiently, reducing waste generation, and managing waste in a way that supports circular economy principles and sustainable development.

Policy Commitment

- To reduce waste production, the Health Board aims to, as far as reasonably practicable, carefully consider the disposal implications of all developments, purchases, and donations.
- To the extent reasonably and economically practicable, the Health Board aims for all members to reuse articles that have not yet reached the end of their life. These articles fall outside waste legislation and can be reused.
- Where opportunities exist and where regulations apply, waste recycling must be encouraged and implemented to minimise the amounts of waste destined for landfill.
- Comply with the Waste Recycling (Wales) Regulations 2023 by separating recyclable materials such as paper, cardboard, glass, metal, plastic, cartons, food

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waste, unsold small waste electrical and electronic equipment (sWEEE), and unsold textiles.

- To ensure the safe treatment of waste or reduce its hazardous properties prior to recycling or disposal, the Health Board aims to comply with legislation by properly segregating, storing, handling, transporting, and treating waste.
- When the production of waste is unavoidable, the Health Board aims to ensure that segregation, storage, handling, transport, and disposal processes comply with legislation and utilise the best available techniques.
- To the extent possible, the Health Board aims to develop waste management systems that comply with applicable mandatory codes of practice, best practices, and guidance related to other Health Board policies and procedures for managing waste.
- Waste is classified and segregated in accordance with legislation, ensuring that the categories of waste transported by or on behalf of the Health Board meet the waste acceptance criteria of the authorised waste receiving site or process.
- All members of the Health Board ensure that the wastes generated by their activities is segregated and identified in accordance with the specific requirements outlined in the Operational Procedures and Waste Legislation.
- Detail safe and correct segregation, handling, transportation and disposal practices.
- Specify training and auditing requirements.

Supporting Procedures and Written Control Documents

- Cardiff and Vale University Health Board Waste Management Procedure
- Cardiff and Vale University Health Board Environmental Policy
- Cardiff and Vale University Health Board Infection Control Policies
- Cardiff and Vale University Health Board Health and Safety Policies
- Cardiff and Vale University Health Board Fire Safety Policy
- Contractor Waste Acceptance Criteria
- Pre-Waste Acceptance Criteria

Other supporting documents are:

List all documents the reader needs to be aware of alongside / in support of this document

Applicable Legislation

Only the primary Acts and main Regulations are listed by the date of becoming law. Subsequent amendments are not included in this list.

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The Health and Safety at Work Act 1974
All regulations enabled by The Health and Safety at Work Act 1974 that pertain to waste management must be adhered to in order to minimise and control risks to the health and safety of all individuals involved in waste management. The following regulations specifically reference waste management:

- Manual Handling Operations Regulations 1992
- The Management of Health and Safety at Work Regulations 1999.
- The Genetically Modified Organisms (Contained Use) Regulations 2014
- Control of Substances Hazardous to Health Regulations (COSHH) 2002.
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009.

Environmental Protection Act 1990
All regulations enacted under this Act that pertain to waste management must be followed to minimise and control risks to human health and the environment. The following regulations specifically address waste management:

- European Waste Framework Directive (2008/98/EC) 2008
- The Controlled Waste (England & Wales) Regulations 2012
- Environmental Permitting (England & Wales) Regulations 2010
- The Animal By-Products (Enforcement) (Wales) Regulations 2014
- Environment (Wales) Act 2016.
- Well-being of Future Generations (Wales) Act 2015
- The Landfill (England and Wales) Regulations 2002
- The Waste Electrical and Electronic Equipment Regulations 2013
- The Hazardous Waste (England and Wales) (Amendment) Regulations 2016.
- Clean Neighbourhoods and Environment Act 2005

Data Protection Act 2018 and the General Data Protection Regulation
The disposal of recycling and waste must be managed such that the requirements of the Data Protection Act are maintained at all times.

The Human Tissue Act 2004
HTA Code of Practice 5: Disposal of Human Tissue. The removal, storage and disposal of human organs and tissue.

Workplace Recycling Regulations Wales 2023
From April 2026, Hospitals must sort their waste for recycling, including paper, card, glass, metal, plastic, cartons, food waste, small waste electrical and electronic equipment (sWEEE), and textiles. recyclable materials must be correctly presented separately for collection.

Applicable Mandatory, Codes of Practice, Best Practice and Guidance

WHTM 07-01: Safe Management of Healthcare Waste
This document has been produced and updated in partnership with Department of Health, Defra, and the Department for Transport and with full support and cooperation of the

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Regulators (Environment Agency and the Health and Safety Executive) and the devolved administrations.

When new or updated guidance documents from government or departmental bodies (such as the Department of Health, NHS Estates, Natural Resources Wales, HSE, WAG, etc.) are issued to regulate waste management practices, the Health Board's policy is to ensure full compliance with these directives.

Scope

This policy applies to all Cardiff and Vale UHB staff, including those with honorary contracts, across all sites and services where healthcare waste is generated.

Responsibilities

To ensure safe and effective waste management within the Health Board, the following responsibilities have been assigned.

Chief Executive
accepts overall responsibility for all matters, including those regarding waste management.

Directors / Heads of Estates and Facilities Departments
Ensure that managers have a clear understanding of their responsibilities and that appropriate training is provided to help staff achieve their objectives.

Head of Waste Compliance and Recycling / Waste Management Team
Ensure that dedicated waste management staff and the services they provide meet the requirements of the policy, procedure and comply with relevant legislation.
Ensure all waste records are maintained in accordance with the regulations.
Ensure audits are conducted to ensure that the Health Board complies with this policy, procedures, and relevant legislation.
Conduct investigations and make recommendations for improvements when accidents and incidents are found to be non-compliant with the policy, procedures, or legislation.
Ensure that contractors who supply the Health Board with waste management services comply with the Policy, Procedure and legislation.
Investigate and report non-conformances to the Regulatory Authority when a waste management accident, spillage, or release occurs, posing apparent risks to human health, the environment, or amenity.
Ensure that all regulatory requirements, including Waste Management Licences, Exemptions from Waste Management Licences, Carriers Certificates, and operator competency, are maintained to the required standards.
Conduct annual Duty of Care Audits of waste contractors and service providers to ensure ongoing regulatory compliance.
Conduct Pre-Acceptance Audits of all Facilities/Premises that produce waste to ensure regulatory compliance.

Departmental / Ward Managers

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Provide appropriate training to all personnel involved in the production and disposal of waste. Share best practices and demonstrate their implementation. Collaborate with the Waste Management Department to improve waste management systems in response to accidents, incidents, or non-compliant disposal events, ensuring adherence to policy, procedures and relevant legislation. **All Health Board Employees** All staff are responsible for adhering to the legislation, policy and the associated procedures. Cooperation is essential at all levels of the Health Board and every staff member should understand their role in these arrangements.
Resources The Health Board shall maintain the level of service, equipment, and facilities necessary to develop and uphold the objectives of this procedure. The Health Board shall implement this Policy and supporting Procedures to the extent reasonably practicable with available resources. When new legislation or technological advancements arise, the Health Board must seek the best value solutions that reduce the environmental impact of waste. It shall be the financial responsibility of a Clinical Board or directing management body to fund internal departmental waste management systems to ensure compliance. It will be the responsibility of the Health Board to allocate sufficient resources to enable the implementation of new waste management systems that are deemed necessary to comply with improvement or enforcement instructions from the regulatory authority. Where wastes are produced that fall outside that which is normally budgeted by a Cardiff and Vale University Health Board Service Level Agreement, then the Waste Management Department reserves the right to levy a charge for the collection and disposal of that waste.

Equality & Health Impact Assessment (EHIA) Part 1 - Equality Impact Assessment (EQIA)	*An Equality and Health Impact Assessment has been completed. No significant negative impacts identified.*

Equality & Health Impact Assessment (EHIA) Part 2 - Health Impact Assessment (HIA)	An Equality and Health Impact Assessment has been completed. No significant negative impacts identified.

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Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	Geoff Walsh, Director of Capital Estates and Facilities
Author	James Randall-Bromley, Head of Waste Compliance & Recycling
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
3	*25 April 2017*	TBC	Updated Organisational Policies to be read alongside Policy. Format of procedure follows UHB corporate template
4	June 2021		
5	TBC	TBC	Full rewrite in line with updated waste legislation and guidance.

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GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Cardiff and Vale University Health Board Waste Management Procedure

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Sections Select the required section below.....

01 CAVUHB Waste Management Policy	02 Sustainable Waste Management	03 Waste Definition and Classification	04 Clinical Waste
05 Clinical Bag Waste	06 Clinical Sharps Waste	07 Gypsum Waste	08 Radioactive Waste
09 Anatomical Waste	10 Pharmaceutical Waste	11 Recycling Waste	12 Electrical Items (WEEE Waste) & Ink Cartridges
13 Food Waste	14 Black Bag Waste	15 Batteries	16 Scrap Furniture, Equipment & Mattresses
17 Chemical Waste	18 Confidential Waste	19 Asbestos, Mercury, Oil and Amalgam	20 Training, Auditing DGSA, Community Waste

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02. Sustainable Waste Management

Circular Economy

To achieve net zero carbon by 2030 and become a zero-waste organisation, the Health Board must apply the principles of a circular economy into the full lifecycle of the procurement of goods and services as per the Health Boards ‘’Shaping our Future Sustainable Healthcare Plan’’. Applying the principles of a circular economy to our procurement and waste management practices is key to delivering the Health Boards objectives.

The Waste Hierarchy

The waste hierarchy is a framework for managing waste which ranks disposal methods according to their environmental impact, with ‘Prevention’ being the most preferrable option and ‘Landfill’ the least. The hierarchy comes from Article 4 of the EU’s Waste Framework Directive and is still used in the UK as guidance for best practice waste management. The Health Board has adopted the waste hierarchy from WHTM 07-01 to drive us towards our goal of becoming net zero carbon by 2030 and a zero-waste organisation.

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Prevention
Prevention represents the highest priority within the waste hierarchy and focuses on actions taken before materials become waste. In the context of healthcare, prevention is integral to delivering sustainable services and reducing environmental impact. By avoiding unnecessary procurement and minimising waste generation, the Health Board can reduce both financial costs and the environmental burden associated with disposal.

All staff are encouraged to adopt the following principles to support waste prevention:

- Think Long-Term: Prioritise quality over quantity. Investing in durable, high-quality items can be more cost-effective and resource-efficient over time. Consider the full lifecycle of products during procurement decisions.

- Assess Genuine Need: Implement effective stock control to avoid over-ordering. Before purchasing new items, assess whether existing stock is still fit for purpose. Replacement should be based on need, not preference. Specialist teams such as Infection Prevention and Control, Manual Handling, Health and Safety, Clinical Engineering, and Maintenance can provide guidance on appropriate replacement criteria.

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- Consider Alternatives: Where feasible, opt for reusable rather than single-use items. Evaluate whether mains-powered equipment can replace battery-operated alternatives to reduce waste and improve efficiency.

- Collaborate and Share Resources: For items used infrequently or subject to minimum order quantities, explore opportunities to share resources across departments. Use internal communication channels and staff networks to coordinate shared purchasing or redistribution of surplus stock.

Reuse
Health Board employees should prioritise reusing materials wherever possible to support waste prevention and sustainability. This includes reusing office supplies, such as folders and binders, repurposing packaging materials, and opting for reusable containers and utensils in place of disposable ones. Incorporating reuse practices into daily routines can significantly reduce the amount of waste generated, conserve resources, and contribute to the circular economy. Reuse retains the value of our products and establishes a circular loop.

While reuse is a key principle of sustainable waste management, several barriers can hinder its implementation. These include limited time to explore alternatives, short decision-making timescales, and insufficient storage capacity. Despite these challenges, it is essential that action to support reuse is taken promptly once an item is identified as surplus to requirements.

To facilitate reuse, staff are encouraged to take the following steps as a minimum:

- **Advertise items** on Viva Engage to increase visibility across the organisation.
- **Email distribution lists** to advertise with colleagues and departments on your own and other sites.
- **Contact the Waste Management Team** to identify potential options.

Recycle
Recycling is a critical component of waste management within the Health Board. From April 2026, all hospitals in Wales, including NHS and private hospitals, must comply with the Environmental Protection Waste Recycling (Wales) Regulations 2023. This legislation mandates that hospitals separate their recyclable waste materials, such as food, paper and card, glass, metals, plastic, cartons, unsold textiles, and small waste electrical and electronic equipment (sWEEE), for collection. The aim of this law is to improve the quality and quantity of recycling, reduce carbon emissions, and tackle the climate emergency by ensuring that recyclable materials are properly sorted and managed.

Staff are encouraged to ensure that recyclable materials such as paper, cardboard, plastics, and metals are correctly sorted and placed in designated recycling bins. By doing so, these materials can be processed and reintroduced into the production cycle, reducing the need for new resources and minimising environmental impact. Effective recycling practices support the principles of the circular economy, where waste is transformed into valuable resources, contributing to a more sustainable and environmentally responsible healthcare system.

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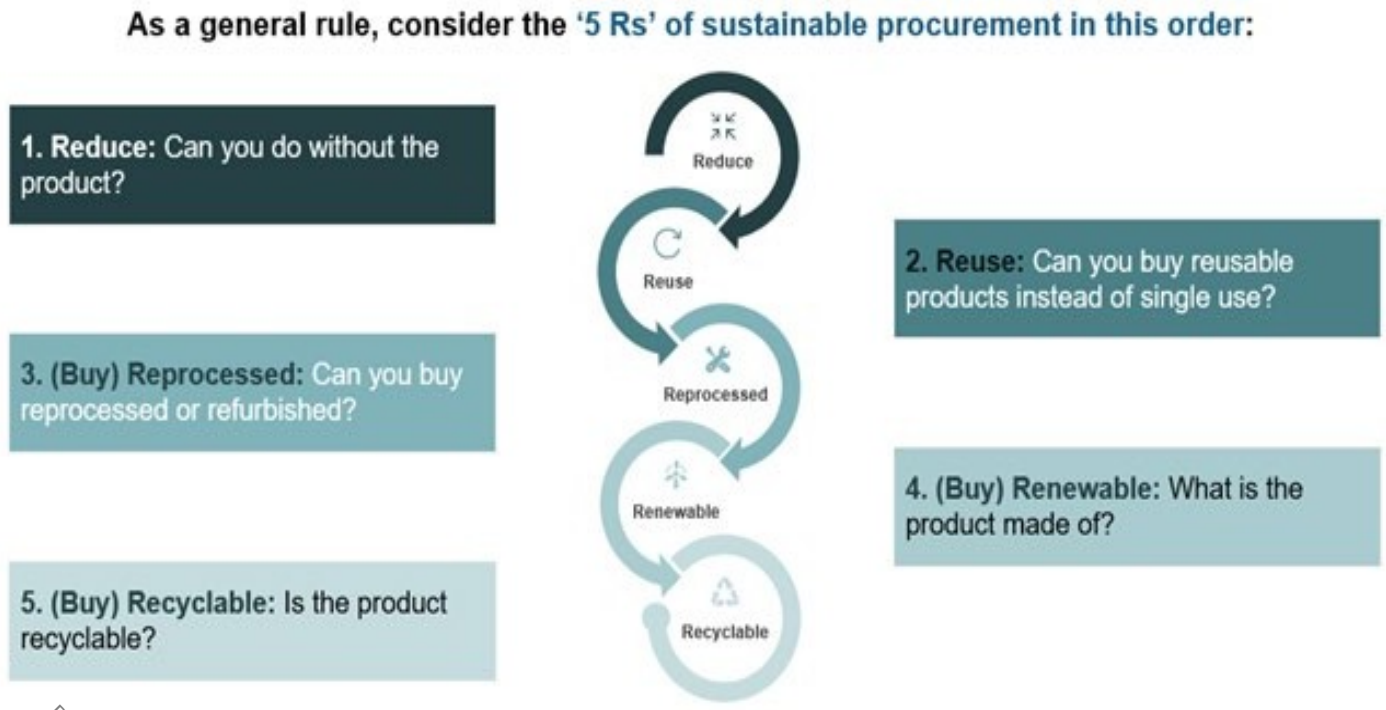
Recover
Waste is processed and used as a fuel or feedstock in energy generation and the recovery of water, heat, materials and nutrients such as in cement production or anaerobic digestion. These generation and recovery processes can produce greenhouse gases and harmful pollutants which create poor air and water quality locally. This method of waste disposal destroys the waste and therefore fails to retain the value of our procured goods and makes them impossible to be recycled or reused.

Disposal
Waste is disposed of via domestic waste stream and is sorted on or off site by waste services or waste contractors. Items that can be recycled are sorted into a separate recycled waste streams and suitable items that cannot be recycled are sent for energy generation or recovery.

Landfill
Waste is disposed of in landfill, abiding by the principles of a linear economy whereby material is not segregated, reused, recycled or used in a recovery process and the value of the material is not retained within the supply chain. The material has escaped the supply chain after one use and cannot be used to create new materials or products.



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02.1. Procurement Engagement and Sustainable Decision-Making

When considering the replacement of a product or service, it is essential to engage with your Procurement colleagues. They are available to:

- Provide expert advice on available options, alternatives, and delivery timelines.
- Review supplier obligations, including take-back schemes for products and packaging.
- Identify standardised items listed on Oracle to ensure consistency and compliance.

Key Considerations for Procuring Products or Services

To support informed and sustainable procurement decisions, consider the following questions:

Suitability and Effectiveness

- Is the current product or service meeting operational and clinical needs?
- What improvements are necessary to enhance outcomes for patients and staff?

Waste Reduction and Environmental Impact

- Can the use of single-use items be eliminated or reduced?
- Will the new provision affect waste management logistics (e.g., storage space or collection requirements)?

Packaging and Circular Economy

- Can suppliers minimise packaging or incorporate circular economy principles?

Supplier Credentials

- Are suppliers affiliated with recognised environmental or quality schemes?
- Can these accreditations be verified?

Workforce Development

- Does the provision include training or awareness initiatives to support staff development and retention?

Benchmarking and Best Practice

- Are there examples of similar products or services being procured sustainably within the sector?

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Table 1 – Waste Disposal Options

Disposal Option	Description	Waste Examples
Recycling	Processing of waste to make new products	Paper, Plastics, Cardboard, Glass, Metals, WEEE, Textiles Wood, Batteries, Printer Cartridges, Absorbent Hygiene Products
Anaerobic Digestion	Breakdown of biodegradable waste creating fertiliser and energy from waste	Food Biodegradable wastes
Composting	The decomposition of biodegradable solid waste	Food Biodegradable wastes
Energy from Waste	Creating energy (electricity or heat) from the treatment of waste	Various
Alternative Treatment	Treatment by heat, chemicals or irradiation to render clinical waste safe	Orange clinical waste
Incineration	Combustion of waste at high temperatures (between 800 – 1100oC)	Medicines Purple / Yellow Sharps Hazardous Waste, Gypsum waste
Landfill	Burial of waste in the ground. Some wastes require burial at a deeper level, or in a specially licensed landfill	Residual Waste Offensive Waste (deep landfill) Hazardous Waste

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03. Waste definition and classifications

Definition of 'waste'

Waste is defined in EU Directive 2008/98/EC as
"Any substance or object which the holder discards or intends or is required to discard."

It includes any kind of household, commercial or industrial waste, as well as clinical and hazardous waste.

Part II of the Environmental Protection Act 1995 (amended) defines waste as:
"Any substance which constitutes a scrap material or an effluent or other unwanted surplus substance arising from the application of any process, and any substance or article which requires to be disposed of as being broken, worn out, contaminated or otherwise spoiled."

Examples of waste produced in the healthcare sector are:

Table 2 – Types of healthcare waste

Hazardous Waste	Non-Hazardous Waste
Infectious Waste	Residual (General) Waste
Anatomical Waste	Recycling Waste
Cytotoxic/Cytostatic Waste	Organic (Food) Waste
Amalgam and Mercury Containing Waste	Furniture
Radioactive Waste	Offensive/Hygiene Waste
Paints and Solvents	Confidential Waste
Waste Electrical Items	Construction Waste
Asbestos	Non-Contaminated Filters
Batteries	
Oils	
Hazardous Chemicals	
Gypsum Waste	
Fluorescent Tubes	
Contaminated Filters	
Furniture containing Persistent Organic Pollutants (POPs)	
Pharmaceutical Waste	
Refrigerated Items	

If you are the last person to use or handle an item that is now considered to be waste IT IS YOUR RESPONSIBILITY TO ENSURE THAT IT IS PUT INTO THE CORRECT DISPOSAL ROUTE (ie bin, bag or other dedicated container).

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The producer of waste products must define, identify and store wastes correctly and prevent unauthorised access or accidental release while awaiting collection.

It is essential to identify and segregate clinical wastes from domestic waste at the point of production. All departments involved with the production and handling of clinical/domestic wastes are therefore required to adopt the following colour coded system detailed in **Table 3 Below.**

The identification tagging and removal of waste bags from bins to waste hold/storage areas is the responsibility of the waste producer and or Facilities Staff. Sharps boxes or other rigid clinical waste containers must be signed on assembly, on closure, properly sealed, identified and delivered to waste hold/storage areas by the waste producer. In laboratory areas it is the responsibility of laboratory staff to deliver all hazardous waste to the designated waste hold/storage areas.

When waste is unsuitable for storage at a designated waste hold/storage area then the producer must ensure that the chosen storage area is safe and secure.

Domestic/household waste should not be placed into orange, offensive, yellow, or purple waste bags/bins, and **under no circumstances** must clinical wastes, sharps or hazardous wastes be placed in the black residual waste bags or clear recycling bags.

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Type of Waste	Receptacle	Disposal Stream
Red Top (LID) Rigid Body Anatomical Waste		**Waste which requires disposal by incineration** Treatment required for safe disposal is incineration in a suitably permitted or licensed facility.
Yellow Bags and Carboard Boxes Non-Sharp infectious or suspected infectious waste that is contaminated with medication		**Waste which requires disposal by incineration** Treatment required for safe disposal is incineration in a suitably permitted or licensed facility.
Yellow Top (lid) Rigid Sharps Box Sharps contaminated with medication other than cytotoxic and/or cytostatic medication		**Waste which requires disposal by incineration** Treatment required for safe disposal is incineration in a suitably permitted or licensed facility.
Orange Bags and Cardboard Boxes Non-Sharp waste that is infectious/hazardous or suspected to be infectious/hazardous that is not contaminated with medication		**Alternative Treatment** Treatment required for safe disposal to be "rendered safe" in a suitably permitted or licensed facility, usually alternative treatment plants (ATPs). However, this waste may also be disposed of by incineration. **Hazardous/infectious waste**

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Table 3 – Waste Colour Code/Disposal Routes

Type of Waste	Receptacle	Disposal Stream
Orange Top (Lid) Rigid Sharps Box Non medicated sharps containing blood/infected products		**Alternative Treatment** Treatment required for safe disposal to be "rendered safe" in a suitably permitted or licensed facility, usually alternative treatment plants (ATPs). However, this waste may also be disposed of by incineration. **Hazardous/infectious waste**
Purple Top (Lid) Rigid Sharps Box and Purple Bags Sharps containing Cytotoxic/Cytostatic medication Bags containing non sharp waste contaminated with Cytotoxic/Cytostatic medication		**Waste which requires disposal by incineration** Treatment required for safe disposal is incineration in a suitably permitted or licensed facility.
Yellow Bag with Black Stripes (Tiger Bag) Non infectious, offensive/hygiene waste. Items used in care of patients and PPE.		Treatment required for safe disposal is recovery for energy or landfill in a suitable permitted or licensed site.

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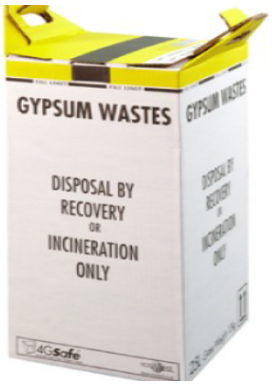
Type of Waste	Receptacle	Disposal Stream
Yellow/Black Box labelled ''Gypsum Wastes'' Materials contaminated with Gypsum. Plaster casts, Surgical plaster and Dental Moulds		**Waste which requires disposal by incineration** Treatment required for safe disposal is incineration in a suitably permitted or licensed facility and/or specialist landfill.
Blue Carboard Cartons Labelled ''Pharmaceutical waste'' Pharmaceutical Waste – tablets in blister packs, empty elixir bottles		**Waste which requires disposal by incineration** Treatment required for safe disposal is incineration in a suitably permitted or licensed facility.
Black Bags Residual (General) Waste. Non-recyclable, non-infectious/hazardous waste found in any household or office.		**Recovery for energy** or landfill in a suitable permitted or licensed facility
Clear Bag Blue Label Recyclable Paper and Card		**Recycling** Waste is recycled in permitted or licensed recycling facility

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Type of Waste	Receptacle	Disposal Stream
Clear Bags, Red label Recyclable Plastics, metals, cartons. Bottles, tins, food cartons etc.		**Recycling** Waste is recycled in permitted or licensed recycling facility
Food Waste Caddy Organic, biodegradable waste		**Anaerobic Digestion** Waste is processed at permitted or licensed anaerobic digestion facility.
Cardboard Large carboard boxes and Packaging		**Recycling** Waste is recycled in permitted or licensed recycling facility
Chemical Waste All chemical waste should be assessed		**Specialists** To be disposed of via specialist waste contractor. Contact Health & Safety or Waste Management for advice.

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Type of Waste	Receptacle	Disposal Stream
I.T Equipment Laptops, Monitors, Hard Drives, Printer, Ink cartridges, Keyboards etc.		**Returned to I.T Department** The I.T Department will cleanse all data from equipment then process for recycling.
WEEE Mixed Electric, electronic equipment Non Hazardous Hazardous		**Specialist Recovery** Recycling, Recovery and Re-Use
Bulky Scrap Waste Chairs, filling Cabinets, tables and other large furniture or equipment.		**Reuse, Recovery, Recycling/RDF or Landfill**
Equipment containing chlorofluorocarbons Fridge-freezers and other Refrigerated Equipment		**Specialist Recovery/ Recycling**

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Type of Waste	Receptacle	Disposal Stream
Batteries Small, Portable, handheld or Household.		**Specialist Recovery/ Recycling** To be disposed of via specialist contractor
Fluorescent Tubes Fluorescent Lighting Tubes		**Specialist Recovery/ Recycling** To be disposed of via specialist contractor
Amalgam Waste Amalgam capsules, Amalgam and Teeth Containing Amalgam (From Dental Department)		**Specialist Recovery** To be disposed of via specialist contractor
Edible Oil/Fat Cooking Oil Segregated for Recycling		**Recycling** Collected in original containers by contractors for recycling
Confidential Waste Information, Patient Records, Financial Records		**Shredded** Collected by contractor for Shredding

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04. Clinical Waste

In the Welsh Health Technical Memorandum (WHTM) 07-01 Clinical Waste is defined as:

"Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles, or other sharp instruments which, unless rendered safe, may prove hazardous to any person coming into contact with it. It also includes waste arising from medical, nursing, dental, veterinary, pharmaceutical, or similar practice, which may cause infection to any person coming into contact with it".

Table 3 provides a detailed description of the clinical waste categories and the European Waste Catalogue (EWC) codes – these can be important reference numbers that users come across.

Broadly, clinical waste can be divided into two categories:

- Waste which poses a risk of infection: including human or animal tissue, sharps, blood and other bodily fluids; and
- Medicinal waste: including waste arising from veterinary or dental practice, investigation, research and treatment.

Waste producers are required to adequately describe their waste using both a written description and the use of appropriate European Waste Catalogue (EWC) codes. The section pertaining to clinical wastes from human healthcare in the EWC catalogue is section 18 01 'wastes from natal care, diagnosis, treatment or prevention of disease in humans'.

EWC Code	Description of Waste
18 01 01	Sharps (except 18 01 03)
18 01 02	Body parts and organs including blood bags and blood preserves (except 18 01 03*)
18 01 03*	**Wastes whose collection and disposal is subject to special requirements in order to prevent infection**
18 01 04	Wastes whose collection and disposal is not subject to special requirements in order to prevent infection (for example dressings, incontinence waste, linen, disposable clothing, diapers)
18 01 06*	**chemicals consisting of or containing dangerous substances**
18 01 07	chemicals other than those mentioned in 18 01 06
18 01 08*	**cytotoxic and cytostatic medicines**
18 01 09	medicines other than those mentioned in 18 01 08
18 01 10*	**amalgam waste from dental care**

*The use of **bold text** and * in the table above denotes hazardous waste.*

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CAVUHB Clinical Waste Training: CAVUHB Clinical Waste Segregation.pptx

05. Clinical Bag Waste

Non-sharp clinical bagged waste refers to waste generated in healthcare settings that does not include sharp objects but may still be contaminated with infectious agents or hazardous substances. This type of waste must be placed in specific colour coded bags for safe disposal to prevent health risks and environmental contamination.

05.1. Yellow Bag / Cardboard Box Soft Box Waste – EWC 18 01 03* & 18 01 09

Description

Non-Sharp infectious or suspected infectious waste that is contaminated with medication. Information Video: Yellow Bag Video

Examples

Infectious waste, medical dressings/bandages, tissue blocks, iv tubing/bags etc that is contaminated with chemical, pharmaceutical residue.

Storage/Disposal

Yellow Bag Waste should be segregated at source and placed in yellow 770l wheeled bins designated for this waste type. **Under no circumstances** should this waste be mixed with any other clinical or non-clinical waste.

05.2. Orange Bag / Cardboard Box Waste – EWC 18 01 03*

Description

Non-Sharp waste that is infectious/hazardous or suspected to be infectious/hazardous that is not contaminated with medication. Information Video: Orange Bag Video

Examples

Infectious Soiled dressings, swabs, incontinence pads, gloves, aprons, empty catheter bags, suction tubing etc, contaminated with Infectious blood or body fluids.

Storage/Disposal

Orange Bag Waste should be segregated at source and placed in yellow 770l wheeled bins designated for this waste type. **Under no circumstances** should this waste be mixed with any other clinical or non-clinical waste.

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05.3. Purple Bag Waste EWC - 18 01 03* & 18 01 08*

Description

Bags containing non sharp waste contaminated with Cytotoxic/Cytostatic medication.

Information Video: Cytotoxic/Cytostatic Video

Examples

This waste will only be produced in small quantities in general wards/departments, when certain patients are receiving chemotherapy treatment. Contaminated dressings, bandages, PPE etc.

Storage/Disposal

Purple bag waste should be segregate at source and placed into 770l Wheeled bins designated for this waste type. Under **no circumstances** should cytotoxic/cytostatic waste bags be mixed with general or any clinical/infectious waste. All areas should display the below list in specific locations i.e treatment/drug rooms and highlight frequently used items.

Cytotoxic/Cytostatic Hazardous Medicine List - Hazardous Medicine List

Yellow/Black Tiger Bag Waste EWC 18-01-04

Description

Non-infectious, offensive/hygiene waste. Items used in care of patients and PPE. Information Video: Tiger Bag Video

Examples

Nappies, incontinence & sanitary waste, PPE, dressings contaminated with blood and body fluids from patients assessed to be non-infectious.

Storage/Disposal

All tiger bags will be disposed of via deep landfill or used as a Refuse Derived Fuel (RDF) and must therefore not contain any infectious, anatomical or pharmaceutical waste, which must either be treated or incinerated.

The Following Clinical Waste Assessment Flow Chart should be used to determine whether the waste they are disposing of is clinical/infectious, offensive or medicine contaminated.

Regan, Nikki

Clinical Waste Bag Assessment Flow Chart

Is the patient known to be infectious?

Does the patient history indicate they may be infectious?.....e.g. MRSA, Shingles, Pulmonary TB?

NO ← | → YES

Does the patient have any signs/symptoms that indicate they may be infectious?

.... i.e. vomiting, diarrhoea, inflamed wound. etc

NO ← | → YES

Do you know/suspect the patient may be infectious for any other reasons?

.... i.e. your clinical judgement assessment, clinical judgement, e.g. history of MRSA

NO ← | → YES

Does the waste contain any PHARMACUETICLE RESIDUE?

.... i.e. iv lines, bags, tubes etc

YES

NON-INFECTIOUS OFFENSIVE WASTE

PPE, Incontinence & Sanitary Waste, Dressings etc.

INFECTIOUS WASTE FOR INCINERATION

Contaminated with Medication

INFECTIOUS WASTE

Do not put Anatomical or pharmaceutical waste into this waste stream

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06. Clinical Sharps Waste

Clinical Sharp Waste refers to specific type of clinical waste that includes any device or object used to puncture or lacerate the skin. This type of waste is classified as biohazardous and must be handled with care to prevent injury and the spread of infectious diseases. Proper disposal of sharps waste is crucial to prevent injuries, the transmission of infectious diseases and harm to the environment.

06.1. Yellow Sharps Boxes – EWC 18 01 03* & 18 01 09

Description

Sharps that are contaminated with medicinal products, excluding Cytotoxic and Cytostatic Waste. These sharps are typically used in medical procedures involving pharmaceuticals.

Examples

Sharps used for the administration of general pharmaceuticals and/or contrasts, including part used vials and ampoules.

Yellow sharps boxes should be segregated at source and must not be stored with orange bags/sharps or any other waste stream.

06.2. Orange Sharps Boxes – EWC 18 01 03*

Description

Sharps that are not contaminated with pharmaceutical or medicinal products. These sharps are typically used in procedures where no medication residue is present, such as blood collection or vaccinations

Examples

Needles, syringes, scalpels, broken contaminated glass that is not contaminated with medicine.

Orange sharps boxes should be segregated at source and must not be stored with any other hazardous/non-hazardous waste stream

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06.3. Purple Sharp Boxes – Cytotoxic/Cytostatic Sharps

EWC 18 01 03* & 18 01 08*

Description

Specifically designed for the safe disposal of sharps contaminated with cytotoxic and cytostatic medicines, which are often used in cancer treatment.

Examples

Needles, Syringes, scalpels contaminated with Cytotoxic/Cytostatic Pharmaceuticals.

Purple Sharps boxes should be segregated at source and must be stored separate from orange/yellow sharps waste and all other waste streams.

Sharps boxes or other rigid clinical waste containers should be filled to maximum three quarters fill OR the fill line, whichever is reached first. Sharps boxes must be signed on assembly, on closure, properly sealed, identified and delivered to waste hold/storage areas by the waste producer. In laboratory areas it is the responsibility of laboratory staff to deliver all hazardous waste to the designated waste hold/storage areas.

The following Clinical Sharps Waste Assessment Chart should be utilised to ensure the correct color-coded sharps box is selected for disposal.

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Clinical Sharps Waste Assessment Chart

SHARPS WASTE DISPOSAL GUIDE

Not following the sharps waste disposal guide correctly could lead to a £*0,000+ figure **fine by Natural Resource Wales (NRW)** plus fines from our waste contractor.

Is the sharp cytotoxic or cytostatic?

YES

Dispose of in a **purple** lidded sharps unit

NO

Is the sharp contaminated with medicines?

YES

Dispose of in a **yellow** lidded sharps unit

NO

Dispose of in an **orange** lidded sharps unit

Do not use sharps units for the disposal of free liquids.

Sharps units should be filled to **maximum** of three quarters full OR to the fill line marked on the container, whichever is reached first.

Ensure to date and sign box when assembled.

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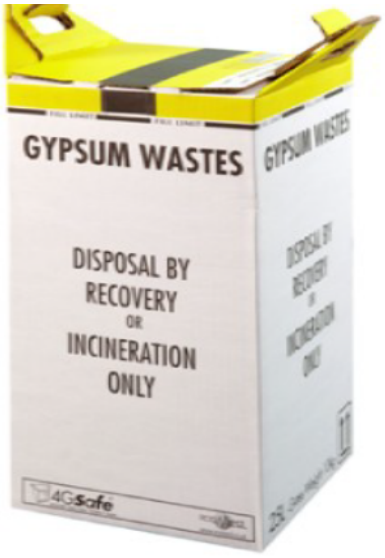
07. Gypsum Waste - EWC 18 01 04



Description

Clinical gypsum waste refers to gypsum-based materials used in healthcare settings, such as dental practices, hospitals, and clinics. These materials include plaster casts, dental study models, and other gypsum products that may be contaminated with infectious agents or hazardous substances.

If gypsum is mixed with other biodegradable waste in a normal landfill, then hydrogen sulphide gas can be released. Hydrogen sulphide is a toxic, colourless, flammable gas with a very distinct foul odour. Exposure can lead to adverse health effects. So appropriate methods of disposal should be followed.

Examples

Plaster Casts and Moulds: Gypsum-based materials are often used in orthopaedic procedures to create casts or moulds for immobilising or supporting injured limbs. Once these casts are no longer needed, they become gypsum waste.

Dental Plaster: Dental offices and clinics use gypsum-based materials, such as dental plaster or dental stone, for making impressions of teeth and oral structures. Waste generated during dental procedures involving these materials would be classified as gypsum waste.

Surgical Plaster Waste: Some surgical procedures may involve the use of gypsum-based materials for wound care or as part of specialised medical devices.

Laboratory Waste: Gypsum may be present in certain laboratory equipment, such as fume hoods, countertops, or sinks, which are used for chemical analyses, experiments, or sample preparations. Waste generated during laboratory activities involving these materials would be considered gypsum waste.

Disposal of Non-Infectious Gypsum

Gypsum is banned from normal landfill and must be disposed of in a way suitable for high sulphide waste. Gypsum waste should always be placed into yellow boxes specifically labelled Gypsum. Gypsum Waste must always be segregated at source and never mixed with any other waste stream, especially waste bags/containers destined for landfill.

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Disposal of Infectious Gypsum

If Gypsum waste is infectious or suspected to be infectious then it must be disposed of in a rigid yellow box through the infectious waste stream for incineration. **(EWC 18 01 03*)**

08. Radioactive Waste EWC 18 01 10*

Description

Radioactive waste refers to any material that contains or is contaminated with radionuclides at concentrations or activities above regulatory thresholds, making it subject to control under environmental and radiation protection legislation. This waste is generated through the use of radioactive substances in medical diagnostics, treatment, and research. The management of such waste must comply with the conditions of Environmental Permits and follow the principles of Best Available Techniques (BAT) and the ALARP (As Low As Reasonably Practicable) approach to ensure safety and environmental protection.

Examples

Within the Health Board, radioactive waste is primarily produced by the RMPCE Directorate and Laboratory Services, with contributions from departments handling nuclear medicine patients. Examples include:

- **Short-lived solid waste** (e.g., contaminated gloves, syringes) from diagnostic procedures.
- **Long-lived solid waste** (e.g., sealed sources, radionuclide generators).
- **Organic liquid waste** from laboratory processes.
- **Aqueous waste** (e.g., patient excreta containing radiopharmaceuticals).
- **Sealed sources** no longer in use, such as gamma camera flood-field sources.

Storage/Disposal

Radioactive waste is segregated by type and half-life and **must be** stored in secure, designated areas. At UHW, this is managed by the MPCE department; at UHL, by the Nuclear Medicine department. Short-lived waste is stored for decay and reclassified after one week for disposal as non-radioactive waste. Long-lived and organic liquid waste is stored for up to three months before being transferred to licensed contractors. Aqueous waste is either stored until out of scope or disposed of via designated sinks, with appropriate signage and record-keeping. Gaseous waste is not produced by the UHB and thus not subject to disposal.

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09. Anatomical Waste - EWC 18 01 02 & 18 01 03*

Description

Anatomical waste is defined as any recognisable body part, tissue or organ arising from healthcare with exception of that which is generated post-mortem. Anatomical waste must be segregated from other wastes and contained in rigid sealed containers, identified suitable only for high temperature treatment.

All human tissue/anatomical waste including samples, specimens and biopsies. Anatomical waste must be disposed of separately to general infectious waste (i.e., not in orange clinical bags).

Disposal

Anatomical waste should be carefully packaged in appropriately size red lidded containers, clearly labelled “Anatomical Waste – For Incineration Only”.

Preserved Items

Items which have been preserved in formalin should be drained of any chemical preservative and carefully packaged in appropriately sized red lidded rigid containers clearly labelled “Anatomical Waste – For Incineration Only”

Post-mortem Anatomical Waste

The removal, storage and disposal of human organ and tissue post-mortem are subject to The Human Tissue Act 2004.

To arrange for the disposal of post-mortem anatomical waste, Section A of the Human Organ and Tissue Disposal Form must be completed. This form should detail the size and type of containers, as well as the type of waste. Once completed, the form should be submitted to the Waste Management Team. Waste Management will then forward the form to specialist waste contractors to arrange the collection. The form will follow the journey of the waste from collection to destruction. Subsequently, the waste management team will organise the transportation of the waste to the main waste compound, ready for collection. After the waste has been collected and disposed of, the contractors will provide proof of destruction.

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Human Organ and Tissue Disposal Form HTA - F6.07.02.pdf

10. Pharmaceutical Waste - EWC 18 01 09

Description

Pharmaceutical waste is defined as any medicine or drug that may be expired, unused, or left over after medical treatment or surgical procedures. It also includes drugs that have been prescribed to patients but are no longer needed. This waste can include a variety of substances, including:

- Prescription drugs
- Over-the-counter medications
- Some dietary supplements
- Compound drugs
- Some homeopathic drugs

Environmental and Health Considerations

Due to the potential risks pharmaceutical waste poses to both human health and the environment, it **must not** be disposed of via sinks, toilets, or general waste systems. Improper disposal can lead to contamination of water sources and ecosystems.

Regulatory Oversight

The management and disposal of pharmaceutical waste are regulated by agencies such as Natural Resources Wales, which ensure that disposal practices are safe, compliant, and environmentally responsible.

Disposal

All unused, returned by patients, or expired medicines must be returned to the Pharmacy in accordance with the Return to Pharmacy Policy. The Pharmacy is responsible for the appropriate classification, packaging, and disposal of these items.

Part-used medicines that do not fall under the Return to Pharmacy Policy must be disposed of in designated blue containers clearly marked “Pharmaceutical Waste.”

Pharmaceutical waste **must be** segregated at the point of generation and **must never** be mixed with other waste streams to prevent cross-contamination and ensure regulatory compliance.

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11. Recycling Waste

From April 2026, all hospitals in Wales, both NHS and private must comply with the Environmental Protection (Waste Recycling) (Wales) Regulations 2024, which require the separate collection of recyclable materials including paper and card, plastic, metal, and cartons. These materials must be sorted at the point of disposal and kept separate throughout the collection and recycling process to ensure high-quality recycling outcomes. The legislation is designed to reduce contamination in recycling streams, increase the volume of materials that can be effectively recycled, and support Wales's broader environmental goals of cutting carbon emissions and moving toward a zero-waste society.

Information Page: Workplace recycling | GOV.WALES

Information Video: Workplace recycling

Avoid Contamination: Biffa | How-To #2: Reduce and Avoid Contamination

Wish cycling: Biffa | How-To #3: Avoid Wishcycling

CAVUHB Non-Clinical Waste Training: CAVUHB Non-Clinical Waste Segregation.pptx

11.1. Clear Bags - Paper and Card – EWC 20 01 01

Description

Paper and card recyclable waste refers to discarded paper and cardboard materials that are clean, dry, and suitable for reprocessing into new paper products.

Examples

Items include office paper, newspaper and magazines, small cardboard, mail and flyers, paper bags etc.

Non-recyclable

Items that are often mistaken for recyclable paper and card: used tissues/paper towels, greasy pizza boxes, waxed cardboard, plastic coated paper, disposable coffee cups, metallic paper etc.

Storage/Disposal

Paper and Card should be clean, dry and separated then disposed of into blue waste bags designated for paper and card waste. Blue bags should be placed into wheeled bins designated for recycling waste. Recycling waste **must never** be mixed with clinical waste.

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11.2. Clear Bags – Plastic, Metal and Carton – EWC 15 01 04, 15 01 02 & 15 12 04

Description

Plastic, Metal and Carton recyclable waste refers to discarded plastic, metal and carton items that are clean, dry and suitable for processing into new products.

Examples

Items include disposable coffee cups, drink bottles, drink cartons and cans, foil used in food packaging, trays made from synthetic polymers.

Non-Recyclable

Items often mistaken for recyclable plastic, metal and carton: plastic bags, toothbrushes, toys, crisp and sweet wrappers, food/drink containers with residue etc.

Storage/Disposal

Plastic, Metal and Carton Items should be clean, dry and separated then disposed of into clear waste bags designated for this waste stream. Clear bags should be placed into wheeled bins designated for recycling waste. Recycling waste **must never** be mixed with clinical waste

11.3. Carboard Waste – EWC 20 01 01

Description

Cardboard waste refers to discarded or unwanted large cardboard materials that are no longer needed for their original purpose.

Examples

This type of waste is typically generated from packaging, shipping boxes, product containers, and other cardboard-based items that are too large to fit in Paper and Carboard waste bins. It is a common form of waste in all departments.

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Storage/Disposal

Carboard should be dry, free from all wrapping, tape and bindings, broken down flat and placed in waste storage areas separated from clinical waste. Proper preparation and segregation of cardboard waste support efficient recycling and help maintain compliance with environmental standards.

12. Waste Electrical and Electronic Equipment (WEEE)

From April 2026, all hospitals in Wales, both NHS and private must comply with the Environmental Protection (Waste Recycling) (Wales) Regulations 2024, which include specific provisions for the management of Waste Electrical and Electronic Equipment (WEEE). Under this legislation, hospitals are required to separately collect and manage unsold small WEEE (sWEEE), such as broken or obsolete medical devices, IT equipment, and other electronic tools. This separation ensures that valuable materials like metals and plastics can be recovered and hazardous substances are safely handled. The regulation aims to reduce the volume of electronic waste sent to landfill or incineration, support the circular economy, and contribute to Wales's broader goals of reducing carbon emissions and addressing the climate emergency.

All WEEE waste collection should be requested through the synbiotix help desk for acute sites. For community sites please contact the Waste Management Department to arrange collection.

Facilities Helpdesk - Synbiotix Healthcare Solutions : Login

12.1 Non-Hazardous WEEE Items - EWC 20 01 36

Description

Non-hazardous WEEE (Waste Electrical and Electronic Equipment) refers to discarded electrical and electronic items that do not contain hazardous substances or persistent organic pollutants (POPs) above regulatory thresholds. These items are safe to handle under standard waste management procedures.

Examples

Basic household electronics without batteries or circuit boards containing hazardous materials and Small Appliances such as toasters and kettles.

Storage/Disposal

Non-hazardous WEEE items must be stored in a designated waste storage area or other suitable area that is segregated from all other waste streams. Items must be clearly labelled with the date on which collection was requested. The request must specify both the type of item and its precise location. Non-hazardous WEEE **must never** be mixed with any other type of waste. Proper segregation ensures compliance with environmental regulations and facilitates safe recycling.

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12.2 Hazardous WEEE Items – EWC 20 01 23*

Description

Hazardous WEEE (Waste Electrical and Electronic Equipment) refers to discarded electrical or electronic devices that contain substances harmful to human health or the environment.

Examples

Fridges and Freezers refrigerated serving counters, old television monitors, energy saving bulbs, printed circuit boards, automatic dispensers ect.

Storage/Disposal

WEEE items must be stored in a designated waste storage area or other suitable area that is segregated from all other waste streams. Items must be clearly labelled with the date on which collection was requested. The request must specify both the type of item and its precise location. **Under no circumstances** should hazardous WEEE be mixed with any other type of waste. Proper segregation is essential to ensure compliance with environmental and safety regulations.

12.3. I.T Equipment – EWC 20 01 35* & 20 01 36

Description

I.T. waste, also known as Information Technology waste, is a subset of electronic waste (WEEE) that specifically includes discarded electronic devices used for computing, data processing, and telecommunications.

Examples

Desktop, laptops, keyboards, mice, routers, hard drives, servers, mobile and tablet devices etc.

Storage/Disposal

All I.T. waste must be delivered to the I.T. Department at UHW or to Central Stores at UHL. Prior to disposal, all devices are securely wiped of data to ensure information security. Licensed contractors then collect the items for environmentally responsible recycling. Community sites should contact Waste Management department to arrange collection.

I.T. waste must be kept separate from all other waste streams to ensure proper handling and compliance with data protection and environmental regulations.

Keeping NWSSP 09/12/2026 11:51:07

12.4. Ink Cartridges – EWC 08 03 07*, 08 03 18, 20 01 27*, 20 01 28

Description/Example

Ink cartridge waste refers to used, empty, or expired printer ink and toner cartridges that are no longer suitable for use.

Storage/Disposal

Used ink and toner cartridges should be transported to the designated central collection points: the UHW I.T Department or UHL Central Stores. Before placing cartridges into the collection area, remove all packaging. Cardboard and other packaging materials must be disposed of locally using appropriate recycling or waste bins. You may use any empty cardboard box to hold the cartridges for transport. Be sure to follow your local disposal procedures, and if you need further assistance, contact the Waste Management Team for guidance.

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13. Organic Food Waste – EWC 20 01 08

Description

Food waste refers to any biodegradable waste material that is intended for human consumption but is discarded, lost or uneaten at any stage of the supply chain.

This type of waste is considered "organic" because it comes from living organisms and can be broken down by microorganisms into natural elements like carbon dioxide, water, and compost.

Examples

Common examples include uneaten meals left on trays due to patients being discharged, transferred, or undergoing medical procedures during mealtimes. Overproduction in kitchens/restaurants, where meals are prepared in bulk to ensure availability. Uneaten food discarded by patients, staff and public.

Storage/Disposal

Food waste **must be** disposed of in the designated food waste containers located within waste storage areas or in the large food waste bins provided at specified collection points. **Under no circumstances** should food waste be placed in general waste or any other waste stream.

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14. Black Bag Waste (Residual Waste) – EWC 20 03 01

Description

Residual waste refers to the waste that remains after all recyclable, compostable, and reusable materials have been separated out. It typically includes items that cannot be recycled or recovered. This waste is usually sent to landfill or energy recovery facilities.

Examples

Examples of residual waste include crisp packets, sweet wrappers, plastic film, polystyrene packaging, broken crockery, and heavily soiled food containers. These items cannot be recycled or composted and must be disposed of as general waste.

Storage/Disposal

Residual waste should be placed in the designated black waste bags. Black bags should be placed into wheelie bins designated for residual (general) waste. **Do not** place recyclable or clinical waste items such as PPE in black waste bags. Residual waste **must never** be mixed with clinical/hazardous waste.

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15. Batteries – EWC 16 06 04, 20 01 34, 16 06 01*, 16 06 03*, 16 06 02*, 20 02 33*

Description

Battery waste refers to used or discarded batteries that are no longer functional or needed, including household, rechargeable, and industrial types. These batteries often contain hazardous materials such as lead, mercury, cadmium, and lithium, which can pose serious environmental and health risks if not disposed of properly. When improperly discarded, battery waste can contaminate soil and water, harm wildlife, and contribute to pollution. To mitigate these risks, battery waste is recycled through certified processes that safely recover valuable materials and prevent toxic substances from entering the environment.

Examples

Examples of battery waste include common household batteries like AA, AAA, and 9V batteries used in remote controls and toys, as well as button cell batteries found in watches and hearing aids. Rechargeable batteries from mobile phones, laptops, and power tools, such as lithium-ion and nickel-metal hydride batteries also contribute to battery waste. Larger sources include lead-acid batteries from vehicles and backup power systems. Even batteries from e-cigarettes, electric scooters, and solar storage systems are part of this growing waste stream

Storage/Disposal

used batteries should be placed in the designated battery waste container located in the waste storage area. Ensure batteries are not leaking or damaged, if they are, report them to the Waste Management Team immediately. Once the container is full, inform the Waste Management Team for safe collection and disposal in line with Health Board procedures. Always wash hands after handling used batteries, Batteries **must never** be placed into any other waste stream. Disposing of batteries in sharps boxes poses a **serious risk** of chemical leakage, fire, or explosion, endangering staff and waste contractors.

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16. Scrap Furniture or Equipment (Non-Electrical) - EWC 20 03 07

Description

scrap furniture and equipment refer to non-functional, outdated, or damaged items that are no longer suitable for use but do not pose any clinical or biological risk. These items are typically generated during refurbishments, equipment upgrades, or routine maintenance. They must be assessed for potential reuse, donation, or recycling before disposal.

Examples

Examples of scrap furniture and equipment includes items such as broken chairs, desks, filing cabinets, worn-out trolleys, old IV stands etc.

Storage/Disposal

All Scrap Furniture and Equipment waste collection should be requested through the synbiotix help desk for acute sites. For community sites please contact the waste management department to arrange collection.

Facilities Helpdesk - Synbiotix Healthcare Solutions : Login

Scrap Waste items must be stored in a designated waste storage area or other suitable area that is segregated from all other waste streams. Items must be clearly labelled with the date on which collection was requested. The request must specify both the type of item and its precise location.

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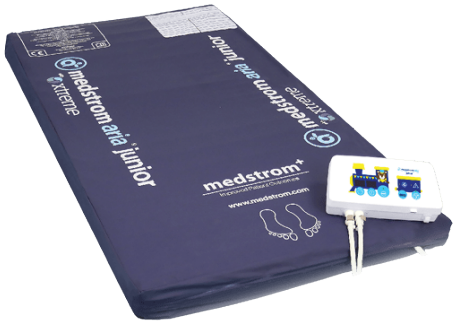
16.1. Mattresses – EWC 18 01 03*



Description

Damaged mattresses from clinical applications which are considered infectious waste.

Assessment/Disposal

Mattress collection must be arranged directly by the ward or department through a specialist contractor. When assessing or disposing of mattresses, please ensure that the following guidelines and procedures are followed carefully to maintain safety and compliance.

Mattress Check - P.R.O. Matt Mattress Check Rev1 Nov23 (002).pdf

Fault Reporting - Fault Reporting Process Rev1 Nov23 (002).pdf

Mattress and Bed Movements - Mattress and Bed Movement Guidlines updated 2023.pdf

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17. Chemical Waste – EWC Various, Contact Waste Management

Description

Chemical waste refers to any discarded solid, liquid, or gaseous substance that is hazardous or potentially harmful due to its chemical properties. Chemical waste can be toxic, corrosive, flammable, or reactive, and must be handled with strict safety measures to prevent harm to staff, patients, and the environment.

Examples

This includes substances such as disinfectants, solvents, laboratory reagents, cleaning agents, and expired or unused pharmaceuticals. Hazardous Chemical waste is usually produced in laboratories, pharmacy, boiler treatment and cleaning/decontamination.

Storage/Disposal

Chemical Waste **Must be** stored in accordance with COSHH requirements. For disposal of Chemical Waste, contact the Waste Management Department providing the data sheet, container size/number and volume remaining in the container.

Chemical Waste **must be** handled with strict safety measures to prevent harm to staff, patients, and the environment. Proper segregation, labelling, storage in secure containers, and disposal through licensed hazardous waste contractors are essential to ensure compliance with health and environmental regulations.

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18. Confidential Waste – EWC 20 01 01

Description/Examples

Confidential waste refers to any material that contains sensitive, personal, or private information which must be securely disposed of to protect privacy and comply with data protection laws.

This includes documents with patient details, staff records, financial information, and any other data that could lead to a breach of confidentiality if accessed by unauthorised individuals.

Disposal

Confidential waste **must be** stored in secure, clearly marked containers and disposed of through approved shredding or secure destruction services to ensure complete data protection. For more information contact the Waste Management Team.

19. Asbestos – EWC 17 06 05 & 17 06 01

Any waste material likely to contain or be contaminated with asbestos

All asbestos waste must be handled in accordance with the approved Asbestos Management Plan and associated policies and procedures. For further guidance, please contact the Compliance and Assurance Team, Health and Safety Team or Estates Team.

If you encounter any material that is suspected to contain asbestos:

- Do not disturb, move, or touch the material.
- Immediately contact the relevant Estates Department.
- Request urgent assistance and report the location and nature of the material.

Oil – EWC Various, refer to Waste Management Team

All waste oils must be stored in suitable, leak-proof containers. These containers should then be placed within an appropriate secondary containment system, such as a drip tray or bund that is capable of holding at least 110% of the total volume stored.

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To arrange for collection, please contact an approved waste contractor.

For further advice or support, Contact the Waste Management Team.

19.1. Mercury – EWC 16 01 08*

Any items containing mercury

Examples

Sphygmomanometers

Thermometers

Disposal

To arrange disposal of Mercury Waste, contact the Waste Management Team. Waste Management will arrange for this waste to be removed and securely stored until it can be disposed of by a specialist contractor.

This waste **must be** kept secure at all times.

19.2. Amalgam Waste – EWC 18 01 10*

Description

Amalgam waste refers to any waste material that contains dental amalgam, a mixture primarily composed of mercury along with other metals such as silver, tin, copper, and zinc.

Because amalgam contains elemental mercury, it is classified as hazardous waste. Improper disposal can lead to mercury contamination in water systems, posing serious environmental and health risks.

Examples

Amalgam waste is commonly generated in dental practices and medical facilities during procedures like cavity fillings, restorations, or the removal of old amalgam fillings.

Storage/Disposal

Amalgam waste must be placed in a designated, clearly labelled container specifically intended for this waste stream. Each department is responsible for arranging collection directly with an approved specialist waste contractor. Contact Waste Management for advice.

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20. Training

It is the responsibility of all departmental managers to ensure that all new staff members receive appropriate waste management induction training before they are considered competent to perform their duties.

New staff must be provided with the following information:

- An overview of the Waste Management Policy and Procedures, including guidance on how to access the most current version.
- Clear instructions on the correct procedures for handling, segregating, disposing, and storing waste relevant to their role.
- A breakdown of roles and responsibilities related to waste management.
- An explanation of the Health Board's current environmental objectives concerning waste.
- Emergency procedures for waste-related incidents and the process for incident reporting.
- Guidance on the correct use of Personal Protective Equipment (PPE) where required.
- Information on the need for appropriate vaccinations, where applicable.
- Departmental managers are also responsible for ensuring that existing staff have received the same level of training as outlined above.

CAVUHB Clinical Waste Segregation.pptx

CAVUHB Non-Clinical Waste Segregation.pptx

Training may be delivered through:

- Dedicated waste management training sessions.
- Inclusion in broader training programmes (e.g., infection prevention and control, medical devices).
- Department-specific training upon request.

Training needs will be identified through a Training Needs Analysis, Departmental Training Plans, and the Value Based Appraisal (VBA) process.

All relevant staff must undergo retraining whenever significant changes are made to waste management policies or procedures.

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Training records must be maintained in accordance with the Health Board's record retention policies

20.1. Audit

The Facilities Team and Assurance and Compliance Team are responsible for the preparation of an annual environmental audit schedule in accordance with the requirements of the ISO 14001:2015 Environmental Management Standard. Given its significance as an environmental aspect, waste management will always be included in the audit schedule.

The extent and focus of waste-related audits each year will be determined based on a risk-based approach and the findings of previous audits.

Each waste management audit will be designed to assess compliance with the Health Boards waste management policy and procedures. At a minimum, the audit will evaluate:

- Safe handling practices
- Correct use of designated waste containers
- Condition and suitability of wheelie bins
- Proper sealing, labelling, and storage of waste
- Adequacy of staff training
- Accuracy and completeness of waste-related records
- Effectiveness of local waste management procedures
- Clarity and execution of local waste management roles and responsibilities

These audits are intended to evaluate the overall effectiveness of the waste management system. They are conducted in addition to more frequent, department-level audits that ensure day-to-day compliance with established procedures.

In addition to internal audits, off-site waste management audits will be conducted to ensure that all contracted waste service providers manage Health Board waste in full compliance with applicable legal and regulatory requirements.

As a minimum, each 'Duty of Care' audit will assess the following:

- Safe handling and storage practices at the contractor's facility
- Traceability of waste – the contractor must demonstrate that waste collected from the Health Board on a specific date was received and processed at the audited site. This will involve a review of waste transfer and consignment notes
- Verification of compliance – including confirmation that the waste carrier is properly registered and that the receiving site holds the appropriate environmental permits or licenses
- Review of any regulatory issues or enforcement actions associated with the site
- Staff training relevant to waste handling and compliance
- Accuracy and completeness of record-keeping
- General housekeeping standards at the site

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These audits are essential to uphold the Health Board's environmental responsibilities and ensure full compliance with waste management legislation.

20.2. Dangerous Goods Safety Advisor (DGSA)

A Dangerous Goods Safety Advisor (DGSA) is required when the organisation transports healthcare waste that is classified as dangerous goods under ADR regulations. This includes:

- Clinical waste (UN 3291) above ADR transport thresholds (e.g., >333 kg).
- Category A infectious waste (UN 2814, UN 2900, UN 3549).
- Medicinal waste that is hazardous in transport (UN 1851, UN 3248, UN 3249).
- Chemical waste arising from healthcare activity that is hazardous for transport (e.g., corrosive, flammable or toxic chemical residues).
- Chemical-contaminated clinical waste (e.g., PPE or absorbents contaminated with hazardous substances).
- Dental amalgam containing mercury (UN 2025).
- Radioactive healthcare waste subject to Class 7 transport controls.

The DGSA ensures that dangerous healthcare waste is correctly classified, packaged, labelled, documented and transported in compliance with ADR and the Carriage of Dangerous Goods Regulations.

DGSA Contact Details

Name: Naomi Heredia Hernández

Organisation: Independent Safety Services Ltd

Telephone: 0114 272 2113

Email: Naomi@issafe.co.uk

DGSA Responsibilities

The DGSA will:

- Advise on correct classification of all dangerous waste types (infectious, medicinal, chemical, dental, sharps, and radioactive).
- Ensure appropriate UN-approved packaging is used (e.g., P621, P622 for clinical waste).
- Verify correct labelling and marking of hazardous waste packaging.
- Ensure waste consignment and transport documentation is compliant.
- Investigate any incidents involving dangerous healthcare waste.
- Provide an annual DGSA compliance report.

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Organisational Responsibilities

The organisation must:

- Appoint a DGSA whenever dangerous healthcare waste above ADR thresholds is transported.
- Ensure correct classification of all dangerous waste types, including chemicals, medicines, infectious waste, amalgam and radioactive waste.
- Ensure staff use the required UN-approved packaging (e.g., P621/P622) and correct hazard labels.
- Complete and retain accurate consignment documentation for all dangerous waste movements.
- Provide ADR awareness training to staff handling or transporting dangerous waste.
- Use only waste contractors who can demonstrate ADR compliance and DGSA support.
- Report any incidents involving dangerous waste to the DGSA and act on recommendations.
- Receive and review the DGSA annual report and implement any required improvements.

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20.3. Community Healthcare Waste

Community midwives and nursing teams generate healthcare waste during the delivery of care in patients' homes and community settings. This procedure outlines the requirements for safely classifying, handling, and transporting this waste in line with legal and organisational responsibilities, ensuring it is managed and returned to healthcare sites for appropriate disposal.

Dangerous goods legislation requires specific types of containers/packaging to be used that are correctly marked and labelled, these are summarised in this document. ALL staff must comply with the dangerous goods regulations and relevant waste legislation.

Offensive Waste (Tiger Bag)

Offensive Waste is not infectious so is not classed as dangerous goods. If a patient is giving birth in their own home and is considered not to have an infection, then with the patient's permission, Health Board staff can leave up to 7 kg of soft waste (pads, dressings, wipes etc. contaminated with body fluids) in the patient's own bin in a black bag. If they do not give permission and the patient is considered not to have an infection, then the waste must be segregated into the tiger striped offensive waste bags and brought back to a Health Board site in the staff member's vehicle and disposed of with other offensive waste bags.

As the waste is not infectious, it is not a dangerous good and so there are no restrictions on how the bag has to be contained in the car although there are still health and safety and practical issues which could be overcome by using a standard plastic box or similar.

Infectious Waste

All infectious waste must be removed from the patient's home by the healthcare worker. It must not be put in the patient's domestic waste bin.

Infectious waste would include contaminated waste from patients with a known or suspected infection and is always classed as dangerous goods.

The infectious waste stream includes all soft infectious waste, which must be segregated into the appropriate colour-coded bags in accordance with the Health Board's clinical waste segregation procedures.

All sharps waste such as needles, vials, and ampoules, must be disposed of in correctly colour-coded sharps containers, following the Health Board's colour-coding requirements.

Sharps containers must be signed and dated before use. All sharps containers must be correctly assembled before use, they are also equipped with a temporary closure mechanism, this must be engaged when the container is being transported.

Community teams that carry infectious clinical waste on behalf of the Health Board must ensure that the relevant packaging is used when the waste is transported on the roads:

- Loose orange clinical waste bags are not compliant for carriage in their own right but can be used as an inner package in an approved outer package (e.g. UN approved Daniels transport container, orange Econix Bio-bin etc.).
- The red lidded anatomical waste containers (or equivalent Bio-bins) are compliant for carriage on the road in their own right but the containers must be sealed and kept upright.
- Sharps bins are compliant for carriage on the roads in their own right provided the temporary closure is engaged, or the container is sealed or otherwise not able to open under duress.

Placenta Waste

Placentas are classified as anatomical waste and must be segregated into a red-lidded anatomical waste container that is capable of being sealed. It must not be placed into the domestic waste stream and must be removed from the patient's home by a healthcare worker if not retained by the mother.

Marking & labelling of clinical waste packaging

All packaging supplied by the Health Board for infectious waste (sharps bins, anatomical waste containers and orange bags) must be pre-labelled and marked with the following dangerous goods information: 'UN3291' and the Class 6.2 Infectious Substance danger label, as shown below:

Provided infectious clinical waste is carried in compliant packaging, i.e. correctly marked and labelled, sharps bins, red lidded anatomical waste containers and orange bags (with the orange bags included in a suitable outer package also suitably marked), then there are no other paperwork, equipment (e.g. fire extinguishers) or vehicle marking requirements.

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20.4. Dangerous Goods Requirements

Exemptions Related to Quantities Carried: Community workers will only move small quantities of dangerous goods under thresholds where exemptions apply. Road Derogation 2 removes the requirement for healthcare workers transporting dangerous goods under the small load threshold to carry a transport document.

Class 2: Medical gases: Road Exception 1 removes the requirement for healthcare workers transporting medical gases to carry a fire extinguisher under the following conditions:

- medical gases are contained in a cylinder(s), as part of a set that includes a regulator, hose and mask with a total maximum number of 6 cylinders per vehicle
- measures have been taken to prevent any leakage of contents in normal conditions of carriage
- healthcare workers are appropriately health and safety trained,
- a risk assessment has been carried out for the carriage.

Diagnostic Specimens

When diagnostic specimens (bloods, urines) are moved on the roads in vehicles, these specimens must be packaged as follows into a three-part packaging system:

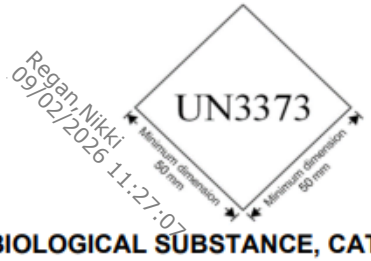
1. The sample container (e.g. blood tube or universal container)
2. Secondary sealable bag containing absorbent material where the specimen is liquid – place the sample container in the secondary bag and seal; and
3. Outer packaging – place the package in the outer container.

Either the secondary or the outer packaging must be rigid. For community healthcare workers, the outer packaging is usually rigid.

The container used must be Health Board approved suitable packaging that has been proven (by the Health Board or via the manufacturer) to be capable of meeting various testing requirements detailed in the legislation.

The outer package must be labelled with the following dangerous goods information. "UN3373" and

"BIOLOGICAL SUBSTANCE, CATEGORY B" text must be at least 6 mm high:



Provided this compliant packaging system is used for specimens (including the use of the absorbents and the correctly marked and labelled outer package), then there are no other paperwork, equipment (e.g. fire extinguishers) or vehicle marking requirements.

Used Medical Equipment

Used medical instruments that are single use should be disposed in the clinical waste (sharp instruments, must be placed in sharps bins). Where instruments are returned to Health Board sites for sterilisation, then a suitable container must be used that is durably, legibly and visibly marked with the words "USED MEDICAL EQUIPMENT" or "USED MEDICAL DEVICE" on an outside surface. The container used must be Health Board approved suitable packaging that has been proven (by the Health Board or via the manufacturer) to be capable of meeting various testing requirements detailed in the legislation.

Pharmaceuticals

Under special provision 601, there are no restrictions on carrying pharmaceuticals in a vehicle, provided the pharmaceutical is ready for use and in its original packaging.

Loading & Security

All dangerous goods must be kept secure and carefully loaded into and stowed in vehicles. You must report an incident to the Waste Management or the Health Boards DGSA if any dangerous goods are lost or stolen whilst in your possession.

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20.5. Monitoring

Departmental managers are responsible for monitoring compliance with this policy at the local level.

Overall oversight and coordination of monitoring activities will be carried out by the Waste Management Team.

Audit Type	Process	Frequency	Owner
Pe Acceptance Waste Audits	assess segregation practices of clinical waste, with results shared with local management to drive improvement and ensure compliance.	>5tone – Annually <5tonne – 5 Yearly	External Independent Auditor Waste Management Team
Local Waste Management Audit	Monitor the correct handling, transport, segregation, and storage of waste in line with Health Board policies and procedures	Monthly	Waste Management Team Infection Prevention and Control
ISO 14001 Audit Programme	Review waste management in line with this policy, key objectives and targets, legal requirements and improvement plans	On Going	Facilities Compliance and Assurance Team Waste Management Team
Training	Competence Testing, Feedback Forms, Training Records	On Going	Departmental Managers Learning and Development Team Waste Management Team
Dangerous Goods Safety Audit	Interviews Examination Disposal Observation of handling and classification	Annual	Capital Estates and Facilities External Independent Auditor

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Report Title:	**Digital Directors' Peer Group**			Agenda Item no.	5.1	
Meeting:	Digital & Infrastructure Committee Meeting	Public	X	Meeting Date:	10th February 2026	
		Private				
Status:	Assurance		Approval		Information	x
Lead Executive:	Director of Digital & Health Intelligence					
Report Author:	Director of Digital & Health Intelligence					

Background and current situation:

The creation of the Digital Directors' peer group in 2021 replaced the previous Digital Delivery Leadership Group meeting which came into existence in 2020 following the dissolution of the National Information Management Board which had been focused on providing an overview of information and IM&T issues nationally.

The establishment of the peer group brings Digital in line with other professions in the NHS in Wales (eg Directors of Finance peer group, Directors of Planning peer group) and is a welcome development.

Assurance is provided by the discussion and exchange of views and updates on a wide range of digital related issues via the regular monthly meetings compromising board-level leads for digital from across all NHS Wales organisations, including Welsh Government's Chief Digital Officer and members of DHCW's executive team.

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

The attached minutes of the last three meetings held in November 2025, December 2025 and January 2026, provide an update on the scope and range of discussions on digital matters impacting on all NHS Wales organisations.

CAV UHB is represented by the Director of Digital and Health Intelligence (the Director of Digital Transformation acts as deputy when necessary).

Recommendation:

The Committee are requested to NOTE the minutes of the last meetings as follows:

a) Minutes of Meeting – 4th November 2025 (Appendix 1)
b) Minutes of Meeting – 5th December 2025 (Appendix 2)
c) Minutes of Meeting – 13th January 2026 (Appendix 3)

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First		Providing Outstanding Quality	
1.		2.	
Click the objective above to view more detail.		**Click the objective above to view more detail.**	

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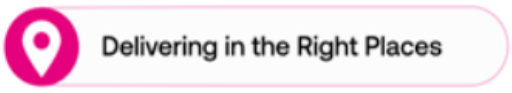 3. **Click the objective above to view more detail.**		 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		

Impact Assessment:
Risk: No
Safety: Yes
Financial: No
Workforce: Yes
Legal: No
Reputational: Yes
Socio Economic: Yes
Equality and Health: Yes
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

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DIRECTORS OF DIGITAL PEER GROUP MEETING

MEETING NOTES

Date: Tuesday 4th November 2025

Time: 9:30am – 4pm

Location: / Microsoft Teams

Attendance

Digital Directors Present	
Initials	**Name**
AT	Anthony Tracey (HDUHB) - **Chair**
BR	Bryn Harries (NWSSP)
CM	Claire Madsen (PTHB)
COL	Claire Osmundsen-Little (DHCW)
DO	David Owen (PTHB)
DT	David Thomas (CVUHB)
IB	Iain Bell (PHW)
IE	Ifan Evans (DHCW)
JS	Jonny Summat (WAST)
MJ	Matt John (SBUHB)
PS	Paul Solloway (ABUHB)
SL	Sam Lloyd (DHCW)
SM	Stuart Morris (CTMUHB)
SP	Steve Probert (Welsh Government)
SR	Sian Richards (HEIW)
SS	Said Shadi (NHSPI)
VC	Vicki Cooper (PTHB)
HB	Harriet Baker (WNHSC)

External Speakers	
Initials	**Name**
BC	Bryony Clark (DHCW)
AJ	Angela Jones (NWSSP)
CB	Caroline Busby (DHCW)
CLJ	Carwyn Lloyd-Jones (DHCW)
DB	David Bromilow (NHSBSA)
DG	Dominika Gorecka (DHCW)
GW	Griff Williams (DHCW)
JB	James Braun (DHCW)

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LR	Louise Richards (NHSBSA)
ME	Mark Edwards (DHCW)
MJo	Matthew Jones (Channel 3 Consulting)
MW	Michael Williams (Channel 3 Consulting)
RJ	Rebecca Jarvis (NWSSP)
SMo	Samantha Morgan (DHCW)

Apologies	
Initials	**Name**
CB	Chris Brown (NHSPI)
CT	Carl Taylor (VNHST)
DR	Dylan Roberts (BCUHB)
HT	Helen Thomas (DHCW)

Agenda Item	Discussion	Action
1.	Welcome and Apologies • Previous Meeting Notes Approval • Action Log • AOB requests	
2.	**DDaT Digital Advisory Group – 10am – 11am** **CLOSED MEETING**	
3.	**Product Delivery and Service Management Arrangements Proposal** BC presented the slide deck. Purpose to review implementation plan and will be managed closely Slide 5 - Each organisation will have a service management review – services provided as an organisation e.g. SLA's Slide 6 – Operational Security Advisory Group to go membership review and restructure to ensure meeting the needs for a national perspective in discussions. Conversations around DDaT governance ongoing. SM welcomed the principles making efficiencies and streamlined. Queried how it interfaces with national structure. SM highlighted a concern for creating more groups and renaming existing ones. Benefit of existing groups is that they are established but they would benefit from additional capacity. The availability of resources to attend which may be difficult. Clarity around regional working would also be welcomed. MJ raised that Service Level Requests have a large remit so further clarification on what would come to DODs and what would go to other mechanisms. DG added that for the New Service Request Board query (Service Management) - currently, we have a so called Service Request Evaluation Group dealing with all new requests for a new service. To enhance decision-making, streamline the data input, a decision has been made to establish a	

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	board in lieu of the current meeting. Requestors will be invited to present the request to be able to improve and expedite decision-making around that request (no more bouncing back of information that is currently causing considerable delays). This will significantly help with dealing with backlog and future planning. IB raised the importance of stress testing with a Trust to ensure needs are met and identifying gaps. Capacity for new work requests in DHCW – worth discussing as future agenda item to confirm process. VC raised if there is enough in each product to warrant this structure considering the climate of reduced capacity and streamlining. Will this modernise systems for better outcomes for patients and speed up delivery of projects? PS welcomed the proposal and streamlining meetings are really positive. Separate governance DHCW and DDaT Leadership Board is needed. Review Group feedback mechanisms to DDaT structure and decision making alongside Welsh Government. MJ added Delivery and Engagement Governance: The frequency of meetings is also important in terms of resource and time. We should really challenge the need for any of the meetings to be more frequent than every other month. Focus should be on clear action in-between, rather than dozens of people sitting on frequent teams meetings. SR was supportive as product model for agile delivery. How do Product/Services link with Leadership Board as these may drive strategy where these are going? SM added that Cancer and NHS App are good examples BC will share feedback form post meeting for further feedback from DoD's and Teams. SL added that the aim is to simplify current process so decisions are made with transparency. Roadmaps will be shared with all decision making and reasons. Not trying to redesign governance but looking at how they interface with DDaT in the future. Regional working – aided by combining meetings if this assists with progression. **Summary:** Further conversations needed for clarity on where specific products sit and the invite list.	
4.	**Developing the Digital Profession** SMo introduced the meeting with the ask for understanding what we do well and focusing as a piece of work to accelerate through a skilled and confident workforce. Removing duplication to deliver value and investment. Capability group which sits in the DDaT Board and this could sit nicely there. Ask: January 2026 to have focussed session to align vision	

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	IB happy to discuss in January. Links with previous agenda item from BC. CM raised that developing Clinican's alongside this would be beneficial. Should there be collaborative working with higher education providers? SR added that the Education Training Plan can be adapted to include this. MJ welcomed the proposal. Worth reaching out with Andrew Griffiths around supporting the workshop. PS raised that consideration is needed from other attempts. Connected community in digital so positive start. JS welcomed the proposal. Role is a safety critical position and professional registration. Industry standards (ethics, approach etc). CPD and mandating and keeping it fresh. Talent pipeline – retention and nurture and retain. Some inconsistency in banding and evaluation piece of work could be done. **Summary:** welcomed and supportive. Workshop plan for middle-end of January. SMo to come back with further plans.	
5.	**National Device Refresh/Lifecycle Management** JB presented: Projected win 10 ESU costs slide – graph if the estate is left as it currently is. Only 2026 managed to achieve a 50% discount per ESU. Ask of the peer group members: feedback and engagement. PS raised that (looking at a local perspective) refresh cycles are in place and the challenges faced for funding and resources availability. Windows 10 was needed for legacy applications. Concern for the timing – pressures for between now and end of financial year. AT welcomes this and trying to do for years. Consideration for business model and replacing of devices. This will help with being smarter with current structures. Digital operations linking to establish baseline. Keen to revisit the medical devises conversation – future agenda item. DT raised the opportunity of looking to exploit bring your own device as most people have smart devices. JS raised that WAST have some bespoke requirements/devices as an ambulance service and some links into things like NARU and the Manchester Arena enquiry that will drive things out of sync with it (timing wise), but broadly agrees with points made so far. IB raised the need to look at whether buying something a bit better may cost slightly more but lasts longer and be overall better value for money and more affordable option. VC added that this is an opportunity for doing something nationally for procurement and challenging costs. Leasing of ICT equipment opportunity needs a review.	

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	Summary: supportive but more rationale needed to land in organisations in a better way. Collective view for a model of delivery conversation is needed prior to discovery. SL to look to review proposal at an early stage of engagement.	
6.	**National Target Architecture** IE introduced and thanked organisations for all the support and amount of work achieved so far. MJo provided the following update: 114 comments received and briefing doc produced as an outcome MJo presented the following: - Level 0 slide - Reference to the open architecture logic layer section - Level 0 roadmap provided in section 4. Framework of what looks good. - Section 5 – governance and standards breakdown. - Roadmap sizing – breakdown of roadmap sizing - Appendix and Dependencies matrix – last slide A lot of effort from organisations and thanks. IE added that the structure will be helpful for mapping a defined target architecture. We should be on DDaT Leadership Board agenda for January for discussion and for Chief Execs. Strategic investment plan also underway for end of March 2026. Channel 3 have completed their contracted work. Next steps: engage with wider key stake holders with the aim to refine and amend for a single picture of a national architecture. IB positive on completed NTA work achieved and it is helpful. Reflection needs on the design it into governance so we don't comprise the achieved process made. May need to really engage with Chief Execs. VC reflected upon the language/lense presented has positively changed following listening to feedback via the sessions and boards and thank you for adapting. COL raised the perspective of a Chief Exec and that they would want to understand where the reds and greens are and how do we get to green? What are the priorities, risks, strengths, highlight at DDaT Board and weaknesses, impact on IMTP over the next 3 years. SM added that framing is important for Chief Exec's for what the next steps are to be taken. AT asked if there had been a reflection on previous architecture piece of work? IE confirmed there was a 2019 review. More of a conceptual review and impacted by COVID. AT added that the journey story would be a useful mechanism to remind Chief Execs and Teams of the good progress made. IE would appreciate a steer on language to use with Chief Execs to ensure successful engagement and landing.	

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	MJo extended offer to speak individually to health board's what the national architecture means and how to shape the conversations suiting individual pressures. **Summary:** thank you for Channel 3 for all the work and health boards for successful engagement. add to agenda in DDaT in January or February. What are the hooks for the workforce e.g. Medical directors? COL raised that case studies would assist. AT added the golden thread and day in the life of are good. How do this link with funding and priorities – how does this fit in with once for Wales?	
7.	**Future NHS Workforce Solution Programme** Contract signed and awarded few days ago. Currently high level detail for approach and build. AJ presented the presentation. Pilot and waves slide: 11 out of 13 organisations happy or be an early adopter for the system. More detail of what this will look like to come. Programme governance slide: working with Helen Arthur to see how this feeds into Welsh Government Transform, Optimise, Improve data, keeping engaged slides: asks for organisations to prepare Will return to dods peer group for updates and engagement opportunities QR code on last slide or programme updates and resources AT commented on the comprehensive and clear structure. Critical few years for significant work and how seamless transition for future discussions. What do we need to do to deliver from a capability perspective. IB queried if there was linking in with data and integration in the NDR as this would be hugely beneficial. AT added the significant impact and undertaking and a workforce plan based on data rather than assumption is best. AJ replied that NHS Wales will have a flow into architecture and then having a regional level before local level. How to fundamentally restructure ESR to answer ongoing questions. JS thanked AJ for presentation. Data/IG link into groups – AI bias and some clarity on this would be useful. Processes of handing off existing ESR built into self-assessment? AJ added the need to capture this information in readiness via the assessment highlighting dependencies you have individually in ESR Need to identify any gaps that haven't been captured. SR looking forward to this and exciting piece of work. Clarity on governance and what the group looks like, tor, accountability, responsibility etc. AJ proposed governance structure included within the slide deck. Understanding with Helen Arthur on Welsh Government involvement level TBC. SR asked for further details on the scope and what is the scope as an early adopter of the model? AJ confirmed Infosys will be confirming this on 13th November. COL highlighted the key message is adopting not adapting. DoDs will see transformation of workforce and nudges into finance and refined information.	

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	Digital transformation opportunity – the mapping of this will create a service transformation. Bringing together the devices lifecycle programme of work. How can a DoD present a whole package of information for programmes linking together to present/explain to stakeholders. CM raised the importance of lessons learnt from old ESR. Adapt and flexible system for creation of new roles would be beneficial. AJ added that the future work force solution and the important things (must do and must haves) which feed into design workshops. How do we gather bug bears in current system to plan into the workshops in the new year. PS highlighted the concerns raised in ABUHB for ESR and volume of work required. Meeting next week for discussion. Good to see building something bespoke rather than buying something off the shelf. **Summary**: reinvite to future meeting. Thank you for attending and looking forward to developments.	
8.	**Programme Typology and Commercial Typology** Shared with Welsh Government and endorsed. IE will share slides with DoDs for comment. MJ highlighted the need for a DoD voice to be heard with Welsh Government taking into consideration local and regional worries. IE encourages a collective recommendation in advance of Chief Execs and Welsh Government meeting. VC enquired if Shared Services have something similar? Worth a scope for DHCW to explore. PS raised the absence of clarity for the roles and responsibilities from the start. VC added the need to the understand beforehand to give structure and reason of why something fits into a tier. IB highlighted the discussions around programmes today has been around correct governance. IE raised that the escalation implementation group need to share with DoD's and Welsh Government (for testing, clarity on roles and responsibilities, consistency) to understand as the new programmes in 2026 can have the opportunity to come up to speed allowing for application of the framework. IB raised the need to standardise across all organisations.	**001- IE**
9.	**AOB** • AI – IE Update provided the update that the Corporate Governance Network are supportive of an All Wales Policy. SR is happy to encourage AI alongside setting clear consistent guidance on its use. MJ – clarity and consistent guidance across all organisations on the software used e.g. Copilot, Gemini, ChatGPT etc. **Summary:** AI to be discussed at future meetings	

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	• App go-live washup – IE Appointments and Referral features went Live last week. Thank you to all staff involved and for the effort/support shown. Next steps: displaying appointment type for users (video or in person appointments), enhancing location details. Looking to expand to more subspecialities so will engage with teams in organisations to ensure there isn't any confusion for patients. Future planning (not included in this year's roadmap): efficiency or symptom options, attachments for appointments (e.g. pre assessment information, advisory, links). CM asked about patients who may be accessing care in England. IE confirmed that the architecture does allow for English systems to access NHS Wales App relying on the CDR. App will require organisational codes in order to apply filters. Building into the App access if there isn't a Welsh GP registration. CVUHB aim to go Live by the end of November as stepped back to allow for successful Go Live dates for other Health Boards/Trusts. • DOP-DOD-DOF – IE Proposal from DOP's and DoF's to share digital roadmap for a clear street from Welsh Government on digital priorities for 2026. COL added that requests have been made outlining the benefits of the digital investments and what can be brought forward. Would like to highlight the number of pressures the volume of work is creating on all areas. Belief that a combined DoD/DoP/DoF meeting would hold value to shape plans collectively, key messages, and agree priorities for local, regional and national choices. SM raised supportive of a combined in person meeting. IB raised the importance of highlighting that with the digital agenda and national programmes the resources are at their maximum. Reflecting that wide range of progress and working towards a common place is key. COL aggreed that if the whole picture of work was presented DoF's understanding will have the insight they don't usually have. **Summary:** Meeting to be organised for Friday 5th December for relevant groups. • M365 – SL Reference to paper circulated day prior for developing a training and adoption package for Copilot licences. Currently there are 1500 licences across the system but then all staff have access to Copilot Chat which is secure. Aim is to train staff in the correct use of AI in the workplace. Adoption is low: 12,000 using Copilot Chat when there are 140,000 licences.	
	End of meeting	
	Details of next meeting:	
	The next **DODs Peer Group meeting** will be taking place on **Friday 5th December 2025** in **Taf Room, DHCW Cardiff, Tŷ Glan-yr-Afon, 21 Cowbridge Rd East, Cardiff CF11 9AD** with Teams accessibility for those joining virtually	

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DIRECTORS OF DIGITAL PEER GROUP MEETING

MEETING NOTES

Date: Friday 5th December 2025

Time: 9:30am – 12:30pm

Location: Taf Room, DHCW Cardiff / Microsoft Teams

Attendance

Digital Directors Present	
Initials	**Name**
COL	Claire Osmundsen-Little (DHCW)
DO	David Owen (PTHB)
DT	David Thomas (CVUHB)
GD	Gareth Daniels (VNHST) - deputising for CT
IB	Iain Bell (PHW)
IE	Ifan Evans (DHCW)
MJ	Matt John (SBUHB)
PS	Paul Solloway (ABUHB)
SL	Sam Lloyd (DHCW)
SM	Stuart Morris (CTMUHB)
SR	Sian Richards (HEIW) - **Chair**
VC	Vicki Cooper (PTHB)

Apologies	
Initials	**Name**
AT	Anthony Tracey (HDUHB)
BR	Bryn Harries (NWSSP)
CM	Claire Madsen (PTHB)
DR	Dylan Roberts (BCUHB)
JS	Jonny Summat (WAST)
SS	Said Shadi (NHSPI)

Agenda Item	Discussion	Action
	Welcome and Apologies • Previous Meeting Notes Approval • Action Log - reviewed and updated. On going Actions: clinical coding improvements, enterprise agreement and resource pressures. • AOB – AI Principles, Clinical Coding, Maternity system implementation	

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2.	**DDaT Digital Advisory Group – 9:45am – 10:45am** **CLOSED MEETING**	
3. National Cyber Metrics	DHCW is developing a national cyber report for monthly presentation to the DDaT Leadership Board, aiming to establish a unified view of NHS Wales' cyber posture and build a case for future cyber investment. The report will cover key areas including current threat landscape, incident response, national initiatives, and technical metrics such as weak passwords, dormant accounts, obsolete operating systems, and incident counts. There are 169 open objectives from recent Cyber Assessment Framework (CAF) audits, indicating significant room for improvement. National SOC functionality exists but lacks 24/7 coverage and full features, prompting calls for investment in a fully operational SOC for Wales Workshops planned for early next year will refine metrics and reporting formats with cyber leads to ensure accurate, contextualised, and actionable information Key challenges include inconsistent password policy enforcement, legacy system vulnerabilities, and recruitment/retention of cyber specialists across NHS Wales Governance gaps remain, with no formal national cyber governance group integrated into Welsh Government structures; current forums fill some gaps but lack formal authority. **Summary:** The group agreed to push for inclusion of cyber and information governance in the national governance framework. The proposal to centralise third-party supply chain management using a solution like Risk Ledger was welcomed to reduce risk and improve efficiency across shared suppliers.	
4. NTA Project	The NTA project team are reviewing the initial draft of the target state architecture produced by Channel 3, focusing on refining the applications layer and reconciling target state designs with existing live data and integrated layers with a plan up update the DDaT Leadership Board in January. The concept of the Welsh Health Data Space was discussed as a potential unifying term and improve stakeholder understanding. **Strategic Investment Plan (SIP) Development** SIP due by the end of March. IE described the plan for the forthcoming strategic investment plan, which will outline high-level priorities, required business cases, and sequencing	

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	for digital investment over the next several years, with an emphasis on device readiness, migration, and the need for increased internal architectural capacity. **Alignment with Prevention and Public Health** IB raised concerns about ensuring that the technology and architecture workstreams adequately address prevention and public health, not just secondary care. The group discussed the importance of joint sessions with directors of public health and the need to reflect prevention priorities in strategic planning. Conversation questioned the link with the blueprint work and closer collaboration not competition was required with these areas of work.	
5. DODs – DOPs Meeting	**Joint DoF and DoD meeting** COL discussed the outline of the joint meeting on 23rd January outlining the principles and outcomes – further details to be shared. **Finance & Digital Inflation** DHCW managing tight finances; digital inflation outpaces general inflation; Microsoft licensing negotiations ongoing; health boards urged to review license volumes. **Public Accountability** DHCW preparing for public accountability meeting; support and positive feedback from health boards encouraged. **Governance, Leadership, and Financial Constraints** Discussion highlighted the fragmented governance structure, the lack of a Chief Digital Officer for Wales, and the challenge of aligning digital priorities with limited financial resources. The group agreed to focus on articulating clear priorities and value propositions for digital investment in the context of cost pressures and productivity demand	
6. Microsoft EA negotiations	**Microsoft Enterprise Agreement Negotiations** COL and SL provided a detailed update on digital finance management, procurement challenges, the impact of inflation, and ongoing negotiations with Microsoft regarding the enterprise agreement and licensing costs. SL explained the challenges in negotiating the new Microsoft enterprise agreement, including the transition to the SPA framework, the request for a new clinical licence SKU, and the impact of public scrutiny on pricing. The group is awaiting formal pricing from Microsoft and considering long-term strategic alternatives if negotiations are unfavourable. **Licence Volume and Cost Management**	

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	COL asked all to review their licence volumes and ensure directors of finance are aware of baseline uplifts, as increases in underlying volumes could significantly affect overall costs. The group discussed the importance of aligning licence types with actual usage patterns.	
7. AOB	**Financial and Contractual Pressures Impacting Digital Programmes** DHCW is managing significant financial risks with a tight budget, facing pressures from inflation, programme slippage, and contractual negotiations, notably with Microsoft The VAT challenge on Microsoft licensing is ongoing with HMRC and NHS Scotland, affecting cash flow but DHCW will absorb interest costs without recharging health boards No additional funding is expected for the LIMS programme next year, with potential £3.3 million cost increases if project slippage occurs; this is largely due to clinical resource constraints impacting testing and go-live schedules Microsoft Enterprise Agreement renegotiations face challenges due to new UK public sector frameworks limiting discounts; DHCW is lobbying for a new clinical licence SKU to better fit NHS Wales' user profiles Pricing figures are expected imminently, with potential for significant cost increases. The strategic relationship with Microsoft is at a crossroads, with DHCW signalling possible exploration of alternatives if negotiations fail. Health boards are urged to review licence volume baselines closely to manage cost exposure ahead of final agreements. Capital disbursements, including for Connecting Care devices (£4.1 million), are under scrutiny with pressure to accelerate spend to avoid financial clawbacks The WCCIS programme faces ongoing integration and clinical risk issues, notably the lack of registration integration between BadgerNet and PAS systems, flagged as a significant clinical safety concern by midwifery leads Local resource shortages and complex technical requirements threaten the end-March go-live, with health boards expressing doubts about meeting this deadline. The governance and clinical assurance around this programme have been insufficient, requiring stronger national wrap-around support. Lessons from intensive care system and WCCIS governance failures underline the need for clear national leadership and resourcing for single-system implementations to avoid fragmented local efforts and increased costs The digital finance outlook anticipates inflation between 8% and 16% for next year, exceeding general inflation, driven by pay, supply chain, and exchange rate factors, compounding budgetary pressures.	

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	DHCW is focusing on demonstrating the digital dividend by quantifying operational savings from digital investments (e.g., 32 whole time equivalents saved via RPA) to reinforce funding arguments with finance directors **Strategic Alignment and Prioritisation for Digital Transformation** There is a shared recognition of the need for the digital leadership group to define a clear set of digital priorities over the next 2–3 years, balancing replacement programmes with transformational initiatives focused on prevention, community care, and patient engagement The group emphasised the importance of working collaboratively with planning and finance teams to position digital as a key enabler of efficiency and value, ensuring investment is aligned with service transformation goals The complexity of governance and funding structures requires a coordinated approach to avoid silos and ensure digital investments support broader health system goals Directors stressed the need to bring clinicians into digital governance and change programmes early to secure buy-in and drive adoption, noting a current lack of clinical representation at governance levels The importance of maintaining momentum on existing infrastructure and digital maturity improvements, while articulating an ambitious vision for the future, was highlighted as critical for sustaining stakeholder support and securing funding Upcoming sessions and engagement activities, including the 23 January DDAT Leadership Board workshop, will focus on affordability, value realisation, and defining achievable digital priorities within constrained financial contexts The group acknowledged ongoing challenges of resource pressures, competing priorities, and balancing short-term delivery with long-term strategic planning, underlining the need for clear communication and shared understanding across NHS Wales	
End of meeting		
Details of next meeting:		
The next **DODs Peer Group meeting** will be taking place on **Tuesday 13th January 2026 9:30am – 2:30pm** on **Microsoft Teams only**.		

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DIRECTORS OF DIGITAL PEER GROUP MEETING

MEETING NOTES

Date: Tuesday 13th January 2026

Time: 9:30am – 2:30pm

Location: Microsoft Teams

Attendance

Digital Directors Present	
Initials	**Name**
AT	Anthony Tracey (HDUHB) **- Chair**
SR	Sian Richards (HEIW) **- Vice Chair**
BR	Bryn Harries (NWSSP)
COL	Claire Osmundsen-Little (DHCW)
DO	David Owen (PTHB)
DJ	Dafydd James (PHW) - deputising for IB
DT	David Thomas (CVUHB)
EG	Elin Griffiths (VUNHST) - deputising for CT
IE	Ifan Evans (DHCW)
IR	Ian Rawlings (NHSPI) - deputising for SS
JP	Justine Parry (BCUHB) – deputising for DR
MJ	Matt John (SBUHB)
PS	Paul Solloway (ABUHB)
SM	Stuart Morris (CTMUHB)
SL	Sam Lloyd (DHCW)
VC	Vicki Cooper (PTHB)

Apologies	
Initials	**Name**
CM	Claire Madsen (PTHB)
CT	Carl Taylor (VNHST)
DR	Dylan Roberts (BCUHB)
IB	Iain Bell (PHW)
JS	Jonny Summat (WAST)
SS	Said Shadi (NHSPI)

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Guest Speakers	
Initials	**Name**

AM	Alison Maguire (DHCW)
KF	Katharine Fletcher (NWSSP)
JS	Jonathan Sullivan (NWSSP)
LP	Laura Panes (DHCW)
MS	Michelle Sell (DHCW)
RL	Rebecca Lynne (DHCW)
MW	Mike Williams (Channel 3 Consulting)

Agenda Item	Discussion	Action
1.	Welcome and Apologies • Previous Meeting Notes Approval - approved • Action Log - check with SR for updated version • Request for AOB items	
2. Chair Nominations	The peer group agreed to nominate SR as Chair and MJ as Vice Chair from February, following a customary two-year term by AT. Thanks was shared by group members for AT in his role as Chair.	
3. RISP /LIMS/WPOCT/Cardiac PAS updates	• RISP The RISP programme faces delivery and contractual challenges with Philips as the single supplier under 10 discrete contracts, causing fragmented management and accountability issues. The current contract management team comprises mainly operational managers lacking the necessary legal and financial accountability, necessitating identification of senior contract owners with decision authority. The commercial team is developing a contract management blueprint to standardise accountability, improve contract enforcement, and avoid late-stage escalations. • LIMS The LIMS implementation faces critical delays with revised go-live dates for blood sciences in July and blood transfusion in August 2026, accompanied by excessive costs requiring negotiation for cost reductions. AM reported strong support from the board for bringing in external specialist testing resources to accelerate delivery, despite some health board concerns; this external support is needed immediately to avoid further delays. A high-risk proposal to abandon the 'trickle feed' data migration in favour of a 'big bang' go-live for blood transfusion across multiple health boards was discussed, with some boards assessing operational risks and contingencies. The programme is under pressure as several health boards received end-of-life notices for Telepath/Daedalus systems	

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	expiring by March 2027, making timely delivery critical to avoid unbudgeted costs. A £3.3 million funding gap for Q1 2026/27 was raised by COL, with a roughly 50/50 split between capital and revenue costs, stressing that Welsh Government is unlikely to provide additional funds, placing the burden on health boards collectively. Health boards were urged to brief their Directors of Finance ahead of the crucial joint meeting with Chief Executives and digital leads scheduled for late January to ensure preparedness for financial decisions. Positive progress was noted with the successful live deployment of Cellpath in SBUHB, providing confidence and lessons for future rollouts. MJ requested formal documentation on the external resource proposals and risk assessments to enable clear communication and challenge within health boards • WPOCT Update to be provided soon. Has a national contract already in place. • Cardiac PAS Would be good to compare against the new Once for Wales requirements and definition of operating model and working alongside DHCW.	

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4. Digital Tail End Spend Solution and Value-Added Reseller Agreement for Software Licences	Directors%20of%20Digital%20Presentation • Value-Added Reseller Agreement for Software Licences Peer Group members supportive for the improvement of value for money. Device modernisation piece of work SL has been developing could be worth linking in with. **Summary:** supportive and keen to have more detail. Extended invite to attend future peer group meeting with developments. • Digital Tail End Spend Solution Finding standardisation for what is already being bought. Organisation control what goes into catalogues alongside standard items. Demonstration available at conferences and KF/JS can arrange. **Summary:** supportive, more detail and more definition along with a timeline.	
5. RISP contract management	RISP Contract Management - Direct Importance of having up to date list for go list contract owner/manager as different prior to go live. Who holds accountability for these contracts in each organisation? Difference of role and responsibilities and clarity needed as differing in each organisation and making sure the right people are sitting within these roles and holding the responsibilities. **Summary:** Bring to future DODs meeting for further discussion: learning for managing different contracts. MS requested names on the list to be confirmed for each organisation.	
6. Target Architecture / Digital Blueprint	Tektology meeting with all NHS organisations and invites are in calendars.	
7. Target Architecture Strategic Investment Plan	SIP_Presentation.pptx MS presented the Strategic Investment Plan (SIP) aligned to the National Target Architecture (NTA), aiming to create a clear,	

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	evidence-based narrative and prioritised roadmap for digital investment in NHS Wales over the next 3–5 years. Digital Directors were urged to support engagement activities and allocate team time despite competing priorities to ensure comprehensive input and consensus. Digital Directors highlighted the importance of aligning the SIP with broader strategic visions for healthcare delivery, such as community-based care models, to ensure investments support future operating models. The SIP will serve as a tool to inform new government ministers and policymakers of the essential scale and sequencing of digital investment required for NHS Wales. **Summary:** MW to write out to DoDs the request for collect data into Ardoq (information requested will be listed). Request will be going to all NHS organisations.	
8. AOB Regan,Nikki 09/02/2026 11:27:07	• SS EMRAM - IE Is there interest for another assessment in each organisation. DHCW funded last assessment, would need to look at funding options. Consideration needed for value it would bring along with other pieces of work being undertaken and reported upon. IE will raise again at February meeting for further discussion and decision. • Digital Maternity Cymru – PS Support from DHCW has been valuable for the implementation at ABUHB. Recommended that organisations are to link with DHCW for support going forward. • Request for peer group members to check disbursements for Q4 – COL • M365 EA negotiations – SL/COL Working with Livingstone for negotiations which has brought additional insight, challenging existing arrangements and supportive. Taking learning forward from the process and huge thanks to the team working on this. Revised offer expected by Thursday 15th January. • VAT negotiations ongoing – COL. • Critical Care – SM DHCW are chasing for decision for go live date from Minister • Eye Referrals – MJ Concern the timeline is too short for work needed for delivery. DT wanting to explore Open Eyes and Referral system working	**001 – IE** **002 - All**

	together. COL to follow up with DHCW team who are working on the Referral System for an update.	
End of meeting		
Details of next meeting:		
The next **DODs Peer Group meeting** will be taking place on **Tuesday 3rd February 2026 9:30am – 4pm** at **Woodland House, Maes-Y-Coed Road, Cardiff CF14 4HH**		

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