Public Audit Committee

Tue 12 March 2024, 09:00 - 11:30

Velindre University NHS Trust Headquarters

Agenda

1.0.0 STANDARD BUSINESS

Led by Gareth Jones, Acting Chair of the Audit Committee

1.2.0 In Attendance

Led by Gareth Jones, Acting Chair of the Audit Committee

1.3.0 Declarations of Interest

Led by Gareth Jones, Acting Chair of the Audit Committee

1.4.0 Draft Minutes from the Public Part A Audit Committee meeting held on 19 December 2023

Led by Gareth Jones, Acting Chair of the Audit Committee

1.4.0 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 19 DECEMBER 2023 cm(GJ).pdf (9 pages)

1.5.0 Draft Minutes from the Public Part A Extraordinary Audit Committee meeting held on 12 January 2024 (To Follow)

Led by Gareth Jones, Acting Chair of the Audit Committee

1.6.0 Action Log Public Part A Audit Committee

Led by Gareth Jones, Acting Chair of the Audit Committee

1.6.0 Public Audit Committee Action Log updates for March 2024 Committee.pdf (9 pages)

2.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

2.1.0 Trust Risk Register (To Follow)

Led by Matthew Bunce, Executive Director of Finance

2.2.0 Trust Assurance Framework (To Follow)

Led by Matthew Bunce, Executive Director of Finance

2.3.0 Review of Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit

Led by Matthew Bunce, Executive Director of Finance

2.3.0a Audit Action Tracker Cover Paper 12 March 2024 Audit Committee.pdf (14 pages)
2.3.0b Appendix 1 - Red Overdue and Orange Not on Target Recommendations Actions Audit Committee 12 March 2024.pdf (3 pages)
2.3.0c Appendix 2 - Audit Action Tracker - Updated December 2023 - 12 March 2024 Auditi Committee.pdf (22 pages)

2.4.0 Clinical Audit Report and Annual Plan (Oral Update)

Led by Matthew Bunce, Executive Director of Finance

3.0.0 EXTERNAL AUDIT

Led by Katrina Febry and Steve Wyndham (Audit Wales)

3.1.0 Annual Audit Report 2023

Led by Katrina Febry and Steve Wyndham (Audit Wales)

3.1.0 VUNHST Annual Audit Report 2023.pdf (20 pages)

3.2.0 Audit Position Update

Led by Katrina Febry and Steve Wyndham (Audit Wales)

3.2.0 VUNHST Audit Cmt 202403 Audit Update.pdf (10 pages)

3.3.0 Annual Plan for 2024 (interim)

Led by Katrina Febry and Steve Wyndham (Audit Wales)

3.3.0a Cancer Services Project Brief.pdf (16 pages)
3.3.0b NHS letter - final 23-24.pdf (10 pages)

4.0.0 INTERNAL AUDIT

Led by Simon Cookson, Director of Audit & Assurance (Audit and Assurance Services)

4.1.0 2023/24 Internal Audit Progress Update

Led by Simon Cookson, Director of Audit & Assurance (Audit and Assurance Services)

4.1.0 Velindre University NHS Trust March 2024 AC Progress Report.pdf (7 pages)

4.2.0 Annual Plan 2024 (Oral Update)

Led by Simon Cookson (Audit and Assurance Services)

4.3.0 Education Strategy Audit Report

Led by Simon Cookson (Audit and Assurance Services)

4.3.0a Cover Paper Education Strategy Internal Audit Report March 2024 Audit Committee.pdf (5 pages)
4.3.0b VT 23-24-05 Education Strategy Final Report.pdf (12 pages)

4.4.0 Private Patients Audit Report

Led by Simon Cookson (Audit and Assurance Services)

4.4.0a Cover Paper Private Patients Internal Audit Report March 2024 Auditi Committee.pdf (5 pages)
4.4.0b Vel Private Patients Final Internal Audit Report.pdf (11 pages)

4.5.0 Estates Assurance: Estates Condition Audit Report

Led by Simon Cookson (Audit and Assurance Services)

4.5.0a Cover Paper Estates Condition Interal Audit Report March 2024 Audit Committee_.pdf (5 pages)
4.5.0b VUNT-SSU-2324-02 Estates Condition Final Report.pdf (26 pages)

5.0.0 COUNTER FRAUD

5.1.0 Counter Fraud Progress Report Quarter 4 23/24

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 5.1.0a Board Committee Report Cover Sheet PUBLIC.pdf (7 pages)
- 5.1.0b VELINDRE Q4 COUNTER FRAUD PROGRESS REPORT - PUBLIC.pdf (5 pages)

5.2.0 Annual Plan 24/25

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 5.2.0a Board Committee Report Cover Sheet ANNUAL PLAN.pdf (7 pages)
- 5.2.0b VUNHST CF ANNUAL PLAN 24-25.pdf (24 pages)

6.0.0 FINANCE

6.1.0 Private Patient Service Plan

Led by by David Osborne, Head of Finance Business Partnering

- 6.1.0a Audit Committee Private Patient Report Mar 2024 Final.pdf (6 pages)
- 6.1.0b PP Action Plan 28.02.2024.pdf (2 pages)

6.2.0 Private Patient Service Debt Position

Led by by David Osborne, Head of Finance Business Partnering

- 6.2.0a Audit Committee - Aged Debt Private Patient Service Mar 2024 Final.pdf (6 pages)
- 6.2.0b PP Aged Debt Appendix One Mar 2024.pdf (1 pages)

6.3.0 Losses and Special Payments Report

Led by Tracy Hughes, Head of Financial Operations

- 6.3.0 AC Losses and write offs paper March 24.pdf (3 pages)

6.4.0 Receipt of Finance Technical Updates

Led by Tracy Hughes, Head of Financial Operations

- 6.4.0 Technical update March 2024 Final.pdf (4 pages)

7.0.0 ADMINISTRATION

7.1.0 Audit Committee Annual Report

Led by Gareth Jones, Acting Chair of the Audit Committee

- 7.1.0 Audit Committee Annual Report Jan - Feb 2024 Draft.pdf (15 pages)

8.0.0 CONSENT AGENDA

Led by Gareth Jones, Acting Chair of the Audit Committee

8.1.0 Endorsement For Approval

Led by Gareth Jones, Acting Chair of the Audit Committee

8.1.1 Audit Committee Terms of Reference

Led by Matthew Bunce, Executive Director of Finance

8.1.1a Audit Committee Terms of Reference Cover Paper.pdf (6 pages)
8.1.1b Audit Committee Terms of Reference MB.pdf (9 pages)

8.2.0 For Noting

Led by Gareth Jones, Acting Chair of the Audit Committee

8.2.1 Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

8.2.1 Procurement Report to Dec 23 to 23 Feb 24 Audit Committee v2.pdf (27 pages)

8.2.2 Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria (To Follow)

Led by Matthew Bunce, Executive Director of Finance

9.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

10.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

11.0.0 ANY OTHER BUSINESS

By prior approval of the Acting Chair of the Audit Committee

12.0.0 DATE AND TIME OF THE NEXT MEETING

Wednesday 10 July 2024 at 10:00AM

13.0.0 CLOSE

The Committee is asked to adopt the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

MINUTES OF THE PUBLIC AUDIT COMMITTEE
MICROSOFT TEAMS
TUESDAY 19 DECEMBER 2023 AT 10:00AM

PRESENT:	
Gareth Jones	Acting Chair and Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Carl James	Director of Strategic Transformation & Digital
Chris Moreton	Deputy Director of Finance
Darren Griffiths	Audit Wales
Steve Wyndham	Audit Wales
Stephen Chaney	Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)
Huw Richards	Head of Capital & Estates Team (Audit and Assurance Services)
Melanie Goodman	Audit Manager (Audit and Assurance Services)
Alison Hedges	Business Support Officer

		Action
1.0.0	**Standard Business** Led by Gareth Jones, Acting Chair, and Independent Member	
	Introduction Led by Gareth Jones, Acting Chair and Independent Member	
1.1.0	**Apologies** Led by Gareth Jones Apologies were received from: • Martin Veale, Chair of Audit Committee and Independent Member • Matthew Bunce, Executive Director of Finance • Steve Ham, Chief Executive Officer • Lauren Fear, Director Corporate Governance & Chief of Staff • Jacinta Abraham, Executive Medical Director • David Osborne, Head of Finance Business Partnering • Katrina Febry, Audit Wales • Simon Cookson, Director of Audit & Assurance • Emma Rees, Deputy Head of Internal Audit • Gareth Lavington, Lead Local Counter Fraud Specialist • Rachel Hennessy, Interim Director of Velindre Cancer Services	
1.2.0	**In Attendance** Led by Gareth Jones Gareth Jones welcomed attendees from Audit Wales and Internal Audit Services to the Audit Committee Meeting.	
1.3.0	**Declarations of Interest** Led by Gareth Jones No declarations of interest were declared.	
1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 19 October 2023** Led by Gareth Jones The AUDIT Committee **AGREED** the minutes of the meeting held on the 19 October 2023.	
1.5.0	**Action Log** Led by Gareth Jones **10/2023 1.5.0 Action Log - 07/2023 10.1.0 - Private Patient Service Debt Position** **10/2023 7.1.0 FINANCE - Private Patient Service Debt Position.** The Committee agreed both items would be discussed later in the agenda and would remain open. **10/2023 4.1.0 EXTERNAL AUDIT - Audit Position Update.**	

	Gareth Jones sought confirmation on when the financial efficiencies work would commence. Darren Griffiths confirmed Audit Wales are currently rolling work out across health boards with a view to rolling it out to the Trust and some smaller bodies late January/beginning of February 2024. **10/2023 8.1.1 Revision to Standing Orders / Standing Financial Instructions.** Vicky Morris clarified that the action was about the Committee structure and the query raised in relation to inconsistences between the narrative in the standing orders, particularly as to whether the Integrated Quality and Safety Group should be shown in the governance structure diagrams. The action remained open as Lauren Fear has not yet had the opportunity to liaise with Vicky Morris. The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions.	
2.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
2.1.0	**Trust Risk Register** Led by Carl James, Director of Strategic Transformation & Digital Carl James took the Committee through the report and highlighting paragraph 3.1 which detailed the changes to risks since the November board meeting. It was important in terms of closing risks down to manage risk appetite and to highlight the next steps of the process for managing risks across the organisation. One of the key elements is embedding that in the culture of the way we do things in the organisation. Accordingly, education and training were noted as specific areas of focus. Vicky Morris raised questions in relation to risk 3184 and 3215. ****ACTION: Risk 3184 has been mitigated from 16 to 8 based on someone being put into the post but they have not yet started so she felt concerned the scoring had been downgraded when someone is still not in post.** **Carl James agreed with the point raised. The appointment is positive but that does not reduce the risk until the person is in post. Carl James will investigate the detail of this and will report back to the Committee.** ****ACTION: Risk 3215 in relation to the incident where there was robust investigation but concerned that the mitigation set out in the report has not been seen by Audit Committee or QS&P Committee. The Committees need to see the action plan that has arisen from that incident so that they can take assurance from what is proposed.** **Carl James agreed to provide the action plan to the Committee for assurance and will pose that question to the Team to see what level of assurance is in place to ensure mitigation.** **This will also be brought into the QS&P Committee.** Gareth Jones asked for clarity around the risks that drop below the risk reporting threshold and asked what visibility we have that those risks are being managed and mitigated. Carl James assured that if the risks are below 12 or 15, they are being managed, as the overall Trust Risk Management Framework approach makes sure risks are identified at the appropriate level of management as part of the normal review and monitoring process. Also need to look at the triangulation of risks. ****ACTION: Gareth Jones raised a question regarding the volume of smaller risks below the reporting threshold across the Trust and whether these might pose a cumulatively greater risk together.** **Carl James responded that it is a case of number versus impact, could not say how many risks the organisation is currently managing but it may be possible to understand the number of risks, the level, and the likely impact as reported in Datix. Carl James will speak to Lauren Fear regarding this to look at potential options for reporting going forward.** Carl James confirmed the Corporate Governance Team monitors the number of risks in Datix. At a functional level the Directors of that function have oversight over the specific functional risks and at a cross cutting level, it is the Executive Management Board and the Committees. Vicky Morris highlighted that it would be helpful for this Committee to receive a paper from each of the divisions over the next two or three Committees, as the Divisional Leads should be able to	**CJ and LF** **CJ and LF** **CJ and LF**

	demonstrate their management of the lower scale risks and being called to Audit Committee on how they manage those risks would be helpful. The Committee agreed this would be picked up with Lauren Fear in between or at the next Audit Committee. The Committee recognised that the update format was helpful with the ongoing management of the Risk Register, now giving updates, together with the likely timescales to reduce the risk score. The AUDIT Committee **NOTED** the risks of 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and the on-going developments of the Trust's risk framework.	
2.2.0	**Trust Assurance Framework** Led by Carl James, Director of Strategic Transformation & Digital Carl James took the Committee through the report. Vicky Morris valued the candid update, but expressed concern with the pace of developing the TAF, which was required to enable the strategic risks to be updated. Gareth Jones noted that the two outstanding risks had gone to Executive Management Board on 18 December 2023. The Board said they wanted to agree those two strategic objectives and needed to do so in a meeting rather than out of Board. Gareth Jones asked for clarification if it is the intention for it to go to the January 2024 Board meeting for that discussion to then have a finalised list of risks in the TAF. Chris Moreton responded that in relation to the strategic risk regarding Financial Sustainability and long-term value, the team are currently updating the risk. Gareth Jones clarified that the original strategic risks came to Strategic Development Committee and agreed six but two needed further development, then the Board had agreed it would be helpful to have a separate meeting to discuss at Trust Board of the totality of those risks. Vicky Morris suggested it would be helpful to have a Board Development session to focus on strategic objectives included in the Integrated Medium-Term Plan (IMTP) and that mapping process. The Board must have a detailed discussion about the strategic objectives and the risks against those. The Board and the Executive Team need to underpin that with all the risks, mitigations and assurances contained within the TAF and then it is up to Divisional Teams to manage those risks. Need to push as an Audit Committee that the Board has more time discussing this TAF. Chris Moreton confirmed this aligns with the plan and expectations of Executive Management Board to make sure the Trust has a completed TAF in preparation for January 2024 Board. Carl James recognised the frustration and agreed to feed this back. ****ACTION: Carl James suggested that on 30 January 2024 the Trust Board has the opportunity to review the completed TAF. Liaise with Corporate Governance Team at agenda setting for the January Board to bring as a separate item.** **Sub points need to pick up Strategic objectives, IMTP and Strategic risks and how they all map across to each other and then the TAF itself. Lauren Fear to keep updated on that progress so that a view can be taken at board on how much of the detail can be collected.** ****ACTION: The Committee were unsure if the TAF should be coming to Audit Committee for assurance rather than noting as it is brought to Audit Committee to provide feedback to Board. The Committee were happy to note on this occasion. Carl James will have a discussion with Lauren Fear if this should be endorsed for approval in future.** The Audit Committee **NOTED** the Trust Assurance Framework.	**CJ and LF** **CJ**

3.3.0	**Review of Audit Action Tracker – Review of Overdue and Completed outstanding Recommendations / Actions from Internal & External Audit** Led by Chris Moreton, Deputy Director of Finance Chris Moreton took the Audit Committee through the report. Chris Moreton took the Committee through the **Red / Overdue Actions - Appendix 1:** • **Capital Systems Final Internal Audit Report – Matter Arising 1: Governance - Capital Procedures (Operation) -** Requested an extension until 31 December 2023. This has been to Executive Management Board and is on the Audit Committee Agenda. • **Trust Priorities - Final Internal Audit Report = Matter Arising 1 - Enhancements to the prioritisation process (Design). -** Requested an extension to 29 March 2024. Meetings have been held with the divisional Senior Leadership Teams and with the Trust Executive Management Board so the extension would give more time to ensure the action is taken accordingly. • **External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust Recommendation 5 - Improving reporting on the benefits arising from digital investments.** Previous request was for an extension to 31 April 2024, but in the December update this has been marked as complete. Carl James has had a discussion with Kate Febry on how we monitor our digital investments internally. The Committee agreed to keep this as the requested extension of April 2024 but noted this was closed and would be closed formally at next Committee meeting. Chris Moreton took the Committee through further updates since the paper was produced: • **Digital Strategy & Transformation Programme - Final Internal Audit Report Matter Arising 4 - Digital Inclusion (Operation) –** Listed in Appendix 2 as requesting a deadline until 30 November 2023. The December update extension request is for January 2024. • **External Audit Report - Review of Workforce Planning Arrangements – Velindre University NHS Trust – Recommendation 4 - Exit surveys –** Listed in Appendix 2 as Deadline of December 2023. The December Update requesting Extension to end of January 2024. • **External Audit Report - Review of Workforce Planning Arrangements – Velindre University NHS Trust - Recommendation 2 - Developing workforce intelligence.** There has been some correspondence to look at the ownership and accountability of the action across the Executive team with it possibly shifting to more of an operational focussed action. This is being worked on to make sure that there is agreement across the Executive team that the action is owned in the right place and secondly to be in contact with Audit Wales to make sure if we are suggesting a change to the action is also agreed. This is in progress and not completed yet. Vicky Morris felt the Executive Lead who was originally assigned should prepare a separate paper for Audit Committee because of the need to understand what works already been undertaken and then what should happen to see this is being actively manged. Gareth Jones commented that a requested extension date is needed and felt that the Responsible Executive Director Lead should not be changed as if we are doing the recommendation , it doesn't matter who's doing it. Carl James responded that it is a workforce issue and we do have a Director of Workforce and whilst they will not be responsible for doing all those activities, they are responsible for ensuring we have a fit for purpose workforce to deliver our services. The Committee wanted to feedback to Executives about the ongoing improvements with timely response to Audit Reports and actions and recommendations, and then the enactment of those.	

	****ACTION: The Committee considered the Executive Director accountability is appropriate for the action and Chris Moreton and Carl James agreed to feed this back to the relevant Executives and Directors.** ****ACTION: Gareth Jones stated that it would be helpful on the table to have a column which shows the date when the recommendation was first made because that is missing currently and it does not show when the Committee were first aware of this and what has been done since.** The Committee recognised the improvement on these recommendations from where they were. The AUDIT Committee **AGREED** the requested extension dates and **AGREED** to formally closing the complete (green) actions to blue status.	**CM and CJ** **MB**
2.4.0	**Clinical Audit Report (Oral Update)** Led by Chris Moreton, Deputy Director of Finance Chris informed the Committee of the need to make sure there is appropriate representation from the Clinical team at the Audit Committee and a report going forward to address the governance arrangements and requirements. Vicky Morris agreed that there needs to be a seamless process for the clinical audit updates and flagged that this had not been to QS&P Committee for some time. The expectation needs to be clear in terms of frequency and preparation of the papers. ****ACTION: The Audit Committee require the Medical Director or a suitable delegate to ensure a Clinical Audit Report is provided for the next Audit Committee.**	**JA**
3.0.0	**EXTERNAL AUDIT** Led by Darren Griffiths (Audit Wales)	
4.1.0	**Audit Position Update** Led by Steve Wyndham and Darren Griffiths (Audit Wales) Steve Wyndham took the Committee through the accounts section and highlighted the completed 2022-2023 audit work in terms of the Trust accounts and confirmed that in the New Year, they will be contacting Officers in relation to the 2023-2024 audit. Steve advised he has had a meeting with Matthew Bunce to discuss. Currently undertaking the audit of charity fund accounts, on track to compete that work by end January 2024. The Audit Plan was not presented to the Charitable Funds Committee in December as it was not ready in time, so it will be going to the Committee in January 2024 at same time as the accounts audit report. Vicky Morris recognised the delays in previous audit and sought reassurance if realistically going to achieve these by year end and asked if this could be more of contemporaneous timing in future. Steve Wyndham responded that this is in a better position this year than last year and he felt Audit Wales would achieve a completion by an earlier date this year but not significantly so. Audit Wales are working through scheduling and resource planning and once complete will be writing to NHS bodies in relation to this. Steve Wyndham assured the Committee the fee consultation was undertaken earlier this Autumn and submitted to Finance Committee at the Senedd and been approved. Darren Griffiths took the Committee through the performance audit work and noted that they have completed 2023 Structured Assessment work and a report issued in draft form, have received organisation response, are working through comments, and this will be brought to this Committee for consideration in the New Year. Audit Wales are due to start the review of financial efficiencies work in the New Year towards the back end of January 2024 / beginning of February 2024 and are tailoring their approach to the smaller bodies. They have several outstanding pieces of local work and apologised for the delays due to resource challenges within the health team but advised they were now back on track and that Katrina Febry will be in touch with leads in New Year. Gareth Jones raised concern that some of the audits have not been commenced. For example, the Local Study Operational Governance work in the 2022 Audit Plan has not commenced and the Trust	

	would not want to be criticised because it is materially late and the Trust doesn't know when it will be sequenced. Darren Griffith took full responsibility for the delay and reassured there will be discussions with the Trust regarding the order of priority. The AUDIT Committee **NOTED** the report.	
4.0.0	**INTERNAL AUDIT** Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)	
4.1.0	**2023/24 Internal Audit Progress Update** Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services) Stephen Chaney took the Committee through the report and highlighted: • The audits are on track. Have a pipeline of work that is moving forward. Everything is scheduled for completion by the year end. Three in progress currently. • Expected to finish the remainder of the work in quarter 4. • Have a review scheduled around nVCC Enabling Works for 2023/2024 but still one in progress for 2022/2023, therefore, sought approval for cancellation of the nVCC Enabling Works 2023/24 audit. • Key Performance Indicators remain on track, the only outlier is timeliness of management responses which is not causing significant problems currently. The Committee felt moving work into quarter 4 adds pressure onto teams. In relation to management response, the Committee appreciated that everyone is busy and were glad it has not delayed work but felt as a Trust, we need to make sure we can respond in a timely manner. Stephen Chaney assured that regarding the delay to quarter 4, Internal Audit tend to pick up larger reviews at the start of the year and that the true nature of progress is probably greater than what it may seem. With Velindre work on a group of two-three audits at different stages. Everything is resourced and work is on track. The AUDIT Committee **NOTED** the report and **AGREED** to the cancelling of the nVCC Enabling Works 2023/2024 audit.	
4.2.0	**Continuity Audit Report** Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services) Stephen Chaney took the Committee through the reasonable assurance Audit Report. The Committee felt that Welsh Blood Service come across as having robust and well-established processes and Velindre Cancer Services not as developed. Stephen Chaney responded that Internal Audit were satisfied to that the report should come out as reasonable overall; there was a gap between the Divisions but not one that was concerning. The Committee were assured that the management action bullet points are not in order of priority. Chris Moreton highlighted the action that states 'Establish a business continuity group' and wanted to provide assurance that actions are taken already and Velindre Cancer Services do have Business Continuity arrangements through the Senior Leadership Team and also make use of Welsh Blood Service good practice, which is shared across the Trust. The AUDIT Committee **NOTED** the report.	
4.3.0	**Recruitment & Retention Audit Report** Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services) Stephen Chaney took the Committee through the reasonable assurance Audit Report.	

	Vicky Morris highlighted a few concerns from the report that did not give much assurance: • 2022 strategy being approved but not communicated across the Trust. • Recruitment and Selection Policy has not been approved. • Effectiveness of the R&R Initiatives needs to be developed. • ARR Group in place and not met since last year doesn't provide assurance. • Does not triangulate with receipt of the Workforce planning audit received at the last Audit Committee and the fact the action plan had not been in place. • No stand-alone plan to support deliverables. Stephen Chaney responded that the review focused on what is being done to improve recruitment and retention, there was a strategy and saw that a lot was embedded throughout the organisation. He agreed that the reasonable assurance was borderline but they did find that what should be done is being done, and there is documentation in place. Carl James confirmed we offer pay pensions and employee assistance programmes, we are working with local HEIW around international recruitment and locally we need to look at what can do to leverage the Velindre reputation and how can we attract people. ****ACTION: The risks identified by Vicky Morris need to be linked back to the TAF as there are some key risks against the implementation. The implementation part of the strategy and the robustness and timeliness of that needs to be picked up. Sarah Morley to pick this up with Vicky Morris to gain assurance.** The AUDIT Committee **NOTED** the report.	**SM**
4.4.0	**nVCC Approvals Audit Report** Led by Huw Richards, Head of Capital & Estates Team (Audit and Assurance Services) Huw Richards and Melanie Goodman took the Committee through the reasonable assurance Audit Report. The AUDIT Committee **NOTED** the report.	
4.5.0	**nVCC Planning Audit Report** Led by Huw Richards, Head of our Capital & Estates Team (Audit and Assurance Services) Melanie Goodman took the Committee through the reasonable assurance Audit Report. The AUDIT Committee **NOTED** the report.	
5.0.0	**COUNTER FRAUD**	
5.1.0	**Counter Fraud Progress Report Quarter 3 23/24** The Committee considered the report which had been prepared by Gareth Lavington, Lead Local Counter Fraud Specialist, who was unable to be present at the meeting. The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	
6.0.0	**FINANCE**	
6.1.0	**Private Patient Service Review - Actions Update Report (Oral Update)** Led by Chris Moreton, Deputy Director of Finance Chris Moreton explained to the Committee that there had been capacity constraints and some challenges with regards to resilience in the Private Patient project and Finance Team. There has been a challenge in relation to translating the improvements recommended by the project and putting them into practice. Work is ongoing and the Trust have received an update on progress from *Liaison* but further work is required to develop a plan. Key Performance Indicators such as Days' Sales Outstanding need some manual adjustments made to the finance data to apply unallocated cash in order to get the data right at source. Chris Moreton advised that it was important for the Audit Committee to note that this is not impacting the Trust's ability to undertake the Business as Usual work of raising invoices and chasing debts for private patient work.	

	Chris Moreton confirmed the team will address the preventative measures, look at timelines for the application of the unallocated cash and include training and education in the plan. The Committee agreed that a comprehensive plan should be produced, ideally for the planned Extraordinary Structured Assessment January 2024 meeting but advised that if the Private Patient Report is not ready when the extraordinary meeting is scheduled, a single meeting for the Private Patient plan could be received in a separate meeting. The Committee required sight of the Private Patient plan ahead of the next schedule Audit Committee meeting. **Action: Chris Moreton to prepare a Private Patient plan for presentation to the Committee.** The AUDIT Committee **NOTED** the oral update.	**CM**
6.2.0	**Private Patient Service Debt Position (Oral Update)** Led by Chris Moreton, Deputy Director of Finance As above in Item 6.1.0.	
6.3.0	**Losses and Special Payments Report** Led by Chris Moreton, Deputy Director of Finance The AUDIT Committee **REVIEWED** and **NOTED** the report.	
6.4.0	**Receipt of Finance Technical Updates** Led by Chris Moreton, Deputy Director of Finance There were no Technical Updates to be presented at this Committee meeting.	
7.0.0	**CONSENT AGENDA** Led by Gareth Jones, Acting Chair of the Audit Committee	
7.1.0	**ENDORSE FOR APPROVAL** Led by Gareth Jones, Acting Chair of the Audit Committee	
7.1.1	**Capital Management Procedure** Led by Chris Moreton, Deputy Director of Finance Chris Moreton explained to the Committee that this is the updated Capital Management Procedure, which has been taken through governance process internally, been to Executive Management Board and been brought to Audit Committee for endorsement for final approval. Gareth Jones noted the requirement from Welsh Government to have a bank account for each project if over £2 million. Chris Moreton confirmed the awareness of that requirement and have been working to manage that requirement in terms of specific projects. The AUDIT Committee **ENDORSED** this procedure for approval.	
8.3.0	**FOR NOTING** Led by Gareth Jones, Acting Chair of the Audit Committee	
8.3.1	**Procurement Compliance Report** Led by Chris Moreton, Deputy Director of Finance The AUDIT Committee **NOTED** the report.	
9.0.0	**HIGHLIGHT REPORT TO THE TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting.	
10.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	None.	
11.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
12.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 12 March 2024 at 10:00am.	

13.0.0	**CLOSE**	
	The meeting CLOSED at 12.03pm.	

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 19 October 2023 Meeting			
10/2023 1.5.0	**Action Log.** **07/2023 10.1.0 - Private Patient Service Debt Position - The Private Patient paper states there wasn't any capacity within the Corporate Finance Debtors Team to support the Private Patient Debtors Team. It was confirmed this is inaccurate and will be amended as they are progressing work to review the unallocated cash.**	**ACTION: David Osborne**	**OPEN**	**DO**
10/2023 7.1.0	**FINANCE - Private Patient Service Debt Position.** **Gareth Jones questioned if the Key Performance Indicators targets to be agreed were actuals now of where the Trust is and are they Key Performance Indicators as such, as there is an interest specifically on how quickly we issue the invoices in respect of the treatments that's covered by them and there is no target for those two measurables.** **David Osborne agreed that it is a profile of debt as opposed to a Key Performance Indicator and agreed to take that back to the improvement group to do a true performance Key Performance Indicator review rather than a profile statement.**	**ACTION: David Osborne**	**OPEN**	**DO**

10/2023 8.1.1	**Revision to Standing Orders / Standing Financial Instructions.** **Vicky Morris raised the question of whether the Integrated Quality and Safety Group should be included in the diagrams as there is inconsistency between PowerPoints and the narrative.** **Lauren Fear clarified that this is not part of Committee structure. Lauren Fear will pick this up with Vicky Morris outside of the meeting to ensure all feedback is incorporated.**	**ACTION: Lauren Fear**	**OPEN**	**LF**
	Actions from 19 December 2023 Meeting			
12/2023 2.1.0	**Trust Risk Register** **Risk 3184 has been mitigated from 16 to 8 based on someone being put into the post but they have not yet started so she felt concerned the scoring had been downgraded when someone is still not in post.** **Carl James agreed with the point raised. The appointment is positive but that does not reduce the risk until the person is in post. Carl James will investigate the detail of this and will report back to the Committee.**	**ACTION: ~~Carl James and Lauren Fear~~** **Rachel Hennessy**	**OPEN** **March 2024:** **This action will be re-allocated to the Chief Operating Officer when recruited into post.** **Currently Rachel Hennessey will pick up in the interim.**	**~~CJ and LF~~** **RH**

12/2023 2.1.0	**Trust Risk Register** **Risk 3215 in relation to the incident where there was robust investigation but concerned that the mitigation set out in the report has not been seen by Audit Committee or QS&P Committee. The Committees need to see the action plan that has arisen from that incident so that they can take assurance from what is proposed.** **Carl James agreed to provide the action plan to the Committee for assurance and will pose that question to the Team to see what level of assurance is in place to ensure mitigation.** **This will also be brought into the QS&P Committee.**	**ACTION: ~~Carl James and Lauren Fear~~** **Rachel Hennessy**	**OPEN** **March 2024:** **Rachel Hennessey to provide action plan to the Audit Committee.**	**~~CJ and LF~~** **RH**
12/2023 2.1.0	**Trust Risk Register** **Gareth Jones raised a question regarding the volume of smaller risks below the reporting threshold across the Trust and whether these might pose a cumulatively greater risk together.** **Carl James responded that it is a case of number versus impact, could not say how many risks the organisation is currently managing but it may be possible to understand the number of risks, the level, and the likely impact as reported in Datix. Carl James will speak to Lauren Fear regarding this to look at potential options for reporting going forward.**	**ACTION: Carl James and Lauren Fear**	**OPEN** **March 2024:** **This will be picked up as part of the risk framework.**	**CJ and LF**

12/2023 2.2.0	**Trust Assurance Framework** **Carl James suggested that on 30 January 2024 the Trust Board has the opportunity to review the completed TAF. Liaise with Corporate Governance Team at agenda setting for the January Board to bring as a separate item.** **Sub points need to pick up Strategic objectives, IMTP and Strategic risks and how they all map across to each other and then the TAF itself. Lauren Fear to keep updated on that progress so that a view can be taken at board on how much of the detail can be collected.**	**ACTION: Carl James and Lauren Fear**	**OPEN** **March 2024:** **The revised TAF has been completed for 2023 – 2024.** **The risk register and TAF will be mapped across into the IMTP Strategic Objectives.** - **Target date: End of March 2024**	**CJ and LF**
12/2023 2.2.0	**Trust Assurance Framework** **The Committee were unsure if the TAF should be coming to Audit Committee for assurance rather than noting as it is brought to Audit Committee to provide feedback to Board. The Committee were happy to note on this occasion. Carl James will have a discussion with Lauren Fear if this should be endorsed for approval in future.**	**ACTION: Carl James**	**OPEN** **March 2024:** **Lauren Fear and Carl James to meet to discuss further.**	**CJ**

12/02023 2.3.0	**Review of Audit Action Tracker – Review of Overdue and Completed outstanding Recommendations / Actions from Internal & External Audit** **The Committee considered the Executive Director accountability is appropriate for the action and Chris Moreton and Carl James agreed to feed this back to the relevant Executives and Directors.**	**ACTION: Chris Moreton and Carl James**	**CLOSED** **March 2024:** **CM provided feedback from the Audit Committee to the relevant Executive members (MB, SM, COB, CJ, LF). The matter was discussed at EMB Run with subsequent conversations taking place with relevant directors and Audit Wales. Following these discussions, it was agreed that the action should sit with the Chief Operating Officer and Director of Welsh Blood Services and Velindre Cancer Services. The action has been updated further with a requested extension date being brought to the March 2024 Audit Committee.**	**CM and CJ**
12/2023 2.3.0	**Review of Audit Action Tracker – Review of Overdue and Completed outstanding Recommendations / Actions from Internal & External Audit** **Gareth Jones stated that it would be helpful on the table to have a column which shows the date when the recommendation was first made because that is missing currently and it does not show when the Committee were first aware of this and what has been done since.**	**ACTION: Matthew Bunce**	**CLOSED** **February 2024:** **The final issue date of the Audit Reports with remaining open actions has been added to the Audit Action Tracker heading. This date will be added to the heading column for new Audit Reports going forward.**	**MB**

12/2023 2.4.0	**Clinical Audit Report** **The Audit Committee require the Medical Director or a suitable delegate to ensure a Clinical Audit Report is provided for the next Audit Committee.**	**ACTION Jacinta Abraham**	**CLOSED** **February 2024:** **The process of the Clinical Audit Report and when it should go to Audit Committee on the Cycle of Business has been discussed and an oral update will be given at the March 2024 Audit Committee.**	**JA**
12/2023 4.3.0	**Recruitment & Retention Audit Report** **The risks identified by Vicky Morris need to be linked back to the TAF as there are some key risks against the implementation. The implementation part of the strategy and the robustness and timeliness of that needs to be picked up. Sarah Morley to pick this up with Vicky Morris to gain assurance.**	**ACTION: Sarah Morley**	**CLOSED** **February 2024:** **There was a discussion between VM and SM prior to the January Quality, Safety and Performance Committee. Risks were triangulated in the paper that went to QSP and are now being built upon in March 24 report to QSP.**	**SM**
12/2023 6.1.0	**Private Patient Service Review - Actions Update Report** **Chris Moreton to prepare a Private Patient plan for presentation to the Committee.**	**ACTION: Chris Moreton**	**CLOSED** **March 2024:** **The Private Patient Plan has been added to the March 2024 Audit Committee Agenda.**	**CM**

	Actions from 12 January 2024 Meeting			
01/2024 2.0.0	**Velindre University NHS Trust Structured Assessment Report 2023** **A process needs to be agreed in terms of notifying the Independent Members on day 15 when the minutes are published and what will be done in terms of feedback. This will be brought for discussion in the Independent Members Group.**	**ACTION: Lauren Fear**	**OPEN**	**LF**
01/2024 2.0.0	**Velindre University NHS Trust Structured Assessment Report 2023** **The Committee were uncomfortable with publishing the Committee recordings and felt publishing unapproved minutes early would be the preference but agreed a process around this is needed. The Secretariats and the Corporate Governance Team to discuss and produce a draft process on how this would work.**	**ACTION: Lauren Fear**	**OPEN**	**LF**

01/2024 2.0.0	**Velindre University NHS Trust Structured Assessment Report 2023** **Vicky Morris raised that the report summary states 'the Integrated Medium-Term Plan (IMTP) does not contain clear objectives and actions' and then within the report says 'it is the corporate crosscutting objectives that do not contain those clear objectives and actions' so queried which of these was accurate.** **Katrina Febry confirmed she would review paragraph 14 and stated she was pleased with the objectives and specific actions in terms of Velindre Cancer Services and Welsh Blood Services so that comment does not reflect that. They are SMART actions and in the most recent IMTP they are supported by the intended outcome.**	**ACTION: Katrina Febry**	**CLOSED.** **February 2024:** **KF has amended the text in the report to make it clear that the reference the Integrated Medium-Term Plan (IMTP) does not contain clear objectives and actions relates to cross-cutting objectives only.**	**KF**
01/2024 2.0.0	**Velindre University NHS Trust Structured Assessment Report 2023** **Katrina Febry confirmed that the SMART actions in relation to the Integrated Medium-Term Plan (IMTP) are addressed by a previous recommendation which is being held open which sits in the last appendix of the report. Previous year made recommendations about SMART objectives. Need to check this is being picked up in the current draft of the IMTP.**	**ACTION: Lauren Fear and Carl James**	**OPEN** **March 2024:** **The IMTP and TAF will be mapped across into** **The TAF will be mapped across into the IMTP. SMART objectives will be set.**	**LF and CJ**

01/2024 2.0.0	**Velindre University NHS Trust Structured Assessment Report 2023** **Following a request from Gareth Jones around the length of papers, Katrina Febry agreed to review if there are any good exemplars from other Health Boards. Katrina Febry will feedback to Lauren Fear on this as there are good examples of reports and cover papers, and some which make good use of appendices.**	**ACTION: Katrina Febry**	**CLOSED** **February 2024:** **KF shared with LF some examples of organisations that have generally good, clear, concise reports and cover papers.**	**KF**
01/2024 2.0.0	**Velindre University NHS Trust Structured Assessment Report 2023** **Vicky Morris informed the Committee that within the Quality and Safety Groups Chairs, there are examples of much more succinct papers. Vicky Morris agreed to forward these examples to Lauren Fear.**	**ACTION: Vicky Morris**	**OPEN** **February 2024:** **Sample Papers will be requested at the meeting with the chairs of Q&S committee on the 4th March 2024. An update will be provided at the March 2024 Audit Committee.**	**VM**

AUDIT COMMITTEE
AUDIT REPORT RECOMMENDATIONS ACTIONS

DATE OF MEETING	12/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Audit Committee on reported progress against audit report recommendations and identified management actions.

RECOMMENDATION / ACTIONS	**RECOMMENDATION** • The Audit Committee are asked to **NOTE** the contents of the report and the assurance it provides regarding the activities undertaken to address audit recommendations in response to audit report recommendations and associated risks.

	• The Audit Committee are asked to **APPROVE** the 14 (63.5%) Internal Audit Report actions and 5 (31%) External Audit Report actions have been completed since the December '23 Audit Committee **(Green Status)**. If agreed these actions will be formally Closed **(Blue Status).** • 2 (9%) Internal Audit Report actions and 1 (6%) External Audit Report actions have passed the agreed implementation date **(Red Status)** since the December '23 Audit Committee. The Audit Committee is asked to **APPROVE** the extension dates identified. • The Audit Committee are asked to **NOTE** the actions that are on target for complete by agreed date **(Yellow Status).** • The Audit Committee are asked to **NOTE** the actions that are not on target for completion by the agreed date (**Orange Status**).

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run	29/02/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Audit Action Tracker was taken to Executive Management Board on 02 January 2024 with the 'December 2023 updates', and 01 February 2024 with the 'January 2024 updates'. This 'February 2024 Updates' Report was taken to 29 February 2024 meeting to provide an update to the Executive Management Board on reported progress against audit report recommendations and identified management actions. The Executive Management Board **ENDORSED** for Committee **APPROVAL** the Recommendations / Actions provided in the report.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix 1	Red/Overdue and Orange/Not on Target Recommendations/Actions Audit Committee 12 March 20242.
Appendix 2	Audit Action Tracker – Updated December 2023 – 12 March 2024 Audit Committee

1. SITUATION / BACKGROUND

1.1 The purpose of this report is to provide an update to the Audit Committee on reported progress against audit report recommendations and identified management actions.

1.2 Following the December 2023 Audit Committee further updates from Action owners on implementation progress were sought for December 2023, January 2024, and February 2024 updates. The latest responses have been added to the 'February 2024 Update' columns in the Tracker. Any further extensions to implementation dates were also requested to be provided in the 'Requested Extension Date' and 'Extension (Months)' columns of the Tracker.

1.3 This report focuses on the status of all actions and Audit Committee is requested to consider the contents of the report and the attached action plan.

1.4 This report relates to both internal and external audit review recommendations.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Context

2.1.1 The Audit Report Action Log tracks the status of management actions against the deadlines identified in all internal and external audits reports.

2.1.2 To aid forward planning, the following timetable was shared with Executive / Director Leads which provided the deadlines for responses on all Tracker updates until July 2024, and the Committee meetings these updates will be presented at.

Audit Action Tracker Update Month	Deadline for Responses	EMB Run Meeting Date	Audit Committee Date
February	16 February 2024	29 February 2024	12 March 2024
March	15 March 2024	02 April 2024	

April	15 April 2024	29 April 2024	
May	15 May 2024	30 May 2024	
June	12 June 2024	25 June 2024	15 July 2024
July	18 July 2024	01 August 2024	

2.1.3 The following table provides a key to the status of actions:

KEY TO STATUS OF ACTION	
BLUE	Closed following Audit Committee agreement
GREEN	Action Completed or discharged
YELLOW	Action on target to be completed by agreed date
ORANGE	Action not on target for completion by agreed date
RED	Implementation date passed - Action is not complete

2.2 Internal Audit Actions Analysis

2.2.1 Four Internal audit reports were added to the Audit Action Tracker following the December '23 Audit Committee which included 9 Matters' arising with 13 recommendations, of which 12 were medium priority and 1 was low priority. In response to these Internal Audit recommendations management identified 13 actions. The reports added were:

- Business Continuity Final Internal Audit Report
- Recruitment & Retention Final Internal Audit Report
- MIM Commercial Approval Points Final Internal Audit Report
- New Velindre Cancer Centre Final Internal Audit Report

2.2.2 Work undertaken by Management / Officer leads to complete actions since the December '23 Audit Committee has resulted in 14 Internal Audit actions being completed.

2.2.3 The table below provides a summary of the movement in total internal audit actions from December '23 Audit Committee to 12 March '24 Audit Committee.

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
December '23 Audit Committee					
Total Outstanding Actions	**23**	0	13	10	0
Less: Completed Actions (Green) – Agreed by Audit Committee to close (Changed to Blue)	(14)	(0)	(8)	(6)	0
Following December '23 Audit Committee					
Total Outstanding Actions	9	0	5	4	**0**
Add: Total Actions from new reports presented by Internal Audit to December '23 Committee	13	0	12	1	**0**
Total Outstanding Actions	**22**	**0**	**17**	**5**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 02 January '24 (Update December 2023)	**3**	**0**	**1**	**2**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 01 February '24 (Update January 2024)	**5**	**0**	**3**	**2**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 29 February '24 (Update February 2024)	**6**	**0**	**6**	**0**	**0**
Total Completed Actions (Green) - propose close (Blue) @ March '24 Audit Committee	**14**	**0**	**10**	**4**	**0**
Total Outstanding Actions @ 12 March '24 (excludes completed actions)	**8**	**0**	**7**	**1**	**0**

2.2.4 An action came out of Executive Management Board requesting a summary table including External Audit Reports. The table below provides a summary of the movement in total external audit actions from December '23 Audit Committee to 12 March '24 Executive Management Board.

External Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
December '23 Audit Committee					
Total Outstanding Actions	**12**	6	6	0	0
Less: Completed Actions (Green) – Agreed by Audit Committee to close (Changed to Blue)	(3)	(3)	(0)	(0)	0
Following December '23 Audit Committee					
Total Outstanding Actions	**9**	**3**	**6**	**0**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 02 January '24	**1**	**1**	**0**	**0**	**0**
Add: Total Actions from new reports presented by External Audit to January '23 Extraordinary Committee	**7**	**1**	**6**	**0**	**0**
Total Outstanding Actions	**16**	**4**	**12**	**0**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 01 February '24	**1**	**0**	**1**	**0**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 29 February '24	**3**	**1**	**2**	**0**	**0**
Total Completed Actions (Green) - propose close (Blue) @ March '23 Audit Committee	**5**	**2**	**3**	**0**	**0**
Total Outstanding Actions @ 12 March '24 (excludes completed actions)	**11**	**2**	**9**	**0**	**0**

2.2.5 The tables below provide a summary of the audit action status position.

February '24 – Internal Audit

Priority	2022/23	2023/24	Total
No. of Audit Reports	21	11	**32**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	3	19	**22**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete December 2023	Action complete January 2024	Action complete February 2024	Closed
High	0							10
Medium	17	2	1	4	1	3	6	116
Low	5			1	2	2		77
N/A (Advisory Audit)	0							10
Total Open Actions	**22**	**2**	**1**	**5**	3	5	6	213
% Open Actions	**100%**	**9%**	**4.5%**	**23%**	**13.5%**	**23%**	**27%**	**N/A**

Action Status by Executive / Director Lead

Executive Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete December 2023	Action complete January 2024	Action complete February 2024	Closed
Executive Director of Finance	2				1	1		64
Director of Strategic Transformation, Planning & Digital	3	1		2				40
Director of Governance & Chief of Staff	0							22
Director of Nursing, AHPs & Health Science	0							8
Director of OD and Workforce	4					2	2	8
Chief Operating Officer	4		1		1	1	1	29
TCS nVCC Project Director	6	1		2			3	19
Executive Director of Finance and Chief Operating Officer	0							2
Chief Operating Officer and Director of Governance & Chief of Staff	0							10
Executive Medical Director	1				1			11
Director of Strategic Transformation, Planning & Digital and Executive Director of Finance	2			1		1		0
Total	**22**	**2**	**1**	**5**	**3**	**5**	**6**	**213**

Red Action Status by Audit Year: Implementation date passed - Action not complete

Priority	2022/23	2023/24	Total
High			
Medium		2	2
Low			
N/A (Advisory Audit)			
Total	0	2	2

2.2.6 There are 2 (9%) actions for which the implementation date has passed and management action is not complete (Red).

2.2.7 There are 14 actions (63.5%) since the December '23 Audit Committee that have been completed.

2.2.8 There are 5 actions (23%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.2.9 There is 1 action (4.5%) identified as not on target to be completed by agreed implementation date (Orange).

2.3 External Audit Actions Analysis

2.3.1 1 External audit report was added to the Audit Action Tracker following the January '23 Extraordinary Audit Committee which included 6 Recommendations, of which 5 were medium priority and 1 was high priority. In response to these Internal Audit recommendations management identified 7 actions. The report added was:

- Structured Assessment 2023 – Velindre University NHS Trust

2.3.2 Management / Officer leads have completed 5 actions (31%) since the December '23 Audit Committee.

2.3.3 The tables below provide a summary of the audit action status position.

February '24 – External Audit

Summary of No. of Audit Reports and Actions Outstanding by financial Year

Priority	2023/24	Total
No. of Audit Reports	4	**4**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	16	**16**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete December 2023	Action complete January 2024	Action complete February 2024	Closed
High	4			2	1		1	12
Medium	12	1		8		1	2	3
Low	0							2
N/A (Advisory Audit)	0							35
Total	**16**	**1**	**0**	**10**	**1**	**1**	**3**	**52**
%	**100%**	**6%**	**0%**	**63%**	**6%**	**6%**	**19%**	**N/A**

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implement-ation on date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete December 2023	Action complete January 2024	Action complete February 2024	Closed
Executive Director of Finance	3			3				10
Director of Strategic Transformation, Planning & Digital	2			1	1			5
Director of Governance & Chief of Staff	7			5		1	1	20
Director of Nursing, AHPs & Health Science	0							2
Director of OD and Workforce	3			1			2	11
Chief Operating Officer	1	1						2
Director Corporate Governance & Chief of Staff & Executive Director Nursing, AHP and Health Science.	0							2
Total	**16**	**1**	**0**	**10**	**1**	**1**	**3**	**52**

2.3.4 There is 1 action (6%) for which the implementation date has passed and management action is not complete (Red).

2.3.5 There are 5 actions (31%) since the December ’23 Audit Committee that have been completed.

2.3.6 There are 10 actions (63%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.3.7 There are no actions identified as not on target to be completed by agreed implementation date (Orange).

2.4 Summary of the position as of 12 March 2024:

- 14 (63.5%) Internal Audit Report actions and 5 (31%) External Report actions that have been completed **(Green Status)** and will be requested to be changed to closed **(Blue Status)** at the March '24 Audit Committee.
- 5 (23%) Internal Audit Report actions and 10 (63%) External Audit Report actions are on target for completion by the agreed date **(Yellow Status).**
- 1 (4.5%) Internal Audit Report action and no External Audit Report actions are not on target for completion by the agreed date (**Orange Status**).
- 2 (9%) Internal Report actions and 1 (6%) External Audit Report action have passed their agreed implementation date (**Red Status**).

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
	Select all relevant domains below

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *There are no specific quality and safety implications related to the activity outlined in this report.* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

	Not applicable for this report **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not applicable Equality Impact Assessments would be undertaken where any of the actions proposed in response to a recommendation require that, for example where a new policy is developed or existing policy changed, a change to a service provision etc.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

Appendix 1. Overdue / Red Actions / Recommendations.

Internal Audit.

Digital Strategy & Transformation Programme - Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 October 2023	Date Final Report Issued: 10 October 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 4	**Digital Inclusion (Operation).** Work to progress the digital inclusion action plan and digital skills and awareness within the organisation should be accelerated.	Medium	A Digital Inclusion action plan is in place. This will be reviewed and opportunities where the work can be accelerated will be identified and included in the next IMTP where appropriate. Where further investment would be required to accelerate the work a business case will be prepared for EMB.	Carl James, Director of Strategic Transformation, Planning & Digital	Carl Taylor, Chief Digital Officer	30th November 2023 Extension request agreed December 2023 Audit Committee 30 January 2024	Overdue	The request for additional non-recurrent revenue funding for Digital Inclusion was approved by EMB. Action plan will be updated according for Jan '24.		A summary of the Digital Inclusion plan will be presented to the March '24 SDC meeting and the action presented for closure.	Requested Extension Date: 21 March 2024.	4	2	

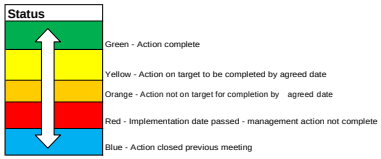
MIM Commercial Approval Points Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 December 2023	Date Final Report Issued: 04 December 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed	
Matter Arisng 2	**Matter Arising 2: Timeliness of closure of recommendations (Operation).** 2.3 The disparity between the September 2023 Project Board CAP4 report and associated minutes should be reviewed and corrected if necessary.	Medium	2.3 The Project Board minutes will be reviewed and, if need be, amended at the next Project Board.	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	December 2023	Overdue			This action is being investigated to clarify that it can be closed. Hopefully to be marked as complete in the March 2024 update.				

Business Continuity Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 December 2023	Date Final Report Issued: 03 November 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Matter Arising 1: Velindre Cancer Centre Business Continuity Arrangements (Design).** 1.1 In taking forward the actions of the Business Continuity & Emergency Planning Work Programme, management should ensure the following is in place for VCC: business continuity plans covering all business continuity scenarios for all departments, with alignment between the departments anddivisions; a clear approval process for business continuity plans; a rota of testing for departmental business continuity plans; a business continuity divisional group; and a centralised location to hold electronic versions of departmental business continuity plans which is accessible to all staff.	Medium	1.1 To continue progressing with the Trust Business Continuity & Emergency Preparedness programme and implement the above via; • Completion of Business Impact Analysis and Business ContinuityPlans Implementation of a quality management system with approval process and provide a centralised location (sourcing electronic management system) Review the Trust's policies of policies to ensure governance for Business Continuity Plans is clear and accurate Review Exercise, Test & Training Programme to be adopted within VCC or on a Trust widebasis Establish Velindre Cancer Centre business continuity group	Cath O'Brien, Chief Operating Officer	Mark David, Business Planning Manager / Operations	March 2024	Not on Target	Ongoing as part of the Trust Business Continuity & Emergency Preparedness Programme. Meetings have been held to review the programme, with completed activities on the current programme being marked as completed / closed, including Velindre Cancer Centre embedded Business Continuity into its Cynefin group. Ongoing work continues to prioritise and progress the programme in its entirety. Trust wide EQMS procurement finalised and progressing (project likely to surpass March 2024 implementation date). Note; currently business continuity focus for Velindre Cancer Centre during December to January has been on the planning and response to the BMA Industrial Action which remainsongoing.	Ongoing as part of the Trust Business Continuity & Emergency Preparedness Programme, limited progress since previous update due to ongoing pressures and industrial action priority which continues. Updates to Trust Policy for Policies requested, to be progressed in coming weeks. Centralised location progressing through project for EQMS, likely to surpass end of March deadline. Exercise, Test & Training programme updated, priorities for VCC being identified for 2024. Cynefin Group met with Business Continuity embedded in routine agenda, group established bimonthly frequency from April - complete.	30/09/2024 Extension requested in February update due to the ongoing planning and response to industrial action and other ongoing service pressures impacting on capacity to complete all department / services business impact analysis and continuity plans. A number of the audit actions that remain outstanding that relate to a central repository for plans, clear approval process and aligning testing to annual review dates will be complete upon implementation of a EQMS which is progressing outside of the business continuity resource and is known to exceed end of March for implementation. Progress has been made to complete other actions identified as stated in January and February updates. Exercise, Test & Training requirements being finalised this month. Updates to the Trust policy for policies no longer required as not applicable to divisional documentation and implementation. Approval process will be via implementation of EQMS within VCC.	6	1	

External Audit.

External Audit Report - Review of Workforce Planning Arrangements – Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 19 October 2023	Date Final Report Issued: August 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 2	**Developing workforce intelligence.** The Trust is developing a baseline of current workforce capacity to inform its Supply and Shape framework. The Trust should do more to understand the extent of workforce planning activity across its business and to understand future service demand and risk. The Trust should develop a consistent approach to model future service demand to understand the longer-term human and financial resource implications and potentialrisks to the organisation (medium priority).	Medium	The Trust will develop an approach to model future service demand which takes account of the longer-term human and financial resource implications and potential risks to the organisation	Cath O'Brien, Chief Operating Officer	Rachel Hennessey, Interim Director of VCS Alan Prosser, Director Welsh Blood Service	First Workshop in November 2023 A full project plan to be developed following the November session Proposed date 31 July 2024 for completion of the first phase of work.	Overdue	The Management action to this recommendation has been reworked to take account of the wider remit, beyond workforce planning, of that recommendation. This will be a service led piece of work which will then take account of workforce and financial triangulation in respect of service planningJDuly 2024 for reasons specified in December update	Service and workforce conversations ongoing throughout January 2024	WBS workshop planned March 4th to map demand capacity plans and current workforce planning arrangements. Recognition that demand plans and workforce plans need to join up formerly to provide a framework for signing off. Learning and agreed actions to be shared with VCS to allow VCS to consider best approach. In addition, Director of WBS met lead auditor to align expectations against recommendation on February 7th 2024..	31 July 2024 – For completion of the first phase of work to agree a detailed project plan. To develop the consistent approach to modelling future service demand and the longer-term human and financial resource implications and potential risks to the organisation will be a longer timescale. Focusing on implementing this across the Trust..	8	1	

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022	Date Final Report Issued: 10 February 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2023	Update December 2023	Update January 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 1	**Matter arising 1: Late payment of invoices (Operation)** 1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary;	Medium	1.1 a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Matthew Bunce, Executive Director of Finance	N/A	Complete	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 1	1.1 The Trust should: b. liaise with NWSSP Procurement Services and Accounts Payable to understand: i. why such late fees are being charged by BT; and why they have signed agreements that they cannot deliver on; ii. how late fees are accounted for (i.e., are they coded to an appropriate loss account in Oracle); and iii. what the wider performance monitoring and accountability mechanisms are to ensure invoices are paid by their due dates (when this is less than 30 days) and to monitor the level of late payment fees incurred.	Medium	b. The recommendation is accepted. Will liaise with NWSSP Accounts Payable to review and understand as per the recommendations and implement as necessary. 31/07/2022	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/07/2022 November 2022 out of Committee Extention agreed: 31 December 2022. Extension Agreed January 2023 Audit Committee: August 2023.	Action Closed				n/a	12	2	Jul-23
Matter arising 2	Matter arising 2: Exception reporting (Operation) 2.1 The Finance team should: a. undertake a formal, documented monthly review of the exception reports, even if no specific matters are identified through the informal weekly reviews;	Medium	2.1 a. The recommendation is accepted. The Divisions will undertake a more formal review which will be signed off by a senior finance business partner. The review will be put in place by the target date.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 2	2.1 The Finance team should: b. take action to address the aged items on the exception reports; and	Medium	2.1 b. The recommendation is accepted. Discussion will take place amongst the Senior Finance Team to agree action to be taken on aged invoices to address the immediate issue and long-term approach which will form part of the review process under item 2.1.a	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 2	2.1 The Finance team should: c. formally monitor progress in clearing aged items at an appropriate forum to ensure action is effectively implemented	Medium	c. The recommendation is accepted. This will be added to the standard agenda of the Financial management meeting under PSPP.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 3	Matter arising 3: Authorisation of proforma invoices (Operation) 3.1 The Trust should: a. remind its authorised signatories only to approve proforma invoices for payment under appropriate circumstances; and	Low	3.1 a. The recommendation is accepted. A reminder will be issued to all staff.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	28/02/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 3	3.1 b. consider producing documented guidance on authorisation of proforma invoices.	Low	b. The recommendation is accepted. Consideration will be given to producing documented guidance on authorisation of proforma invoices.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 3	3.2 The Finance team should investigate the specific circumstances of the exception noted in our testing (details have Low been provided) to understand: a. whether a duplicate payment has been made;	Low	3.2 a. The recommendation is accepted. The item has been investigated and no duplicate payment made.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed				n/a	n/a	n/a	Jul-22

Audit Action Plan

Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - management action not complete
	Blue - Action closed previous meeting

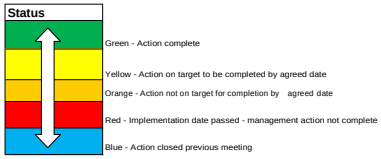
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022	Date Final Report Issued: 10 February 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2023	Update December 2023	Update January 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 3	3.2 b. whether the goods were received; and	Low	b. The recommendation is accepted. The item has been investigated and goods received.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 3	3.2 c. why the proforma was authorised for payment, liaising with NWSSP Accounts Payable if necessary.	Low	c. The recommendation is accepted. NWSSP has advised that this specific supplier operates a cash account requiring payment against estimate before items are released. Practice is not local to the Trust and NWSSP would be required to undertake any further actions in particular ensuring the process for this supplier (and any other suppliers operating cash accounts requiring payment against estimate) is incorporated into any existing documented guidance in place or developedfor proforma invoices.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 4	Matter arising 4: Compliance with Fixed Assets FCP (Operating effectiveness) 4.1 The Finance team should remind the divisions of the requirement to complete, approve and submit asset disposal forms prior to asset disposal, not least to ensure value for money is obtained from assets' residual values.	Medium	4.1 The recommendation is accepted. Reminders will be provided at the Capital Planning Group and Divisional Business Planning Group meetings.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 4	4.2 a. The Trust should update its Fixed Assets FCP to: − reflect actual practice regarding maintenance of the FAR, capital ledgers and AUC and the related reconciliations to the general ledger; and − incorporate the asset verification coverage target of 80%.	Medium	4.2 a. The recommendation is accepted and the FCP will be updated.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 4	4.2 b. The Audit Committee should approve the updated FCP.	Medium	4.2 b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee..	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	31/05/2022 November 2022 out of Commiteee Extention agreed 26 January 2023. Extension Request agreed in April 2023 Audit Committee: 31 July 2023. Extension request agreedin October 2023 Audit Committee 31 December 2023.	Complete	The procedure has been reviewed and received comment from the Capital Planning Group and Strategic Capital Board. The Procedure is on the agenda for EMB run on 4th December where it is expected to be endorsed for approval before being submitted to Audit Committee for approval on the 19th December.	The procedure has been endorsed for approval by EMB and is on the Audit Committee agenda for approval in December.	**Complete** - Action Closed. Procedure was approved at Audit Committee on the 19th December.		19 months	3	Jan-24
Previous Matter arising 1	Previous Matter arising 1: Pursuance of Private Patient (PP) debts (Operating effectiveness) 1.1 a. We concur with the actions taken by the Trust to address the aged Private Patient debt balance. The Trust should maintain its focus on this area through formal continuous monitoring, including reporting to Audit Committee until an acceptable position is reached.	Medium	1.1 a. The recommendation is accepted. A detailed aged debt position has been documented, with monitoring arrangements in place including the status of each debt line and the outcome of actions taken to-date. A standard report will be developed for continuous monitoring by the VCC SMT and EMB and reported to the Audit Committee detailing the position and progress made until the Audit Committee agree they have assurance that private patient debt management is acceptable.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	31/05/2022	Action Closed				n/a	n/a	n/a	Sep-22
Previous Matter arising 1	1.1 b. To support reporting on Private Patient aged debt, the Trust should consider identifying formal key performance indicators with clear targets, for example: • split of debt between self-payers and insured; • percentage of aged amounts vs total debt; • percentage of debt recovered vs total debt (with a similar sub-metric for aged debts); • maximum accepted level for Private Patient aged debts (by percentage and / or value) and monitoring performance against this at an appropriate forum to ensure accountability.	Medium	b. The recommendation is accepted. Key performance indicators are being collated from a patient and financial perspective and the measures identified within this recommendation will be considered and presented to VCC SMT and then EMB for formal approval / sign off.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	30/04/2022	Action Closed				n/a	n/a		Aug-22

Audit Action Plan



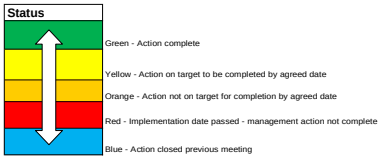
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022	Date Final Report Issued: 10 February 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2023	Update December 2023	Update January 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Previous Matter arising 2	Previous matter arising 2: Unallocated and Unidentified Receipts (Operating effectiveness) 2.1 a. The Trust should: i. discuss the aged unallocated/unidentified receipts position with Counter Fraud, Audit Wales and Welsh Government to understand their view on how this balance should be addressed; and ii. based on the above discussions, take appropriate action to address the aged unallocated/unidentified receipts balance.	Medium	2.1 a. The recommendation is accepted. Discussions will take place with relevant parties and appropriate action taken. Due to the upcoming year end, it is likely that Audit Wales and Welsh Government will wish to prioritise discussions on that, and the target date is therefore reflective of that.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	30/06/2022 **Extension requested to 30/09/2022** **Extension requested to 30/11/2022.** November 2022 out of Commiteee Extension agreed: 30 November 2022.	Action Closed				n/a	n/a		Dec-22
Previous Matter arising 2	2.1 b. We concur with the Finance team's intention to increase the frequency of its Long Term Agreement reconciliation. We recommend that the Finance team should undertake this review at monthly to support and ensure aged unallocated and unidentified receipts balances are reduced to a minimum level, ensuring the review is documented, and evidenced.	Medium	b. The recommendation is accepted. Monthly reconciliations of LTA money due and received are now standard practice.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed				n/a	n/a		Jul-22
Previous Matter arising 2	c. The Trust should ensure the SOP for Private Patients unallocated and unidentified receipts is approved at an appropriate forum (e.g., by the Audit Committee).	Medium	c. The recommendation is accepted. A Departmental SOP has been drafted for the management of unallocated and unidentified receipts, with significant work undertaken to date resulting in a reduction in the reported aged debt position. The SOP will be submitted for approval to the Audit Committee.	Cath O'Brien, Chief Operating Officer	Ann-Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Service	30/04/2022	Acton Closed				n/a	n/a	n/a	Aug-22
Previous Matter arising 3	Previous matter arising 3: Management of Aged Debts (Operating effectiveness) 3.1 We concur with the Trust's continued focus on general and charity aged debts. We further recommend: a. Charity debts: the Trust should formally review its processes for charity invoicing and debt collection, both internally between finance and the divisions and through discussions with relevant charities (particularly Macmillan and Marie Curie) to identify inefficiencies within the process;	Low	3.1 a. The recommendation is accepted. Increased frequency of liaison and enhanced formal processes will be put in place both internally and with partners	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/03/2022	Action Closed				n/a	n/a	n/a	Jul-22
Previous Matter arising 3	3.1. b. General debts: the Trust should consider identifying and monitoring formal key performance indicators with clear targets for general debts, similar to those set out in recommendation 1.1(b) of prior year recommendation 1.	Low	b. The recommendation is accepted. Consideration will be given to identifying and monitoring formal key performance indicators with clear targets for general debts.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022 Complete but request to keep action open until **October 2022 meeting** to allow review	Action Closed				Update October 2022: Complete. Action should have been marked as complete for October 2022 Audit Committee.	n/a	n/a	Sep-22

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022	Date Final Report Issued: 21 April 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department	Agreed Implementation Date	Status	Update October 2023	Update November 2023	Update December 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 1	Matter arising 1: Charitable Funds Policies (Design) 1.1 Management should ensure that all out of date policies are reviewed, updated, approved and made available on the Trust's intranet site as soon as possible.	Low	1.1 Accepted - Due to Covid and capacity issues within the finance team the policy/ procedures were not reviewed last financial year, however the policies and procedures are still relevant so per the recommendation is low priority but recognise that they need to go through the formal process for re-approval.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Jul 2022 November 2022 out of Committee Extention agreed: 31 December 2022 (For one of the three Policies). (Two of the three polices have been approved). Extension Requested to March in December update Further extension requested in February updated to allow CEO to review scheme of delegation before submission to the CFC. Agreed Extension Date in April 2023 Audit Committee: 30 June 2023 (For one of the three Policies). (Two of the three polices have been approved). Extension request agreed in October 2023 Audit Committee 30th December 2023.	Complete	The updated scheme of delegation paper was approved by the CFC on the 7th September. The Policy has been updated to reflect the agreed changes with expectation that it will be approved by the CFC in December.	The updated scheme of delegation paper was approved by the CFC on the 7th September. The Policy has been updated to reflect the agreed changes with expectation that it will be approved by the CFC in December.	Closed - The policy was approved at the CFC meeting in December.		18	3	Dec-23
Matter arising 2	Matter arising 2: Retrospective Purchase Orders (Operation) 2.1 Management should remind requisitioners and approvers that purchase orders should be placed on the Oracle system prior to the goods and services being ordered and received.	Medium	2.1 Accepted – This is policy and should be followed. The Charitable funds finance manager will review monthly reports shared by NWSSP Accounts Payable team and specifically target repeat offenders. A reminder will be sent to all Fund holders and requisitioners.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	May-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 3	Matter arising 3: Appropriate evidence for, and timely claiming of, expenses (Operation) 3.1 Management should: a. communicate to relevant individuals and authorisers the requirement for timely submission of expense claims supported by appropriate evidence; and	Low	3.1 a. Accepted. Whilst we do request a timely submission of claims, the reason this was held up was due to Covid, and this has been confirmed by the consultant in question when asked for the reason in the delay. We do however recognise that this delay is excessive and the employee has been reminded of the importance in submitting claims in a timely manner.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22
Matters arising 3	3.1 b. ensure that expenses submitted late or without appropriate evidence are appropriately challenged before payment and the challenge and justification for payment are clearly documented.	Low	3.1 b. Accepted. This is linked to the above and it is not uncommon for receipts to go missing, however we were aware that the named individual went by flight to Sierra Leone and the cost of the ticket / reclaim was in line with what you would expect to pay. We do however recognise that this needs to be clearly documented, such as printing off an illustration of the cost of a flight to Sierra Leone in order to accompany and support the claim, and articulating this with the employee at the time.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 4	Matter arising 4: Acknowledgement letters (Operation) 4.1 Management should update the 'Database Donation Entry instructions' document to detail when acknowledgment letters are not issued.	Low	4.1 Accepted – the manual will be updated	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22

Audit Action Plan

Velindre UNHS Trust

Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - management action not complete
	Blue - Action closed previous meeting

Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022	Date Final Report Issued: 21 April 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department	Agreed Implementation Date	Status	Update October 2023	Update November 2023	Update December 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 4	4.2 Management should review the 13 receipts identified above to satisfy itself that it was appropriate that an acknowledgement letter was not issued.	Low	4.2 Accepted – review is being undertaken	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 5	Matter arising 5: Allocation of funds (Operation) 5.1 Management should: a. develop guidance on when funds should be allocated to funds other than the general-purpose fund and what supporting evidence should be retained in such circumstances;	Low	5.1 a. Accepted – All funds are donated into the General funds unless specifically requested from a Donor or a fundraising event / activity is raising money for that particular fund. We can develop a quick guide to demonstrate this. It will be in the guidance that we expect written confirmation when donations are requested to be received into another fund, and we will make every effort to ensure that the guidance is followed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 5	5.1 b. confirm that the four above receipts have been posted to the correct fund number code and update the donation database as necessary; and	Low	5.1 b. Accepted – All donations have been reviewed and confirmed that they are in the correct place.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 5	5.1 c. consider whether a review of the accuracy of the information in the database is required.	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 6	Matter arising 6: Incorrect fundraising event noted (Operation) 7.1 Management should: a. remind staff of the need for accurate recording of fundraising events in the donation database;	Low	7.1 a. Accepted - the Fundraising team are aware and have been reminded that it is important that information is recorded accurately in the database.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 6	7.1 b. confirm that the four above receipts have been allocated to the correct fundraiser and update the donation database as necessary; and	Low	7.1 b. Accepted - A review will be undertaken to ensure that the receipts have been allocated to the correct fundraiser, however we are confident that they are in the correct fund for accounting purposes.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	May-22	Action Closed				n/a	n/a	n/a	Jul-22
Matter arising 6	7.1 c. consider whether a review of the accuracy of the information in the database is required (see also MA5).	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed				n/a	n/a	n/a	Jul-22
Ma eth	Matter arising 7: Advancing Radiotherapy Fund Board Terms of Reference (Operation) 8.1 Management should ensure the ARF Board ToR is formally approved and kept under review.	Low	8.1 Accepted – The ToR has been reviewed and regularly updated, however due to the lack of meetings which were stood down for a period during Covid it has delayed formal approval for the latest version. The latest version of the ToR is going to ARF Board on 27th April for approval.	Matthew Bunce, Executive Director of Finance	Moondance Programme Manager / ARF Programme Manager (Elizabeth Crompton) / ARF Admin Support (Hannah Fox)	Apr-22	Action Closed				n/a	n/a	n/a	Jul-22
Previous matter arising 3	Previous matter arising 3: Desktop Procedure - Monies Received (Control design) 3.1 Management should draw up a desktop procedure that details the processes to be followed by the fundraising staff and finance staff for recording, safeguarding and banking of Charitable Funds income.	Medium	3.1 Accepted – a new procedure will be developed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed				n/a	n/a	n/a	Jul-22
Previous matter arising 3	3.2 Management should ensure that the original recommendation is reinstated on the Trust's audit tracker.	Medium	3.2 Accepted – original recommendation will be reinstated.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed				n/a	n/a	n/a	Jul-22

Audit Action Plan

Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - Action not complete
	Blue - Action closed previous meeting

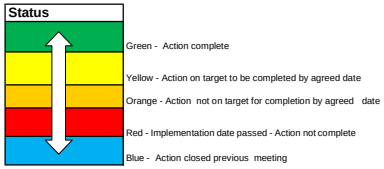
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Managing Attendance at Work - Divisional Deep Dive					Assurance Rating: Reasonable			Date Received at Audit Committee: 12 January 2023	Date Final Report Issued: 04 November 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2023	Update November 2023	Update December 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Strengthening attendance at MAAW training (Operation)** 1.1 Share MAAW training attendance and feedback data with divisional and directorate/OSG management to enable local action to address identified low training attendance.	Medium	Workforce Education Development Manager to ensure this is available/sent to Managers/SLT/SMT as part of their monthly performance feedback.	Cath O'Brien, Chief Operating Officer	~~Angela Voyle Smith, Workforce Education Development Manager~~ Claire Budgen, Head of Organisational Development	31 December 2022	Action Closed				Extension requested in February Update: 31 March 2023 - to enable discussions which will confirm all actions have been completed. This has been delayed due the post of Workforce Development Manager being vacant.	n/a	n/a	March/April 2023
	1.2 Consider reviewing the MAAW training feedback mechanisms in place and whether they adequately capture the required feedback to assess and respond to current training attendance levels.	Low	Review current mechanism for obtaining course feedback.	Cath O'Brien, Chief Operating Officer	~~Angela Voyle Smith, Workforce Education Development Manager~~ Claire Budgen, Head of Organisational Development	31 December 2022 Extension request agreed April 2023 Audit Committee: 30 April 2023. The Workforce Development Manager post is vacant and this review will take time out of another team member's work therefore an extension to 30 April 2023 will allow the work to be completed as required.	Action Closed				30 April 2023. The Workforce Development Manager post is vacant and this review will take time out of another team member's work therefore an extension to 30 April 2023 wil allow the work to be completed as required.	4	1	May-23
	1.3Consider mechanisms to further support line managers in the application of discretion or use of innovative solutions to support sustained attendance or RTW	Low	Case studies on managing absence are already included in the Fundamentals of Management Training Package, these will also be added to the MAAW Training package to further support learning, on managing absence. People and OD team will continue to consider other mechanisms that may be useful.	Cath O'Brien, Chief Operating Officer	Judy Stafford, People and Relationships Manager	31 January 2023	Action Closed				n/a	n/a	n/a	March/April 2023
Matters Arising 2	**Accuracy of absence recording (Operation)** 2.1 Remind managers of the importance of accurate absence recording and reiterate the process for recording Covid absences.	Low	Managers are regularly reminded of requirement and importance of accurate reporting. Specific feedback will be given to all managers and raised at SLT/SMT meetings.	Cath O'Brien, Chief Operating Officer	Senior People and OD Business Partners. Sue Price (for WBS and Corporate), Donna Dibble (for VCC).	31st October 2022	Action Closed				n/a	n/a	n/a	Jan-23

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Managing Attendance at Work - Divisional Deep Dive					Assurance Rating: Reasonable			Date Received at Audit Committee: 12 January 2023	Date Final Report Issued: 04 November 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2023	Update November 2023	Update December 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
	2.2 Consider requesting that line managers review absences recorded as non-Covid on ESR during the pandemic to ensure they have been recorded accurately.	Low	Managers will be asked to sample their ESR information to assess accuracy but there will not be a formal review due to current service demands and benefits gained.	Cath O'Brien, Chief Operating Officer	Rachel Hennessy/Paul Wilkins, Director of VCC and Alan Prosser Director of WBS	30th November 2022	Action Closed				n/a	n/a	n/a	March/April 2023
Matters Arising 3	**Demonstrating compliance with the MAAW Policy (Operation)** 3.1 Remind line managers of the importance of: • timely storage of absence records in the appropriate location, which is accessible in their absence, including the information noted as outstanding in this audit (a detailed list has been provided to management); and • ensuring absence records contain sufficient information to justify decisions made and actions taken, including forshort-term absences, delays in LTS meetings, application of discretion, and discussions around sustained attendance / returning to work.	High	Develop key messages for SLT/SMT members, for cascade to their managers, which defines the process for storage of such information i.e, shared files, use of personal 'P' drives, password protected, accessibility etc. Develop examples of good practice and checklist examples for cascade through Divisions and use in training events.	Cath O'Brien, Chief Operating Officer	Judy Stafford, People and Relationships Manager Judy Stafford, People and Relationships Manager	30th November 2022 Extension Agreed April 2023 Audit Committee: 31 August 2023 31st December 2022 Extension Agreed April 2023 Audit Committee: 31 August 2023	Action Closed				n/a	9 Months 8 Months	n/a	May-23
	3.2 Pursue the rollout of centralised personnel folders for VCC, in line with the solution implemented within WBS.	Medium	Finalise the business requirement case for centralised workforce folders at VCC (in line with WBS) and implement the system.	Cath O'Brien, Chief Operating Officer	Rachel Hennessy/Paul Wilkins, Director of VCC and Alan Prosser Director of WBS	31st July 2023 Extension request agreed in October 2023 Audit Committee 31st December 2023.	Complete	Completed roll out to Fundraising, Corporate Management Accounts and Financial Accounts, People and OD, and TCS. Pharmacy and Sact will be completed next week and dates are now in calendars to roll out over next few weeks to Corporate Governance, Radiotherapy, Medical Physics, Medical Records, and Operational Services.	Completed roll out to Corporate Governance, Operational Services (Catering,Domestics,Porters,Switchboard and H&S). Also completed RD&I and IPC, Radiotherapy, Medical Records and Estates. Dates are set for roll out to Radiation Protection,Physics Engineering, Medical Physics, and OPD throughout November and for Operations and Delivery, and Nursing Quality in December. Pharmacy and SACT have been delayed due to management sickness but date is now in calendar toroll out in the next couple of weeks. Further Update provided to give assurance action will be completed by 31 December 2023: Pharmacy and SACT have been completed and dates are set in the calendars for the remaining departments over the next few weeks. These departments are Medical Physics, CSMO, Digital projects, Quality and PE. The last of these dates is scheduled for 18/12/2023 which will be the completion date of the project.	**Complete** - All departments throughout the Trust have their staff files and appropriate permissions for access applied. Last department to be rolled out will be Nursing Quality which is armaged for 20th December. There are a couple of files that Workforce need to mop up as need to check ESR for where they belong, but other than those the full roll out will be complete.		5	1	Dec-23
	3.3 Implement the planned programme of audits to ensure continued adherence to the MAAW Policy and update EMB on the status of this programme.	Medium	A rolling programme of audits was agreed in September 2021 by EMB; this was impacted by COVID and replaced by spot audits in hotspot areas due to service pressures. The rolling programme agreed is now back on track and is ongoing with targeted dates on updates to EMB in December 2022 and March 2023.	Cath O'Brien, Chief Operating Officer	n/a	n/a	Action Closed				n/a	n/a	n/a	Jan-23

Audit Action Plan

Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - Action not complete
	Blue - Action closed previous meeting

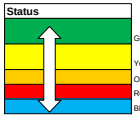
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 25 April 2023	Date Final Report Issued: March 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 1	**Improving administrative governance arrangements** We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: - missing committee meeting papers. - the Register for Gifts, Hospitality and Sponsorship and the Declaration of Interest Register; and	High	Tracking has been implemented to ensure the completeness and timely publication of committee agenda bundles and other key governance papers as part of the weekly Corporate Governance Team meeting.	Lauren Fear - Director of Corporate Governance and Chief of Staff	Kay Barrow, Corporate Governance Manager	22nd March 2023	Action Closed				n/a	n/a	n/a	May-23
Recommendation 1	**Improving administrative governance arrangements** We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: - the ten year strategy and enabling strategies. The Trust should establish a clear and robust process to ensure it publishes key papers and documents on its website in a timely and ongoing basis	High	10-year strategy: An engagement and communications plan has beendeveloped to the support the launch of the Trust 10-year strategy in May 2023. This will include publishing the strategy on the Trust website	Carl James - Executive Director of Strategic Transformation, Planning and Digital	Carl James - Executive Director of Strategic Transformation, Planning and Digital	31st May, 2023 Extension request agreed in October 2023 Audit Committee 31 October 2023	Action Closed					5	1	Nov-23
Recommendation 2	**Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies** The Quality, Safety, Performance Committee has not received the log which tracks recommendations relating to the quality and safety of services made by external inspection and regulatory bodies since early in 2020. The Trust should immediately reinstate the tracker to enable the committee to oversee, scrutinise, and challenge the progress it is making in addressing both quality and safety recommendations and any relating to performance	High	The Quality & Safety Extract of the Trust Wide Legislative & Regulatory Compliance Register will be received at each meeting of the QSP Committee - together with the associated Improvement Plan using the 7 levels of assurance template. Note: The Trust wide Legislation & Regulatory Compliance Register is already established and received in full by the Trust Audit Committee.	Nicola Williams Executive Director of Nursing, AHP & Health Science	Zoe Gibson, Head of Quality & Safety and Emma Stephens, Head of Corpoate Governance	Mar-23	Action Closed				n/a	n/a	n/a	May-23
Recommendation 3	**Establishing measurable outcomes for strategic priorities** The Trust has translated its strategic priorities into specific objectives and actions in the 2022-25 IMTP (including timescales for delivery). The Trust should seek to articulate the intended outcomes for each strategic objective/action in future IMTPs, including what success would look like	High	The Trust IMTP 2023-2026 sets out a range of specific objectives related to their delivery which are timebound. Further work will be undertaken to: (i) improve the SMART elements of the objectives (ii) align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	30th March, 2023	Action Closed				n/a	n/a	n/a	May-23
		High	(ii) align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Dec-23	Action Closed				n/a	n/a	n/a	May-23
Recommendation 4	**Enhancing reporting on 2022-25 IMTP Delivery** The Trust's arrangements for reporting delivery of the 2022-25 IMTP are reasonable, but it needs to better describe the impact the actions are making. The Trust should report on the impact of actions delivered to date to allow the Board to better understand the extent that delivery of the IMTP is making a difference and determine any actions that need to be rolled forward to the 2023-26 IMTP	High	The Trust IMTP for 2023-2026 will outline the impact/benefits of actions we are taking as outlined in our IMTP. The process for developing the IMTP has included an assessment of actions which should be rolled forward to 2023-2026. In respect of reporting, we will ensure that progress update are provided to - Senior Leadership Team at their monthly meetings - Executive Management Board at their monthly meetings - Quality, Safety and Performance Committee at their bi-monthly meetings - Trust Board at their bi-monthly meetings	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Action Closed				n/a	n/a	n/a	Jun-23
Recommendation 5	**Improving reporting on the benefits arising from digital investments** Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessments of what difference they are making, whether they are sufficiently recurred, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	High	The further development of digital benefits will be undertaken in several ways: (i) a range of key performance indicators that are reported to the Executive Management Board	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023 Extension request agreed at December 2023 Audit Committee 31 April 2024.	Complete	The Executive Director of Transformation, Planning and Digital discussed this recommendation which Kate Febry, Wales Audit Office in relation to the iterative process of technology, how its supports service benefits and the fact that it's an ongoing/iterative process. This was noted, together with the good progress to date, and the need to have recommendations which have a finality. It was agreed that the progress to date demonstrates the Trust commitment to ensuring that the benefits of digital are constantly developed and appropriately monitored and assessed. It was also agreed that this needs to be undertaken through a range of dimensions e.g. business case benefits; service benefits; and key measures (from service and digital) which is currently in place within the Trust. It was therefore agreed that this action should be closed and this line of activity/assurance should be undertaken through other audits i.e. realisation of benefits in business cases; benefits arising from services; tracking of the delivery of the digital strategy.					Dec-23
Recommendation 5		High	(ii) improving the clarity of benefits in projects/business cases on a case-by-case basis	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Not time bound - as related to each business case	Action Closed				n/a	n/a	n/a	Jun-23
Recommendation 5		High	(iii) implementing the measures set out within the digital strategy and key service plans (e.g., quality metrics) which will demonstrate the impact of digital services on service quality and outcomes and including an overall % spent on digital technology	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Feb-24	On Target	Digital measures have been agreed and will be available for the PMF for inclusion in Feb 24 as planned.						

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Clinical Audit (Velindre Cancer Centre) Final Internal Audit Report			Assurance Rating: Reasonable				Date Received at Audit Committee: 25 April 2023	Date Final Report Issued: 26 January 2023					

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2023	Update November 2023	Update December 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Arising 1: Clinical Audit Actions** 1.1 a. The clinical audit action plan should be updated in a timely manner. We understand the implementation of AMaT will support this, as the Clinical Leads will be responsible for inputting and updating action plans.	Medium	1.1a The Clinical Audit Team is currently piloting AMaT with the anticipation to roll the system out across all audits in the team. A review of audit systems in the organisation is being undertaken to ensure no duplication of systems and explore how AMaT can support other areas of the Trust.	Jacinta Abraham, Medical Director	Nicola Hughes, Medical Directorate Manager	Jun-23	Action Closed	n/a	n/a		n/a	n/a	n/a	Jun-23
Matters Arising 1	1.1 b. Where clinical audits lead to clear actions, Clinical Leads should ensure actions noted within the clinical audit action plan are SMART. The use of AMaT will provide the foundation for standardisation and should assist with creating SMART actions. The Clinical Audit Team should undertake spot checks on the actions to verify this.	Medium	1.1b Once the SMART action guide (see 1.1c below) has been produced, the Clinical Audit Team will undertake spot checks on actions to ensure they are SMART.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Apr-23	Action Closed	n/a	n/a		n/a	n/a	n/a	Jun-23
Matters Arising 1	1.1 c. Guidance and training on developing SMART actions should be provided to Clinical Leads.	Medium	1.1c Produce a SMART action training guide for all audit leads to follow.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Apr-23	Action Closed	n/a	n/a		n/a	n/a	n/a	Jun-23
Matters Arising 1	1.2 a. The clinical audit action plan should identify whether a re-audit is required, along with the reason and timescales therefor.	Medium	1.2a Where re-audit is required, this is included in the action plan, a section will be added to document the reason for re-audit. Timescales are usually recorded. Not all audits require re-audit this is identified via the recommendation or documented on the proforma. Ensure where re-audits are required that all documentation reflects this clearly.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Mar-23	Action Closed	n/a	n/a		n/a	n/a	n/a	May-23
Matters Arising 1	1.2 b. The Trust should develop a process for independently verifying implementation of actions and benefits realisation where re-audit is not planned. This could be undertaken on a spot-check / sample basis and could be done by the Clinical Audit Team or, to create resilience, by a clinician who was not involved in the original audit.	Medium	1.2b Formalise the current process to evidence actions and benefits have been undertaken or realised.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jun-23	Action Closed	n/a	n/a		n/a	n/a	n/a	Jun-23
Matters Arising 2	**Matter Arising 2: Clinical Audit Best Practice** 2.1 The Trust should consider the above points and the wider HQIP clinical audit best practice guidance as it continues to develop its clinical audit activities, and reviews quality governance mechanisms as part of the Quality & Safety Framework Implementation Plan.	Low	2.1 All best practice identified in this report to be reviewed and applied where possible to improve the effectiveness of clinical audits.	Jacinta Abraham, Medical Director	Catherine Pembroke, Medical Clinical Audit Lead (Oncology Consultant)	Jul-23	Action Closed	**Complete.** Best practice principles identified in the report have been reviewed. using AMat for all clinical trials will support a rolling clinical audit programme that covers the different stages of individual projects. A new report is being developed from AMaT identifying new audits and progress of open audits which will be subitted to VCCQSMG bi-monthly along with best practice guidance if clinical audit is best suited to develop improvements. . Working towards a QI hub, however this will take time to implement and embed. Current practice to continue with best practice principles in mind with agreed governance route for approval and submissionto QSMG.	n/a		n/a	n/a	n/a	Oct-23
Matters Arising 3	**Matter Arising 3: Centralised Clinical Audit Function** 3.1 The Trust should consider joining the divisional clinical audit teams into a centralised Trust clinical audit team.	Low	3.1 Discuss the options regarding feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation.	Jacinta Abraham, Medical Director	Jacinta Abraham, Medical Director	01/07/2023 Extension request agreed in October 2023 Audit Committee 31 December 2023	Complete	Discussions have taken place, WBS are reviewing with a view to recruit a post where clinical audit is identified in the JD, and will work along side the VCC clinical audit team. This will support Trust working,proceses and governance alignment. Extension is required for WBS to identify what role will include Clinical Audit.	JD completed and currently going through Job Matching Panel. Further discussions between VCS/WBS to be implemented.	**Complete:** The JD is currently with Welsh Translation and will be advertised shortly.	Requested Extension to January 2024 in October 2023 Update.	6		Dec-23
Matters Arising 4	**Matter Arising 4: Robustness of SST Minutes** 4.1 The Trust should ensure that SST meeting minutes clearly demonstrate discussions around clinical audit (plan progress, audit findings, learning, action implementation, etc).	Medium	4.1 Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jul-23	Action Closed	n/a	n/a		n/a	n/a	n/a	Jun-23

Audit Action Plan

Velindre UNHS Trust

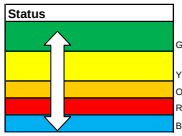
Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - Action not complete
	Blue - Action closed previous meeting

Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Clinical Audit (Velindre Cancer Centre) Final Internal Audit Report					Assurance Rating: Reasonable		Date Received at Audit Committee: 25 April 2023	Date Final Report Issued: 26 January 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2023	Update November 2023	Update December 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 4		Medium	4.1 Review of SST meetings to establish how discussions are documented with progress of clinical audits	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jul-23	Action Closed	n/a	n/a		n/a	n/a	n/a	Jun-23
Matters Arising 5	**Matter Arising 5: Clinical Audit Reporting and Oversight Mechanisms** 5.1a As part of the review of quality and safety governance and reporting mechanisms, the Trust should address the above points to further enhance the efficiency and effectiveness of the scrutiny and oversight of clinical audit activities from 'floor to Board'.	Low	5.1a The new Trust Integrated Quality and Safety Governance group will help with the triangulation of clinical audit outcomes across the Trust and ensure escalation to the Quality and Safety committee as appropriate. VCC will develop a process map to evidence the report structures within VCC for clinical audit. Reporting requirements are being reviewed in line with the quality hubs.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Dec-23	Action Closed	Process and governance map of current reporting structure has been developed for VCC and will be submitted for comment to VCCQSMG.	**Complete.** To be Noted at the next VCCQSMG meeting.		n/a	n/a	n/a	Nov-23
Matters Arising 5	5.1 b The Trust should ensure that the agreed clinical audit reporting mechanisms are clearly communicated to relevant staff and adhered to at all levels of the Trust.	Low	5.1b **VCC**: Current process map of the VCC governance and reporting mechanism to be added to the clinical audit intranet page.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	May 2023	Action Closed	n/a	n/a		n/a	1	1	Jul-23
		Low	5.1b **WBS:** We have strengthened the reporting of Clinical Audit within the WBS by making it an integral part of the Welsh Blood Service Clinical Governance Groups, reporting to the Regulatory Assurance and Governance Group (RAGG). We have recently added a separate report including national comparative audits.	Jacinta Abraham, Medical Director	Edwin Massey, Deputy Medical Director WBS	Completed	Action Closed	n/a	n/a		n/a	n/a	n/a	May-23

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

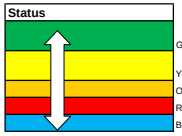
*Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Capital Systems Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023	Date Final Report Issued: 22 March 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Arising 1: Governance - Capital Procedures (Operation)** 1.1 FP01 Capital Management Procedure should be reviewed and updated.	Low	1.1 Accepted: The Capital Management Procedure will be updated and will be submitted for approval following Trust governance requirements.	Carl James, Director of Strategic Transformation, Planning & Digital / Matthew Bunce, Executive Director of Finance	SteveColiandris,Head of Financial Planning & Reporting	30 November 2023 Extension Agreed at December Audit Committee 31 December 2023	Complete	Procedure is expected to be approved at Audit committee on the 19th December. The procedure was endorsed for approval at the EMB meeting on the 4th December.	**Complete** - Action Closed. Procedure was approved at Audit Committee on the 19th December.			1	1	Jan-24
Matters Arising 2	**Matter Arising 2: Governance - Divisional Structure Operation)** The 2.1 VCC capital governance structure should be reviewed, and either: a) The Business Planning Group re-instigated as per the terms of reference; or b) A revised structure implemented, to ensure an appropriate forum is in place for the monitoring of capital requirements and reporting to the Senior Leadership Team.	Medium	2.1 Accepted: The VCC Business Planning Group will be re-instigated in line with the approved Term of Reference.	Carl James, Director of Strategic Transformation, Planning & Digital	Paul Wilkins, Director of Cancer Services, Velindre Cancer Centre	30 June 2023	Action Closed				n/a			Sep-23
Matters Arising 3	**Matter Arising 3: Governance - Capital Planning Group (Operation)** 3.1 Capital Planning Group (or other equivalent forum) minutes should: • Be prepared in a timely manner after each meeting, and in readiness for sign-off at the subsequent meeting; • Clearly document any decisions taken (for example in relation to formulation of the annual discretionary programme); and • Be centrally retained in a location accessible by key forum members, including as a minimum the Chair and Deputy Chair. It is noted that a number of organisations now utilise Microsoft Teams to facilitate meeting administration, with a dedicated Teams channel being a useful central location for retention of key meeting documentation.	Medium	3.1 Accepted: The following actions will be taken: • Minutes will be made available no later than two weeks after each meeting for review by the Chair of the Group • All key decisions taken will be clearly documented • A shared folder will be established and all members of the Capital Planning Group will have access to minutes and other associated papers	Carl James, Director of Strategic Transformation, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	30 June 2023	Action Closed				n/a	n/a	n/a	Jun-23

Audit Action Plan

Velindre UNHS Trust

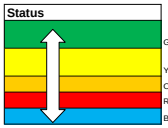


Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

*Unless a more appropriate timescale is identified / agreed

Capital Systems Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023	Date Final Report Issued: 22 March 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 4	**Matter Arising 4: Governance - Capital Delivery Group Terms of Reference (Operation)** 4.1 The terms of reference for the Capital Delivery Group should be approved in a timely manner, in line with the wider change timeline.	Low	4.1 Accepted: The revised terms of reference will be submitted for approval through Trust agreed governance arrangements.	Carl James, Director of Strategic Transformation, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital	30 June 2023	Action Closed				31-Aug-23	2	1	Sep-23
Matters Arising 5	**Matter Arising 5: Prioritisation Framework - Consistency of application (Operation)** 5.1 Clarification is required within the Capital Prioritisation Framework as to whether there are any exceptions to the requirement to complete the Capital Prioritisation Information Template (including in the management of "discretionary" funds).	Low	5.1 Accepted: The Capital Prioritisation Framework will be reviewed and updated in line with the recommendation.	Carl James, Director of Strategic Transformation, Planning & Digital	Deputy Director of Planning & Performance	30 June 2023	Action Closed				n/a	n/a	n/a	Jun-23
Matters Arising 6	**Matter Arising 6: Prioritisation Framework - Annual Approval Timeline (Operation)** 6.1 The discretionary capital programme should be formulated and agreed prior to the start of the financial year wherever possible. The planning cycle in the Divisions should be aligned to support this.	Medium	6.1 Accepted: Where possible the capital programme will be approved prior to the start of the financial year. However, it should be noted that this is not always possible due to uncertainty regarding our discretionary capital allocation from WG and / or our contribution to centrally funded schemes e.g. delay in approval of All-Wales business cases e.g. nVCC.	Carl James, Director of Strategic Transformation, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital With support from VCC and WBS.	31 March 2024 and ongoing thereafter	On Target	The IMTP planning process has been amended to enable the discretionary capital programme to be agreed before the commencement of each financial year. The process has commenced for 2024/2025 and is on-track			n/a	n/a	n/a	

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

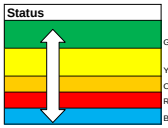
* Unless amore appropriate timescale is identified / agreed

Velindre UNHSTrust

Trust Priorities - Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 26 July 2023	Date Final Report Issued: 19 July 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Enhancements to the prioritisation process (Design).** 1.1 The Trust could further enhance the benefits of the Prioritisation Framework by using it in discussions with external stakeholders (e.g., Welsh Government, commissioners, Llais, etc.) during the annual planning process.	Low	1.1 Agreed - The Trust is currently developing its engagement plan of the development of our plan during 2023/24. This will include a process for clearly articulating our key organisational priorities (output of the prioritisation framework) to both our internal and external stakeholders.	Carl James, Director of Strategic Transformation, Planning & Digital / Matthew Bunce, Executive Director of Finance	Philip Hodson, Deputy Director of Planning & Performance	29/09/2023 Extension request agreed at December 2023 Audit Committee 29 March 2024	On Target	Meetings have been held with the divisional Senior Leadership Teams and with the Trust Executive Management Board. Follow-up meetings have been arranged with the Trust Board (14th December 2023) and with the Executive Management Board (18th December 2023). Follow-up meetings will be held with all key stakeholders from January - March 2024.		Meetings have been held with the divisional Senior Leadership Teams, the Trust Executive Management Board , the Trust Strategic Development Committee and with the Trust Board. Follow-up meetings from February - March 2024.	~~Revised implementation date of 22nd December 2023.~~ Revised implementation date of 29th March 2024 in line with the updated submission date to the Welsh Government.	6	1	
Matters Arising 1	1.2 The Trust could consider extending or tailoring the Prioritisation Framework to incorporate the divisional and enabling strategies to support consistency and robustness in prioritisation and decision-making at all levels within the Trust.	Low	1.2 Agreed – The Trust will review how the prioritisation framework and supporting methodology could be used to support other areas of service development. As part of this work, we will consider if it should be used to support prioritisation in divisional and enabling strategies.	Carl James, Director of Strategic Transformation, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	31/10/2023	Action Closed					n/a	n/a	Oct-23
Matters Arising 2	**Risks to delivery – finance and resourcing (Design).** 2.1 The Trust should use the deliverability section of the Framework as part of the annual planning process, alongside the existing financial planning approach to enhance the overview on the deliverability of Trust priorities as a whole, rather than potentially considering priorities on a more granular basis.	Medium	2.1 Agreed - The Trust will use the deliverability section of the Framework to support the development of our plan for 2023/24.	Carl James, Director of Strategic Transformation, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	31/10/2023	Action Closed					n/a	n/a	Oct-23
Matters Arising 2	2.2 The Trust should revisit the Prioritisation Framework, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned	Medium	2.2 Agreed - The Trust will revisit the Prioritisation Framework at the end of the financial year, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned.	Carl James, Director of Strategic Transformation, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	31/03/2024	On Target	Trust will revisit the Prioritisation Framework at the end of the financial year, including the completion of the deliverability section.		Trust will revisit the Prioritisation Framework at the end of the financial year, including the completion of the deliverability section.		n/a	n/a	

Audit Action Plan

Status



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - Action not complete

Blue - Action closed previous meeting

Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

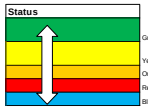
* Unless amore appropriate timescale is identified / agreed

Velindre UNHSTrust

Digital Strategy & Transformation Programme - Final Internal Audit Report	Assurance Rating: Reasonable	Date Received at Audit Committee: 19 October 2023	Date Final Report Issued: 10 October 2023	

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Digital Strategy Publication (Operation).** 1. The digital Strategy should be published, and a communications exercise undertaken to publicise the strategy and the Trusts digital intent.	Medium	1.1 The Digital Strategy has been approved and it is being prepared for publication alongside the refreshed Trust strategy and other enabling strategies. This will include an engagement plan.	Carl James, Director of Strategic Transformation, Planning & Digital	Carl Taylor, Chief Digital Officer	31 October 2023	Action Closed							Nov-23
Matters Arising 2	**Governance Framework (Operation).** The governance structure for digital should be re-considered, with further consideration given to establishing a group where all digital items are considered.	Medium	A Digital Programme Group is being established which will bring Digital together for oversight into the Executive Management Board.	Carl James, Director of Strategic Transformation, Planning & Digital	Carl Taylor, Chief Digital Officer	31st October 2023 for Digital Programme Group.	Action Closed							Nov-23
Matters Arising 2		Medium	An Executive / Board level review will be needed to look at the case for creating a single forum where Digital is owned in the Board committees	Carl James, Director of Strategic Transformation, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital	30th November for Exec/Board Review.	Action Closed							Nov-23
Matters Arising 3	**Digital Culture (Operation).** Work should be undertaken to change the digital culture within the organisation: -Communication of Digital Strategy and its aims; -Embedding digital within the service and ensuring ownership; and -Ensuring staff understand digital and their role in successful delivery of digital transformation.	Medium	The Digital Programme is in the process of being set up and the first meeting to confirm arrangements and terms of reference is scheduled for the 5th Oct. The proposed remit for the Digital Programme includes work on VUNHST as a digital organisation. The communication of the Digital Strategy is to be completed by the end of October 2023.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	31st October 2023	Action Closed							Nov-23
Matters Arising 4	**Digital Inclusion (Operation).** Work to progress the digital inclusion action plan and digital skills and awareness within the organisation should be accelerated.	Medium	A Digital Inclusion action plan is in place. This will be reviewed and opportunities where the work can be accelerated will be identified and included in the next IMTP where appropriate. Where further investment would be required to accelerate the work a business case will be prepared for EMB.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	30th November 2023 Extension request agreed December 2023 Audit Committee 30 January 2024	Overdue	The request for additional non-recurrent revenue funding for Digital Inclusion was approved by EMB. Action plan will be updated according for Jan '24.		A summary of the Digital Inclusion plan will be presented to the March '24 SDC meeting and the action presented for closure.	Requested Extension Date: 21 March 2024.	4	2	
Matters Arising 5	**Older Technology Risks (Operation).** The risk relating to the use of older technologies on the delivery of the Digital Strategy and the Trusts digital transformation aims should be clearly stated.	Medium	Review risks to the Digital Strategy relating to the use of older technologies and make sure they reflected accurately in risk registers and the Trust Assurance Framework.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	31st October 2023	Action Closed							Nov-23

Audit Action Plan



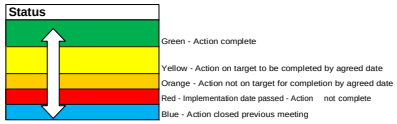
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Audit of Accounts Report Addendum– Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 19 October 2023	Date Final Report Issued: October 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
Exhibit 1 - Matter Arising 1	**The majority of declaration of interest returns were completed in January or February rather than at the year end.** Declaration of Interest returns should be competed as close to the year end as possible or if completed before the year end, officers should confirm in writing that there have been no changes.	High	Partially accepted. Declarations of interest could not be requested in late March /early April (as per recommendation) as this would fall at the end of the Financial Year when a number of Trust Officers take Annual Leave before the end of the Financial Year as it falls over the Easter period. This would prevent a complete return from being received in time to enable the necessary due diligence to be undertaken by Finance and Governance Leads when assessing returns for any impact to the Trust financial accounts/statements, in readiness for submission of the First Draft of the Trust Accounts each year. Trust Officers note their obligation to inform the Trust should there be any changes to their declaration on submission in accordance with the established due process. As such, the Trust is content that should there be any changes in the few weeks prior to the end of year from the date of return that this would then be reported as such. Declarations of Interest Returns for the next financial year will be requested at the end of February 2024, with a further request made to Board members in late March 2024 to confirm in writing that there have been no changes.	Matthew Bunce. Executive Director of Finance	Tracy Hughes, Head of Financial Operations	31 March 2024	On Target	As indicated, this action is not due to be initiated until February 2024 when the Declarations of Interest Returns for the 2023/2024 Financial year will be requested at the end of February 2024, followed by a further request made to Board members in late March 2024 to confirm in writing that there have been nochanges.		As indicated, this action is not due to be initiated until February 2024 when the Declarations of Interest Returns for the 2023/2024 Financial year will be requested at the end of February 2024, followed by a further request made to Board members in late March 2024 to confirm in writing that there have been nochanges.				
Matter Arising 2	Errors were identified in the accruing of costs relating to the enabling works for the new Velindre Cancer Centre. Any significant capital accruals should be reviewed to ensure they are valid accruals and can be fully supported.	Medium	The nVCC Project notes the comments raised by the external auditors and accept the points raised. The nVCC Project will ensure more accurate reporting from its Advisors so as to ensure that the project costs reflect a more accurate financial position.	Matthew Bunce. Executive Director of Finance	Mark Ash, Assistant Project Director (Finance & Commercials)	31 March 2024	On Target							
Matter Arising 3	Weaknesses were identified in the presentation of inter NHS income and expenditure within the accounts. To support the accuracy of the income and expenditure disclosures, the Trust should revisit their approach to identifying the agreed transactions with Welsh NHS Bodies and Welsh Government so that a suitable audit trail provided to support the disclosure notes and the FRS6 return to the Welsh Government.	Medium	We will revisit our approach to identifying the agreed transactions with Welsh NHS Bodies and Welsh Government. This will include continuing to build on the work to improve the coding of transactions in the financial ledger and reminding colleagues to ensure that the transactions are coded to the appropriate codes.	Matthew Bunce. Executive Director of Finance	Tracy Hughes, Head of Financial Operations	31 March 2024	On Target	Work is ongoing to strengthen the process. Divisional finance colleagues are reminded on a monthly basis of the importance of the coding of transactions and are tasked with reviewing and amending the coding. The planned completion date is still on target to be met.		Work to strengthen this process is ongoing and the planned completion date is still on target to be met.				
Exhibit 2	**Recommendation from previous years audits. Progress against previous year's recommendations. 2021-22. We recommend that those officers posting transactions are reminded of the need to use the appropriate coding so that inter Welsh NHS and Welsh Government can be accurately disclosed in the accounts**	N/A	Not adequately addressed. See recommendation 2 above within Exhibit 1. See above action.	Matthew Bunce. Executive Director of Finance	Tracy Hughes, Head of Financial Operations	31 March 2024	N/A				n/a	n/a	n/a	n/a

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

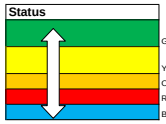
Velindre UNHS Trust

External Audit Report - Review of Workforce Planning Arrangements – Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 19 October 2023	Date Final Report Issued: August 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 1	**Developing an implementation plan** The Trust's People Strategy is not effectively supported by an implementation plan. This limits the Trust's ability to ensure it has sufficient resource to deliver the strategy, manage risks associated with its delivery, and provide effective oversight of its implementation at committee. The Trust should develop a plan to implement the People Strategy. The plan should include a section that identifies the costs, staff capacity, skills and other resources associated with implementing the People Strategy (high priority).	High	An implementation plan for the Strategy has been developed which highlights risk and governance arrangements.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	September 2023	Action Closed							Nov-23
Recommendation 2	**Developing workforce intelligence.** The Trust is developing a baseline of current workforce capacity to inform its Supply and Shape framework. The Trust should do more to understand the extent of workforce planning activity across its business and to understand future service demand and risk. The Trust should develop a consistent approach to model future service demand to understand the longer-term human and financial resource implications and potentialrisks to the organisation (medium priority).	Medium	The Trust will develop an approach to model future service demand which takes account of the longer-term human and financial resource implications and potential risks to the organisation	Cath O'Brien, Chief Operating Officer	Rachel Hennessey, Interim Director of VCS Alan Prosser, Director Welsh Blood Service	First Workshop in November 2023 A full project plan to be developed following the November session Proposed date 31 July 2024 for completion of the first phase of work.	Overdue	The Management action to this recommendation has been reworked to take account of the wider remit, beyond workforce planning, of that recommendation. This will be a service led piece of work which will then take account of workforce and financial triangulation in respect of service planningJDuly 2024 for reasonsspecified in December update	Service and workforce conversations ongoing throughout January 2024	WBS workshop planned March 4th to map demand capacity plans and current workforce planning arrangments. Recognition that demand plans and workforce plans need to join up formerly to provide a framework for signing off. Learning and agreed actions to be shared with VCS to allow VCS to consider bestapproach. In additon, Director of WBS met lead auditor to align expectations against recomendation on February 7th 2024..	31 July 2024 – For completion of the first phase of work to agree a detailed project plan. To develop the consistent approach to modelling future service demand and the longer-term human and financial resource implications and potential risks to the organisation will be a longer timescale. Focusing on implementing this across the Trust..	8	1	
Recommendation 3	**Managing risk.** The Trust's Supply and Shape Framework has the potential to highlight new workforce risks. The Trust should review the information in its corporate and strategic risk registers using fresh insight from the Supply and Shape document to identify potential additional sources of assurance and new risks (high priority).	High	The Trust Assurance Framework (TAF) has been under review and is now in the final stages. There has been Strategic Risk refresh working collaboratively with Senior Leadership / Management Teams, Board and Committees and the Executive Management Board. The new template has been developed, taking into consideration Trust-wide frameworks.	Sarah Morley, Executive Director of Workforce and OD	Sarah Morley, Executive Director of Workforce and OD	The TAF is due to Trust Board on 28th September 2023 for approval.	Action Closed							Nov-23

Audit Action Plan

Velindre UNHS Trust

Status



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - Action not complete

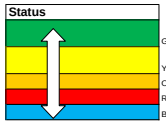
Blue - Action closed previous meeting

Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

External Audit Report - Review of Workforce Planning Arrangements – Velindre University NHS Trust			Assurance Rating: N/A				Date Received at Audit Committee: 19 October 2023	Date Final Report Issued: August 2023					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update December 2023	Update January 2024	Update February 2024	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 4	**Exit surveys.** Whilst the Trust uses exit surveys to understand the underlying reasons for staff turnover, we found that the Trust could do more to actively encourage survey completion. The Trust should develop an approach to increase exit survey response rates and ensure feedback feeds into retention activities (medium priority).	Medium	A project group has been established to review the current exit interview process and create a revised, easy to follow process that utilises technology to its best advantage and avoids single points of failure, resulting in a better experience for the end user and providing informed data for the business to use. The deliverables to achieve this scope are: •Clear and easy process – managers guide on importance of termination; •Increased uptake of return of completed exit interview forms; •Highlight service improvements; •hDighlight culture and inform culture change requirements; •rDemoves single point of failure / reliance on one person; •Provides consistent approach across the whole Trust; •Provides valuable information for recruitment and retention; •Streamlined, digital process, rendered for easy access mobile use, utilising current technology; and •Paperless process reduces risk.	Sarah Morley, Executive Director of Workforce and OD	Amanda Jenkins, Head of Workforce and OD	December 2023 Extension request agreed December 2023 Audit Committee 30 January 2024	Complete	The new process is in trial period and there are some details to tweak before final completion Comms roll out plan starts in Jan 2024	Piloting of process now in place. Final engagement workshop to be held in March 2024.	**Complete.** Process now in place.	Extension requested to allow for piloting and engagement of final process. March 2024	2	3	Feb-24
Recommendation 5	**Education commissioning process.** We found that the Trust is working on improving the basis of its education commissioning. The Trust should develop mechanisms to triangulate the number of staff it trains through the education commissioning process and how many it then employs which will provide the Trust with important intelligence to further strengthen its basis (medium priority).	Medium	Education commissioning places are agreed via the Education and Training Steering group. The students are commissioned by NHS Wales Shared Services Partnership and feedback on progress given to the Steering group. Attrition rates forcommissioning are monitored via Health Education and Improvement Wales and fed into the steering group. Moving forward the Supply and Shape report will be developed to include updates on commissioning. Better triangulation with the performance report is also being worked on.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	March 2024	On Target	To be reported to the March Education and Training Steering group following the current Education Commissioning process now in train	On target, update as per Jan 2024.	On target update as per Jan, meeting to take place in March				
Recommendation 6	**Monitoring and oversight.** We found weaknesses in the Trust's approach to monitoring and overseeing delivery of its People Strategy. It does not understand the impact of its efforts and a lack of clear information limits thorough scrutiny by the Quality, Safety and Performance Committee. The Trust should develop an approach to better understand the impact of key workforce initiatives and the extent that they are delivering the intended improvements and outcomes. Going forward this should be reported in the annual report on the delivery of the People's Strategy (medium priority).	Medium	Assurance is provided currently via the Workforce and Operational Design report on KPIs to: •Executive Management Board; •Quality Safety and Performance Committee; •Quarterly supply and shape papers are approved by the Executive Management Board and Quality Safety and Performance Committee. The Trust provides an annual report that summarises KPIs and provides an update on the People Strategy Moving forward the Supply and Shape report will be developed to deliver better triangulation with the performance report to provide details of the benefits of Workforce and Operational Design interventions. This will also be summarised in the Annualreport.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	March 2024	Complete	Supply and Shape papers to EMB and QSP in January and March 2024 will continue to provide an updated on strategic and operational actions to deliverthe People Strategy	January paper presented to EMB and QSP. This will now been an ongoing quarterly reporting mechanism to provide updates and assurance of actions.	**Complete**. Reporting mechanism in place via EMB and QSP and an integral WOD risk meeting now established as additional level of assurance.				Feb-24

Audit Action Plan



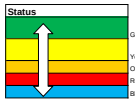
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Business Continuity Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 December 2023	Date Final Report Issued: 03 November 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Matter Arising 1: Velindre Cancer Centre Business Continuity Arrangements (Design).** 1.1 In taking forward the actions of the Business Continuity & Emergency Planning Work Programme, management should ensure the following is in place for VCC: • business continuity plans covering all business continuity scenarios for all departments, with alignment between the departments and divisions; • a clear approval process for business continuity plans; • a rota of testing for departmental businesscontinuityplans; • a business continuity divisional group; and • a centralised location to hold electronic versions of departmental business continuity plans which is accessible to all staff.	Medium	1.1 To continue progressing with the Trust Business Continuity & Emergency Preparedness programme and implement the above via; • Completion of Business Impact Analysis and Business Continuity Plans • Implementation of a quality management system with approval process and provide a centralised location (sourcing electronic management system) • Review the Trust's policies of policies to ensure governance for Business Continuity Plans is clear and accurate • Review Exercise, Test & Training Programme to be adopted within VCC or on a Trust wide basis • Establish Velindre Cancer Centre business continuity group	Cath O'Brien, Chief Operating Officer	Mark David, Business Planning Manager / Operations	March 2024	Not on Target	Ongoing as part of the the Trust Business Continuity & Emergency Preparedness Programme. Meetings have been held to review the programme, with completed activities on the current programme being marked as completed / closed, including Velindre Cancer Centre embedded Business Continuity into its Cynefin group. Ongoing work continues to prioritise and progress the programme in its entirety. Trust wide EQMS procurement finalised and progressing (project likely to surpass March 2024 implementation date). Note; currently business continuity focus for Velindre Cancer Centre during December to January has been on the planning and response to the BMA Industrial Action which remainsongoing.	Ongoing as part of the the Trust Business Continuity & Emergency Preparedness Programme, limited progress since previous update due to ongoing pressures and industrial action priority which continues. Updates to Trust Policy for Policies requested, to be progressed in coming weeks. Centralised location progressing through project for EQMS, likely to surpass end of March deadline. Exercise, Test & Training programme updated, priorities for VCC being identified for 2024. Cynefin Group met with Business Continuity embedded in routine agenda, group established bimonthly frequency from April - complete.	30/09/2024 Extension requested in February update due to the ongoing planning and response to industrial action and other ongoing service pressures impacting on capacity to complete all department / services business impact analysis and continuity plans. A number of the audit actions that remain outstanding that relate to a central repository for plans, clear approval process and aligning testing to annual review dates will be complete upon implementation of a EQMS which is progressing outside of the business continuity resource and is known to exceed end of March for implementation. Progress has been made to complete other actions identified as stated in January and February updates. Exercise, Test & Training requirements being finalised this month. Updates to the Trust policy for policies no longer required as not applicable to divisional documentation and implementation. Approval process will be via implementation of EQMS within VCC.	6	1	
Matter Arising 2	**Matter Arising 2: Business Continuity Training (Operation).** 2.1 Management should ensure that: • business continuity training requirements for all staff within the organisation are clearly identified, including frequency ofrenewal; and • business continuity training records are kept up to date (including training required, training undertaken, date of training and date of renewal) and regularly monitored to ensure all staff are appropriately trained. This includes any staff required to complete mediatraining.	Medium	2.1 Review and update the Exercise, Test & Training Programme to include media training and frequency of renewal on the training needs analysissection	Cath O'Brien, Chief Operating Officer	Andrew Mapstone, Business Continuity Lead	December 2023	Complete	**Complete.** Training Needs Analysis updated to include a column for frequency and excel spreadsheet documenting the dates individuals have completed certain training has been updated to include a due date for renewal. The agreed action identified as part of this audit has been completed. Note; discussions and agreement required by the Executive Management Team to commit to completing the Local Resilience Forum Wales Gold courses - to date various cancellations post booking onto the course have beenrecieved.					Jan-24
Matter Arising 3	**Matter Arising 3: Business Continuity Communications (Design).** 3.1 Management should ensure that: • the major incident communication plan is approved at appropriate fora and regularly tested;and • the Communications team works with those responsible for business continuity within the divisions to develop a Trust-wide bank of standard, consistent communications, including reference where local business continuity plans hold prewritten communications.	Medium	3.1 To continue progressing with the Trust Business Continuity & Emergency Preparedness programme and implement the above via; • Receivethe Major Incident Communications Plan at the Trust Business Continuity & Emergency Preparedness Group 14/12/2023 for review and comment by the group which will include adding a statement referencing local division continuity plan communications. Note: VUNHST communications have been tested via response to live incidents i.e. adverse weather, Covid-19 pandemic and ongoing industrial action.	Cath O'Brien, Chief Operating Officer	Non Gwilym, Assistant Director of Communications	February 2024	Complete	Redrafted Major Incident Communications Plan shared with Business Continuity Lead and to be presented the the Business Continuity and Emergency Preparedness Group08/02/2023.	**Complete.** Crisis Communications plan considered and approved by Business Continuity and Preparedness Group on 8 February 2024. Next steps to include mind amendments prior to presentation to SLT at both services with the end goal of EMB sign-off April/May 2024. Training for the relevant communications and engagement personel planned for March 2024.				Feb-24

Audit Action Plan



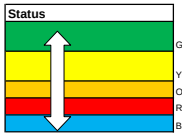
Priority	
low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Recruitment & Retention Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 December 2023	Date Final Report Issued: 01 December 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Matter Arising 1: Trust Workforce Strategy (Operation).** 1.1 The Trust should look at ensuring the People Strategy: Being an employer of choice is communicated effectively throughout the organisation.	Low	1.1 The People Strategy was formerly launched alongside the Trust strategy and other enabling strategies on the 10th November 2023. This was followed with Trust wide communications through the weeks following the launch. The strategy is now widely available and easy to locate on the Trust Intranet. The narrative and terminology within the People Strategy will be used in all staff engagement events and work programmes going forward. The Trust will have specific articles highlighting the People Strategy in January 2024 Trust and Divisional Newsletters.	Sarah Morley, Director of Workforce & OD	Susan Thomas, Deputy Director of Workforce & OD	31 January 2024	Complete	**Complete.** The People Stratedgy has been referenced in key engagment work within the Trust including: Trust Listening Events, Speaking up Safely Intranet Pages and Divisional Newslettter. The People plan is featured in the Trust and enabling straedy communication plan.					31 January 2024
Matter Arising 2	**Matter Arising 2: Staff Recruitment (Design).** 2.1 The Trust should ensure the Recruitment and Selection Policy is approved and communicated throughout the Trust.	Medium	2.1 The Recruitment and Selection Policy has been endorsed by EMB and is on the agenda for January 2024 Quality, Safety and Performance Committee for endorsement before approval at Trust Board on 30th January 2024. The Policy will then be promoted and published on the Trust Intranet by the end of February 2024.	Sarah Morley, Director of Workforce & OD	Amanda Jenkins, Head of Workforce	29 February 2024	Complete	On target for February completion.	**Complete.** The Recruitment and Selection Policy has been promoted and published on the Trust Intranet site.				02 February 2024
Matter Arising 3	**Matter Arising 3: Monitoring and Reporting (Design).** 3.1a The Trust should implement performance measures to ensure regular monitoring of the current position and the impact of actions implemented. The information should be reported into appropriate committees.	Medium	3.1a Currently the Trust has in place Divisional dashboards to monitor recruitment and retention which are updated monthly. The Supply and Shape report that is reported to Quality Safety and Performance Committee via EMB quarterly will have a robust section on Attraction and Retention and monitor recruitment measures and hotspot areas from January 2024.	Sarah Morley, Director of Workforce & OD	Susan Thomas, Deputy Director of Workforce & OD	31 January 2024	Complete	**Complete.** A Section on Attraction and Retention is now routinely evident in the quarterly Supply and Shape paper. The January Supply and Shape Paper was approved by EMB 4th Jan and will be presented to QSP on the 16th Jan.					16 January 2024
Matter Arising 3	**Matter Arising 3: Monitoring and Reporting (Design).** 3.1b The Trust should measure the effectiveness of its recruitment and retention initiatives.	Medium	3.1b The People Strategy Implementation Plan contains details of recruitment and retention activities. General reporting takes place on a monthly basis, however, the effectiveness of specific initiatives will be monitored throughout and reported on a quarterly basis through EMB onto Quality, Safety and Performance Committee. To allow sufficient time to embed current initiatives, reporting will commence in July 2024.	Sarah Morley, Director of Workforce & OD	Amenda Jenkins, Head of Workforce	31 July 2024	Complete	Reporting being progressed via Supply and Shape quarterly papers to EMB and QSP and the People Strategy Implementation plan.	**Complete.** Reporting being progressed via Supply and Shape quarterly papers to EMB and QSP and the People Strategy Implementation plan. A internal WOD risk meeting has been established from April 2024. Reporting arrangments have been agreed and are in place				02 February 2024

Audit Action Plan



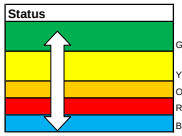
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

*Unless amore appropriate timescale is identified / agreed

Velindre UNHSTrust

MIM Commercial Approval Points Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 December 2023	Date Final Report Issued: 04 December 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Matter Arising 1: Progress Reporting (Operation).** 1.1 The Project Board should receive more frequent updates on progress towards implementation of outstanding CAP recommendations, including the risk impact of failing to address recommendations within the stated timeframes.	Medium	1.1 The Project will complete a review of all CAP requirements for the next CAP – CAP 5. We will report on the CAP 5 requirements and all outstanding CAP recommendations that need to be actioned.	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	Pre CAP5 process	Complete		**Complete.** The review of CAP 5 requirements has been actioned and is complete.				Feb-24
Matter Arising 2	**Matter Arising 2: Timeliness of closure of recommendations (Operation).** 2.1 Appropriate timelines should be internally allocated to recommendations, and monitored routinely, to ensure recommendations are closed out as soon as possible.	Medium	2.1 Programme to FC includes all timelines for CAP 5 process. The Project will complete a review of all CAP requirements for the next CAP – CAP 5. We will report on the CAP 5 requirements and all outstanding CAP recommendations that need to be	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	Pre CAP5 process	Complete		**Complete.** The review of CAP 5 requirements has been actioned and is complete.				Feb-24
Matter Arising 2	**Matter Arising 2: Timeliness of closure of recommendations (Operation).** 2.2 Where partial actions have been taken, but not of a sufficient nature to close a recommendation, the Review Grid Action Plan and associated progress reports should clearly document what actions remain outstanding to enable the recommendation to be closed, and what the associated risks / impacts are of the outstanding elements of work.	Medium	2.2 The Project will complete a review of all CAP requirements for the next CAP – CAP 5. We will report on the CAP 5 requirements and all outstanding CAP recommendations that need to be actioned.	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	Pre CAP5 process	Complete		**Complete.** The review of CAP 5 requirements has been actioned and is complete.				Feb-24
Matter Arising 2	**Matter Arising 2: Timeliness of closure of recommendations (Operation).** 2.3 The disparity between the September 2023 Project Board CAP4 report and associated minutes should be reviewed and corrected if necessary.	Medium	2.3 The Project Board minutes will be reviewed and, if need be, amended at the next Project Board.	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	December 2023	Overdue		This action is being investigated to clarify that it can be closed. Hopefully to be marked as complete in the March 2024 update.				

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

*Unless amore appropriate timescale is identified / agreed

Velindre UNHSTrust

New Velindre Cancer Centre Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 19 December 2023	Date Final Report Issued: 04 December 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Matter Arising 1: More cohesive monitoring of planning applications (Design & Operation).** 1.1 A comprehensive list of all applications made to Cardiff Council, Natural Resources Wales, and other organisations should be maintained using portal reference numbers/ descriptions, noting approval status (including conditions and Discharge of Conditions) and expiry dates of consent. The report mentioned in 2.29 above would be an appropriate report to be obtained from the external planning consultants on a monthly basis.	Medium	1.1 A database for all statutory approvals (planning permissions; EPSL approvals) relating to the nVCC will be developed that aligns to the Cardiff County Council and NRW reference numbers. The database will outline any statutory approvals awaiting approvals such as discharging planning conditions.	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	March 2024	On Target						
Matter Arising 2	**Matter Arising 1: More cohesive monitoring of planning applications (Design & Operation).** 1.2 The full aforementioned list should be published as an appendix to the Project Board papers or otherwise distributed to the Project Board, on a monthly basis, to facilitate discussion and raise awareness of planning, licencing and land transfer issues, and possible impacts.	Medium	1.2 Monthly Statutory approvals report to be developed for Project Board.	David Powell, Project Director, TCS	Mark Ash, Assistant Project Director	March 2024	On Target						

Audit Action Plan

Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - Action notcomplete
	Blue - Action closed previous meeting

Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHSTrust

Structured Assessment 2023 - Velindre University NHS Tust - External Audit Report					Assurance Rating: N/A			Date Received at Extraordinary Audit Committee: 12 January 2024	Date Final Report Issued: December 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2024	Update February 2024	Requested Extension Dates	Extension (Months)	Extension Requests Total	Date Completed
R1	**Transparency of Board business.** The Trust rarely publicises its Board meetings on its social media channels. The Trust should establish a process to ensure more frequent reminders about Board meetings are posted on social media.	Medium	The Governance and Communications teams have a pre-Trust board meeting process to confirm the communications plan for promoting the meetings which will include messaging via the Trust's external and internal digital channels. Messages will be promoted two weeks in advance and in the lead up the meeting.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	Complete	Complete	Complete on report that was presented at the January 2024 Extraordinary Committee.					
R2	**Transparency of Board business.** The Trust does not publicise what is to be discussed in private Board or committee meetings or publish summaries of what is discussed. The Trust should: • include a list of the items to be discussed in private sessions on public Board and committee meeting agendas; and	Medium	The refresh of the Corporate Governance Manual includes revisions to the meeting secretariat documentation. • The revised agenda template includes an agenda item, 'Summary from the PRIVATE / PART B Board or Committee meeting held on DD/MM/YYYY'	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	31 March 2024	On Target	N/A as no updates sought.					
R2	**Transparency of Board business.** • provide (and publish) brief summaries of private Board and committee discussions	Medium	• Brief summary to be included in Chair Report (for Trust Board) or Committee Highlight reports	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	31 March 2024	On Target	N/A as no updates sought.					
R3	**Transparency of Board business.** Committee minutes are published on the Trust's website when included in papers for the next meeting, usually two months later. The Trust should publish unconfirmed minutes as soon as possible after committee meetings, following accuracy checking, whilst still retaining full confirmation of accuracy by committee members in the following meeting.	Medium	The refresh of the Corporate Governance Manual has a timescale for completion of the DRAFT UNCONFIRMED minutes of the previous meeting, which is 16 working days and then five working days to allow for Welsh translation to be able to upload the English and Welsh versions at the same time DRAFT UNCONFIRMED minutes will be published within 22 working days of the Board or Committee..	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	31 March 2024	On Target	N/A as no updates sought.					
R4	**Board and committee reports.** In Board and committee cover papers, the summary of previous discussions undertaken in other fora often do not make evident what the outcome was and whether any agreed actions have been implemented. The Trust should establish a process to ensure that summaries of previous discussions include the resulting agreed actions, and whether they have been implemented.	Medium	The revised Board/Committee Report Template has a section 'Governance Route' which lists the names of the previous Fora and dates together with a summary and outcome of previous governancediscussions. The revised Corporate Governance Manual will be updated to ensure that that the Governance Route section of the Board/Committee Report template is updated to reflect the summary and outcome of any previous discussions by the report author and signed off by the Executive Sponsor/Lead.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Kay Barrow, Corporate Governance Manager	31 March 2024	On Target	N/A as no updates sought.					
R5	**Operational risk assurance.** Recent cover papers on the Corporate Risk Register did not include the reasons why some risks are no longer featured. This means that meeting members have no assurance that the reason for any omissions is a result of risk mitigation having a positive impact. In future Corporate Risk Register cover reports, the Trust should provide a summary on the reasons why risks have been removed from the Corporate Risk Register.	High	The Risk Register cover paper will include additional tracking information of risks ie: • new with reason for inclusion; • removed with justification for removal; and • revised with reason for revision.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	31 January 2024	Complete	N/A as no updates sought.	**Complete.** From January 2024 the Risk Register report cover paper now includes additional information that reflects the movements in the Risk Register since the previous reported position and the rationale i.e. new risks added; risks closed/removed; risk revisions, etc.				Feb-24
R6	**Board and committee reports.** Often, Board and committee cover reports, papers and presentations are operationally detailed, and activity focused but provide less clarity on the impacts of initiatives or actions taken. The Trust should establish a process to ensure that Executive Lead sponsors review to make sure that cover reports, papers and presentations are focused on key issues and impacts.	Medium	The refresh of the Corporate Governance Manual is explicit in relation to the responsibilities of the report author and Executive Lead regarding the report content and focus.	Lauren Fear, Director of Corporate Governance and Chief of Staff	All Executive Directors	31 March 2024	On Target	N/A as no updates sought.					

Annual Audit Report 2023 – Velindre University NHS Trust

Audit year: 2022-23

Date issued: January 2023

Document reference: TBC

Purpose of this document

This document is a draft supplied in confidence solely for the purpose of verifying the accuracy and completeness of the information contained in it and to obtain views on the conclusions reached.

Handling prior to publication

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

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

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Velindre University NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Trust, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- audit of accounts; and
- arrangements for securing economy, efficiency, and effectiveness in the use of resources.

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 31 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Trust's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing

that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive, the Executive Director of Finance and the Director of Corporate Governance and Chief of Staff have agreed the factual accuracy of this report. We presented it to the Audit Committee on 12 March 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Trust to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit Committee for improvement.

13 I identified no material financial transactions within the Trust's 2022-23 accounts that were not in accordance with authorities or not used for the purpose intended,

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2022-23 accounts.

14 I placed no substantive report alongside my opinion this year as there were no issues to report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- Across Wales, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- The Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities.
- Overall, the Trust continues to be generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances. However, opportunities remain to further enhance public transparency of Board business, strengthen strategic risk management arrangements, and ensure corporate plans and strategies contain clear objectives and actions for all Trust functions.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

20 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit Committee for improvement.

21 The Trust submitted their draft accounts within the required deadline. The accounts, and supporting working papers, were of good quality. We did experience some difficulties in obtaining timely responses to some of our audit queries which delayed the completion of our audit. A major issue impacting on this was the staffing capacity within the Trust's finance team to support the audit process.

22 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My financial audit team reported these issues on 26 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were no uncorrected misstatements.
Corrected misstatements	As a result of our audit there were a number of adjustments to the financial statements.

Issue	Auditors' comments
Other significant issues	We reported the difficulties we experienced in obtaining timely responses to clear some audit queries and that this delayed the completion of our audit. A major issue impacting on this was the staffing capacity within the Trust's finance team to support the audit process. A planned secondment and unforeseen sickness absence had a significant contribution to this.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position on 31 March 2023 and the return was prepared in accordance with the Treasury's instructions.

24 My audit of the Trust's charitable funds accounts commenced during November 2023. Whilst our audit fieldwork is substantially complete, we will not be able to certify the accounts until March 2024 due to a delay in the receipt of the independent assurances upon the activities of the fund's investment management company, Brewin Dolphin. Given the material nature of these activities it is essential that we receive these assurances prior to our audit certification.

Regularity of financial transactions

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

26 I identified no material financial transactions within the Trust's 2022-23 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2022-23 accounts.

27 I placed no substantive report on the accounts alongside my opinion this year as there were no issues to report.

28 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties - to break-even over a three-year period and to have an approved three-year plan in place - or my opinion is qualified, I will issue a substantive report.

29 The Trust met its financial duties for 2022-23, reporting a small surplus of £76,000 at the end of the financial year. The Trust also achieved its statutory financial duty

to achieve break-even over a three-year rolling period 2020-23, reporting an overall three-year surplus of £155,000. As a result, my opinions were unqualified, so I did not issue a such a report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

30 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- Publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally.
- Reviewing the effectiveness of the Trust's workforce planning arrangements.
- Undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

31 My conclusions based on this work are set out below.

NHS workforce data briefing

32 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties hasn't kept up with increasing demand.

33 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

34 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies are able to recruit sufficient graduates, once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

Workforce planning arrangements

35 My review examined whether the Trust has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

36 My work found that the Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities.

37 The key workforce issues at the Trust relate to filling vacancies for professions in areas with longstanding national challenges. Vacancy levels are higher than average across Wales, with some notable gaps including consultant radiologists, acute oncology consultants and medical physicists and some nursing roles. The Trust is still dealing with the effect of the pandemic with high sickness levels experienced in some service areas. Spending on agency staff increased considerably in 2020-2021 to £2.7 million but fell to £1.3 million in 2022-23.

38 The Trust has a clear strategic vision for its workforce; however, to effectively deliver it, it needs to develop its strategic workforce planning approaches and develop an underpinning implementation plan. The Trust has a reasonable understanding of current service demands, based on current service models. It is working well with internal and external stakeholders to find shared solutions to workforce challenges. However, there is scope for the Trust to strengthen its analysis of anticipated future demand to shape future workforce requirements and inform workforce modelling. At the time of reporting, the Trust was working to finalise its Supply and Shape Framework.

39 The Trust has clear intent to improve workforce planning capacity and capability. However, limited corporate capacity and operational pressures meant that service leads do not have sufficient time to develop workforce planning solutions to help address operational challenges. The Trust understands high-level workforce risks associated with delivering its People Strategy, but actions to mitigate these risks have achieved minimal effect to date. The development of the Supply and Shape Framework should help to identify workforce gaps and inform future corporate risk assessment. The Trust is taking steps to help it respond to current workforce challenges through a range of recruitment and retention activities.

40 Whilst the Trust's Board and its committees maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks. Whilst the Quality, Safety and Performance Committee receive timely workforce performance reports, the Trust needs to strengthen how it reports on the impact of the People Strategy's delivery to demonstrate what difference it is making. Where possible the Trust benchmarks its workforce performance with other health bodies in Wales and networks with comparing organisations across the UK.

Structured assessment

41 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

42 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

Board transparency, effectiveness, and cohesion

43 My work considered whether the Trust's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business;
- Arrangements to support the conduct of Board business;
- Board and committee structure, business, meetings, and flows of assurance;
- Board commitment to hearing from staff, users, other stakeholders; and
- Board skills, experiences, cohesiveness, and commitment to improvement.

44 My work found that the Board and its committees generally operate well, with an ongoing commitment to public transparency, continuous improvement and to hear from patients and donors. However, opportunities remain to further enhance certain arrangements further.

45 The Board remains committed to conducting its business transparently. Board meetings are live-streamed, and papers made available in advance of meetings. However, opportunities remain to further enhance transparency of Board business. This includes promoting Board meetings via social media, publishing committee agenda papers in advance of meetings, giving the public a brief summary of decisions made in private sessions, and publishing unconfirmed Board and committee minutes shortly after meetings.

46 There are effective arrangements to support the conduct of Board business. Board and committee meetings are well managed, with good scrutiny, challenge, and debate. However, some committees are finding it difficult to run meetings to time. Board and Committee papers often contain too much detail and do not provide enough assurance on the impact of initiatives or actions taken.

47 The Board promotes and demonstrates a commitment to hear from patients and donors and is stepping up activities to enable Board members to hear from service

users. The Board is stable and continues to demonstrate a positive commitment to continuous improvement. However, the Trust will need to ensure that appropriate arrangements are in place to ensure continued stability once it has successfully recruited a replacement independent member.

Corporate systems of assurance

48 My work considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- Overseeing strategic and corporate risks;
- Overseeing organisational performance;
- Overseeing the quality and safety of services; and
- Tracking recommendations.

49 My work found that positive improvements have been made to key corporate systems of assurance, particularly in relation to managing performance, tracking recommendations, and responding to the new duties of quality and candour. However, progress in refreshing strategic risks has been slow, limiting the Board's ability to maintain effective oversight of them.

50 The Trust has continued to develop its Board Assurance Framework, but progress to refresh strategic risks has been slow. Consequently, the Board Assurance Framework was not reviewed by the Board for more than six months. However, the new template was populated with the revised risks and associated controls and assurance by the end of 2023. In January 2024, both the Quality, Safety, and Performance Committee and the Strategic Development Committee received the new Board Assurance Framework and endorsed the new strategic risks for Board approval later in the month. Improvements to information included in the Corporate Risk Register are providing better clarity about operational risks. This has drawn attention to the long-standing nature of many of the risks, and the Board wants to give more attention to the longest open risks over the coming months.

51 The Trust is strengthening its corporate approach to reporting, overseeing, and scrutinising organisational performance. It is looking to develop a Business Intelligence solution to help automate the collection and reporting of performance measures. The Trust has taken appropriate steps to review its compliance with the new duties of quality and candour. There are good arrangements to oversee and scrutinise progress to address audit and review recommendations.

Corporate approach to planning

52 My work considered whether the Trust has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- Producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
- Overseeing the delivery of corporate strategies and plans.

53 My work found that the Trust has set out a clear vision in its long-term strategy and its supporting enabling strategies. The Trust has effective corporate planning arrangements but needs to ensure that when it develops priorities for future Integrated Medium-Term Plans (IMTP), it considers the collective resources required to deliver them all rather than on an individual basis. There was good Board-level engagement throughout the development of the 2023-26 IMTP.

54 The 2023-26 IMTP contains clear objectives and actions, supported by timescales for delivery and intended measurable outcomes for blood and cancer services. However, the objectives for cross-cutting corporate functions are not underpinned by specific actions, and nor are they time-bound or measurable. Progress reporting against the 2023-26 IMTP has been limited to blood and cancer services only, and progress reports have not been received by the full Board. Going forward, the Trust recognises that IMTP progress reports need to provide better narrative to explain the resulting impact of both delivered and non-delivered actions on service quality and performance.

Corporate approach to managing financial resources

55 My work considered whether the Trust has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- Achieving its financial objectives;
- Overseeing financial planning;
- Overseeing financial management; and
- Overseeing financial performance.

56 My work found that the Trust continues to have good arrangements for financial planning and managing and monitoring its financial position.

57 The Trust met its financial duties for 2022-2023 and is forecasting to break-even in 2023-24. The Trust has a clear process for financial planning, with good involvement from the Board, although the development and the identification of recurrent savings plan has been a challenge. Its arrangements for controlling, overseeing, and scrutinising financial management are robust.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2023.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2023
Opinion on the Financial Statements	July 2023
Audit of Accounts report	October 2023
Performance audit reports	
Review of Workforce Planning Arrangements	August 2023
NHS Workforce Data Briefing	September 2023
Structured Assessment 2023	November 2023
Other	
2023 Detailed Audit Plan	July 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts

Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Financial Efficiencies	March 2024
Operational Governance	May 2024
Follow-up of quality governance review	May 2024
Examination of the setting of well-being objectives	May 2024

Appendix 2

Audit fee

The 2023 Audit Plan set out the proposed audit fee of £243,111 (excluding VAT). The actual fee for the year was £252,111. Additional audit fee was charged owing to the additional audit required to complete the audit of the Trust's 2022-23 financial statements. [In addition to the fee set out above, the audit work undertaken on the shared services provided to the Trust by the NHS Wales Shared Services Partnership cost £2,779.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Trust's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
Significant risks		
Management Override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	Planned audit work completed and no issues arising.
Other areas of audit focus		
IFRS16 – Leases A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23. IFRS16 will significantly change how most leased assets are accounted for, as leased assets will need to be recognised as assets	My audit team will: • consider the completeness of the lease portfolios identified by the health board/trust/authority needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and	Planned audit work completed and no issues arising.

Audit risk	Proposed audit response	Work done and outcome
and liabilities in the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	disclosed in accordance with the Manual for Accounts; and • ensure that all material disclosures have been made.	
Asset Valuations The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	Planned audit work completed and there was one significant audit adjustment to asset valuations as a result of the correction of a validation error raised by the Welsh Government. This resulted in a £7.090m increase in the closing Net Book Value of the Trust's property plant and equipment.
Inventory Whilst decreasing, the inventory balance within the Trust's annual accounts remains material. In	We will undertake audit procedures to obtain assurance upon the accuracy and completeness of the write-downs undertaken during the	All audit work completed as planned and there were no issues arising.

Audit risk	Proposed audit response	Work done and outcome
addition there have been material write-downs of some stock values during the financial year. There is a risk that these write-downs are not founded on correct assumptions, accurately calculated or complete.	financial year to help inform whether the inventory balance within the financial statements is materially correct.	
Welsh Risk Pool The Trust hosts the Welsh Risk Pool Services on behalf of NHS Wales bodies in respect of costs associated settling clinical negligence claims, including structured settlement cases. As a result of the typically high value of these claims the aggregate value within the Trust's accounts far exceeds our materiality level. As a result, there is an inherent risk that any errors in presenting and disclosing these liabilities within the annual accounts could be material.	We will undertake audit testing and seek assurances from the work undertaken by other NHS Wales auditors in order to obtain assurance that the liabilities are materially correct.	An audit adjustment was made of £4.587m to reduce the Welsh Risk Pool Provision and corresponding debtor due from the Welsh Government due to the duplication of a case that became a Structured Settlement case in the year.

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: February 2024

Document reference: ACU202403

This document has been prepared for the internal use of Velindre University NHS Trust as part of work performed / to be performed in accordance with statutory functions.

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

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

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

Contents

About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Velindre University NHS Trust (the Trust). We presented a detailed Audit Plan for our 2023 work programme to the committee on 26 July 2023.

2 Also included is information on:

- other relevant examinations and studies published by the Audit General;
- relevant corporate documents published by Audit Wales (eg fee schemes, annual plans, annual reports); and
- details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

2022-23 Charitable Funds Audit

4 The audit of the Trust's 2022-23 charitable fund accounts is substantially complete, but there is one key area of audit remaining. This concerns the fact that we have insufficient audit assurances upon Brewin Dolphin, the charity's fund/investment manager, and so have an assurance gap concerning material transactions and balances within the accounts. Brewin Dolphin engage the services of PWC to provide assurances to third parties, and the assurance report covering the whole of the 2022-23 period has not yet been issued, and we are unable to certify the accounts without obtaining assurance on this area. We expect to conclude and certify the accounts in April.

2023-24 Accounts audit update

5 Earlier this month, our Executive Director for Audit Services, wrote to NHS Bodies setting out the timings of our audit work for the year ahead and our intention to certify all NHS accounts by 15 July 2024. Early planning work has commenced at the Trust to support achieving this deadline and there are no matters to bring to the attention of Audit Committee members at this early stage of the audit.

Performance audit update

6 **Exhibit 1** summarises the status of our current and planned performance audit work.

Exhibit 1 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local study - Operational Governance (2022 Audit Plan)	TBC	A review of each division's governance arrangements to support effective scrutiny of quality, performance, and finance.	**Not started** Timing of fieldwork to be confirmed.	To be confirmed
Structured Assessment	Director of Corporate Governance and Chief of Staff	A review of the corporate arrangements in place at the Trust in relation to: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	**Complete**	(January 2024)

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment Deep Dive - Financial efficiencies	Executive Director of Finance	Review of arrangements for making financial efficiencies – to be undertaken across all health bodies.	**Fieldwork commenced**.	July 2024
Local project work - Follow-up of quality governance review	Executive Director of Nursing, AHP & Health Science	A follow-up the Trust's progress in implementing actions to address the findings of the 2022 report on quality governance arrangements.	**Fieldwork commenced**.	July 2024
Local project work - Examination of the setting of well-being objectives	Executive Director of Strategic Transformation, Planning and Digital	An assessment of the extent to which the Trust has acted in accordance with the sustainable development principle when renewing its well-being objectives.	**Fieldwork commenced**.	July 2024

Other relevant publications

7 **Exhibit 2** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 2 – relevant examinations and studies published by the Auditor General

Title	Publication Date
From firefighting to future-proofing – the challenge for Welsh public services	**February 2024**
NHS Workforce data briefing	September 2023
NHS Wales Finances Data Tool - up to March 2023	September 2023
Approaches to achieving net zero across the UK	September 2023

Additional information

8 **Exhibit 3** provides information on corporate documents published by Audit Wales in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Audit Wales corporate documents

Title	Publication Date
Fee Scheme 2024-25	**January 2024**
Equality Report 2022-23	November 2023
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2025	October 2023
Supporting information for the Estimate for Audit Wales 2024-25	October 2023
Interim Report 2023	October 2023
Welsh language report 2022-23	October 2023

Archwilio Cymru
Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Project Brief – Review of the Strategic Approach to Improving the Timeliness of Cancer Diagnosis and Treatment

Audit year: 2024

Date issued: February 2024

Document reference: 3956A2023

This document has been prepared for the internal use of the Welsh Government, the NHS Wales Executive, Health Boards; Velindre and Public Health Wales NHS Trusts; NHS Shared Services Partnership, Digital Health and Care Wales; Health Education and Improvement Wales; and third sector organisations as part of work to be performed in accordance with statutory functions 145A of the Government of Wales Act 1998 and section 135 of the Government of Wales Act 2006.

No liability is accepted by the Auditor General or the staff of the Wales Audit Office in relation to any member, director, officer or other employee in their individual capacity, or to any third party in respect of this report.

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

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Background

1. Cancer has been the biggest cause of mortality in Wales since 2016 and survival rates for some cancers are worse than in other comparable countries. The Less Survivable Cancers Taskforce Wales has highlighted the importance of cancer survival initiatives noting that Wales has relatively poor survival rates for three of the six deadliest forms of cancer. There was a 25% increase in new cancer diagnoses in 2019 compared to 2002. Demand is forecast to continue increasing until at least 2030[1]. For many cancers, early diagnosis dramatically increases survival rates. NHS Wales estimates[2] that 38% of cancer cases in Wales each year could be prevented from occurring in the first place.
2. Numerous organisations are involved in the prevention, early detection, diagnosis, and treatment of cancer, and in supporting patients and their families. The Welsh Government's Quality Statement for Cancer published in in 2021 set out what good quality cancer services look like. The Welsh Government requires NHS bodies to plan, deliver and improve cancer services in line with the Quality Statement and associated service specifications for specific tumour sites. The Welsh Government also required health boards to report performance against a new Suspected Cancer Pathway from February 2021. It set a target that 75% of patients should start their first definitive treatment within 62 days of first suspicion of cancer.
3. The NHS Executive leads national delivery and improvement of cancer services through the Wales Cancer Network and the Wales Cancer Network Board. In 2023, the Network published the Cancer Improvement Plan for NHS Wales 2023-26. The Plan describes some of the challenges facing cancer services with the biggest being insufficient capacity to meet current demand. It explains that NHS bodies are already 'struggling to cope' with demand for cancer services, particularly at diagnostic stage where the volume of suspected cancer referrals is increasing. The Plan describes underlying factors restricting capacity as: workforce shortages; weaknesses in facilities and equipment; and the configuration of healthcare services. There are also opportunities to increase capacity by preventing some cancers occurring in the first place and by making cancer services more efficient.
4. The timeliness of cancer services is one indication of how well NHS Wales is matching capacity to demand. The Cancer Improvement Plan explains that the NHS Executive has agreed a milestone with health boards and Trusts of 70% compliance against the Suspected Cancer target by March 2023 and 80% by March 2026. Performance against the target is poor. All health boards missed the 70% compliance target in March 2023, and, at 56% compliance in October 2023[3], NHS Wales is a long way from its target. The Cancer Improvement Plan recognises that longer waiting times 'will inevitably lead to later diagnosis and treatment of disease and poorer cancer outcomes'.

Legal basis

5. We are carrying out this audit under section 135 of the Government of Wales Act 2006 and section 145A of the Government of Wales Act 1998. The work may also help discharge our responsibilities under section 15 of the Well-being of Future Generations (Wales) Act 2015.

[1] Wales Cancer Network, A Cancer Improvement Plan for NHS Wales 2023-26, NHS Wales, 2023.

[2] Ibid.

[3] The most recent figures as of 13th November 2023.

Our audit

Audit objective

6. Our objective for this audit is to evaluate NHS Wales's strategic approach to achieving efficient, effective and good quality cancer services with a specific focus on addressing systemic barriers to timely cancer diagnosis and treatment. The audit will look to make recommendations if we identify areas for improvement.

Audit questions

7. This proposed audit will seek to answer the overall question: 'At a national level, does NHS Wales have a well-founded strategic approach to improving the timeliness of cancer diagnosis and treatment?'
8. Appendix 1 contains the audit questions and audit criteria.

Audit scope

9. Our main focus will be on NHS Wales's strategic approach to address systemic or collective barriers to timely cancer diagnosis and treatment. Our work will focus on the Welsh Government and NHS Executive (and Wales Cancer Network) as the system leaders. We will also look at Health and Education Improvement Wales and Digital Health and Care Wales, Public Health Wales NHS Trust and the NHS Wales Shared Services Partnership as contributors to the national approach. We will also engage with health boards and trusts for their perspective on the opportunities and challenges associated with delivering timely cancer diagnosis and treatment. We are currently considering undertaking separate work in 2024, via the Auditor General's local audit plans, that will examine how individual NHS bodies are planning and delivering cancer services. Once that is confirmed, a separate project specification will be produced to cover this work.
10. We recognise that services for cancer patients are part of wider planned and emergency services and often compete with non-cancer patients for the same capacity. We will consider whether there is clear national direction to guide health boards in prioritising capacity to meet demand from cancer and non-cancer patients and the cohesiveness of the strategic approach including clinical, performance and planning frameworks, strategies and plans, and initiatives to improve efficiency.
11. We will focus on the timeliness of cancer diagnosis and treatment as an indication of how well NHS Wales is managing capacity to meet demand. We will not conduct a thorough examination of quality, patient outcomes or satisfaction or other aspects of cancer care.

Audit criteria

12. Appendix 1 sets out our proposed audit criteria. They are informed by our learning from previous audits of planned care[4] and local health audit work, analysis of national strategic documents[5], and research by relevant organisations highlighting the challenges facing cancer services in Wales.

Audit methods

13. Our audit methods will include:

- document review including strategic documents, minutes of meetings, evidence and reports from relevant Senedd enquiries, and information on the oversight of cancer performance and the delivery of relevant national strategies and plans;
- interviews with relevant officials in the Welsh Government;
- discussions with relevant officers in selected NHS bodies;
- analysis of available data;
- engagement with relevant third sector and representative organisations;
- establishing a virtual 'reference panel' of representatives from relevant organisation to provide additional insight into challenges and opportunities for cancer services in Wales.

This list is not exhaustive. We may consider other audit methods during the course of the study if required. We will also work closely with colleagues from our local NHS audit teams to ensure we are sighted of relevant documents and discussions related to the scope of the study.

Output

14. We are aiming to publish an evaluative report as part of this audit. We may also decide to produce other outputs, for example, blogs, additional commentary on specific findings from our work, data briefings and / or short animations to highlight key themes.

Timetable

15. We are aiming to share our draft findings in late spring 2024 and publish our report in the late summer 2024. However, we will keep our timetable under review to allow NHS bodies flexibility to respond to our requests as they respond to seasonal pressures. We will keep stakeholders informed if the timeframe changes.

Audit Wales contacts

16. Exhibit 1 sets out the Audit Wales team that will be working on this audit.

[4] Audit Wales, NHS Waiting Times for Elective Care in Wales, 2015; Audit Wales, 10 Opportunities for Resetting and Restarting the NHS Planned Care System, 2020; and Audit Wales, Tackling the Planned Care Backlog in Wales, 2022.

[5] Including Welsh Government, A Healthier Wales – a Long term Plan for Health and Social Care, 2021; Welsh Government, Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales, 2022, Welsh Government, The Quality Statement for Cancer, 2022, Welsh Government, Diagnostics Recovery and Transformation Strategy for Wales 2023 to 2025; and the Wales Cancer Network, A Cancer Improvement Plan for NHS Wales 2023-2026, 2023.

Exhibit 1: Audit Wales contacts

Name	Contact details
Audit Director	Dave Thomas – dave.thomas@audit.wales
Audit Manager	Mark Jeffs – mark.jeffs@audit.wales
Audit Lead	Verity Winn – verity.winn@audit.wales
Senior Auditor	Philippa Fido – philippa.fido@audit.wales

Fieldwork schedule

17. We aim to conduct the bulk of our interviews and analysis from January to March 2024, although we may need to make some follow-up enquiries after that. We will be flexible in our timescales to avoid putting undue pressures on NHS bodies responding to seasonal pressures. We will conduct our fieldwork in line with the organisation's stated language preference and make every reasonable effort to accommodate language preferences of individuals who request interviews and correspondence in Welsh with enough notice. As a general rule we will undertake interviews and stakeholder discussions virtually, but will look to set up in-person meetings by agreement if this is deemed to be beneficial.

Appendix 1 - Audit questions and criteria

Level 2 questions	Level 3 questions	Criteria
Is the strategic approach to secure timely diagnosis and treatment of cancer based on a good understanding of the key issues relating to the timeliness of cancer diagnosis and treatment?	Is the strategic approach based on a good understanding of the current timeliness of cancer diagnosis and treatment?	NHS Wales has clear information (at an individual NHS body and all Wales level, and for all tumour sites) showing timeliness at all stages of the patient pathway, specifically: • Performance against the Single Cancer Pathway target (including median and 75th percentile waits) • Performance against the target for the resident population including those being treated by other NHS Wales, NHS England and other commissioned providers • Performance against the target by health board, sex at birth, age and ethnicity to understand equality of timeliness • Timeliness at all stages of the cancer pathway including beyond first definitive treatment: recurrent disease; and when patients move between different organisations for treatment
	Is the strategic approach based on a good understanding of the risks of not delivering timely diagnosis and treatment on patient outcomes?	At a national level, NHS Wales can demonstrate it understands: • Whether cancer patients are coming to harm as a result of slow diagnosis and treatment and broad estimates of how many patients may be affected (for instance information on whether there has been an increase in patients presenting at a later more severe stage) • Whether some cancer patients are disproportionately affected by slow diagnosis and treatment (depending on patient tumour

	site, health board of residence, sex at birth, age and ethnicity) • Comparable impacts on cancer and non-cancer patient outcomes resulting from slow diagnosis and treatment to inform decisions about where to deeply limited capacity across cancer, planned and emergency care
Is the strategic approach based on a good understanding of the barriers to improving timeliness?	At a national level, NHS Wales can demonstrate it understands: • Common operational issues for NHS bodies including blockages and areas of inefficiency along the cancer pathway (such as compliance against the National Optimal Pathways) • Systemic barriers to improving timeliness (for instance, there may be issues associated with the geographical configuration of services or arrangements to allocate funding) • Broader demand from planned and emergency care on NHS resources • Existing capacity in terms of workforce equipment, technology, estates and workforce
Is the strategic approach based on a good understanding of the opportunities and challenges associated with preventing cancer occurring in the first place?	At a national level, NHS Wales can demonstrate that it understands: • Cancer incidence, mortality and survival across Wales including potential health inequalities • Available evidence on whether (and which) health improvement interventions are likely to reduce cancer incidence • The costs and benefits associated with delivering evidence-based health improvement interventions to at risk population groups

Does NHS Wales have a coherent and integrated strategic approach to address the systemic barriers to improving timeliness of cancer diagnosis and treatment?	Has NHS Wales clearly articulated how it will address the systemic barriers to improving timeliness of diagnosis and treatment?	At a national level, NHS Wales has clearly set out: • Coherent actions to address the systemic barriers to timeliness (that are complementary and not contradictory) • Timescales to address the systemic barriers to timeliness • Targets and / or outcomes associated with improving timeliness • Roles and responsibilities to delivering actions to address the systemic barriers to timeliness (including where the Welsh Government or NHS Executive is the lead)
	Is the strategic approach to improving timeliness of cancer diagnosis and treatment well integrated with the broader strategic approach to delivering sustainable healthcare?	There are clear links between the strategic approach to cancer, health improvement and prevention, diagnostics, planned care and emergency care (that are complementary and not contradictory).
	At a time when capacity for cancer and non-cancer care is under pressure, is the strategic approach clear about how to prioritise capacity between cancer and non-cancer patients and the impact on other services?	At a national level, NHS Wales has clearly articulated guiding principles for NHS bodies to prioritise capacity between non-cancer and cancer patients
	Has NHS Wales developed consensus and buy-in across key stakeholders to deliver the strategic approach?	At a national level, NHS Wales can demonstrate its activities to involve NHS bodies and third sector organisations and develop consensus and buy-in to deliver the strategic approach NHS bodies have a clear understanding of the strategic approach and their role in delivering it
	Does NHS Wales know what human and other resources are required to achieve improvement?	At a national level, NHS Wales has a broad understanding of the resources the system needs to improve timeliness including: • Workforce • Funding

		• Physical space / estates • Equipment and technology, including relevant informatic systems
	Is the strategic approach sufficiently focused on balancing the shorter term demands of recovering cancer services with longer term goals of creating sustainable health services?	At a national level, NHS Wales has set out actions to address shorter term recovery challenges that do not restrict longer term goals of creating sustainable cancer services
Does NHS Wales have good arrangements to oversee delivery of the strategic approach to secure timely diagnosis and treatment of cancer?	Has NHS Wales clearly set out who will oversee implementation of the strategic approach to improving timeliness?	At a national level, NHS Wales has clearly set out which organisations are responsible for overseeing implementation of the strategic approach including the Cancer Improvement Plan, Diagnostic Recovery and Transformation Strategy, and relevant aspects of NHS bodies Integrated Medium Term Plans. We would expect to see clear information setting out: • Which groups, forums or networks are responsible for national oversight or elements of oversight including responsibility for overall oversight of the strategic approach • National structures for sharing oversight information • Where national oversight arrangements are split (for instance between the Welsh Government and the NHS Executive), NHS Wales has set out how arrangements fit together to drive improvement
	Has NHS Wales set out what information it will monitor to understand collective and individual progress implementing the strategic approach to improving timeliness?	At a national level, NHS Wales has clear performance measures to understand progress implementing the strategic approach by individual organisations and collective progress to understand how individual activities contribute to overall improvement goals. In particular, we would expect to see: • Clear performance measures to monitor implementation of actions in the Cancer Improvement Plan

	• Clear performance measures to monitor implementation of the Diagnostic Recovery and Transformation Strategy • Clear performance measures to monitor implementation of any other key elements of the strategic approach arising from our fieldwork • Clear information linking delivery of relevant parts of individual Integrated Medium-Term Plans to the implementation of the strategies above to understand overall progress
Has NHS Wales set out how regularly it will review progress implementing the strategic approach to improving timeliness?	At a national level, NHS Wales has set out clear timescales for reviewing progress implementing the strategic approach to improving timeliness including the Cancer Improvement Plan, Diagnostic Recovery and Transformation Strategy, and relevant aspects of NHS bodies Integrated Medium Term Plans
Has NHS Wales set out where it will report progress implementing the strategic approach to improving timeliness?	At a national level, NHS Wales has set out where it will report progress implementing the Cancer Improvement Plan, Diagnostic Recovery and Transformation Strategy, and relevant aspects of NHS bodies Integrated Medium Term Plans including how it will share progress updates with stakeholders including NHS Wales, third sector organisations, and the public.

Appendix 2 - Fair processing notice

Date issued: December 2023

This privacy notice tells you about how the Auditor General for Wales (AGW) and staff of the Wales Audit Office (WAO) process personal information collected in connection with our work.

Who we are and what we do

The AGW's work includes examining how public bodies manage and spend public money, and the WAO provides the staff and resources to enable him to carry out his work. "Audit Wales" is a trademark of the WAO and is the umbrella identity of the AGW and the WAO.

The purposes of the processing

We will use personal data when exercising our powers and duties, which chiefly concern the audit of public bodies and activities to support such work.

Data Protection Officer (DPO)

Our DPO can be contacted by telephone on 029 2032 0500 or by email at infoofficer@audit.wales.

Relevant laws

We process your personal data in accordance with data protection legislation, including the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR). Our lawful bases for processing are the powers and duties set out in the Public Audit (Wales) Acts 2004 and 2013, the Government of Wales Acts 1998 and 2006, the Local Government (Wales) Measure 2009, the Well-being of Future Generations (Wales) Act 2015, the Local Government & Elections (Wales) Act 2021 and various legislation establishing particular public bodies, such as the Care Standards Act 2000.

Further details are available in our publication, A guide to Welsh public audit legislation, which is available on our website.

Depending on the particular power or function, these statutory bases fall with Article 6(c) and (e) of the UK GDPR—processing necessary for compliance with a legal obligation, for the performance of a task carried out in the public interest or in the exercise of official authority.

Where we process special category data, the additional legal basis for processing this will ordinarily be Article 9(2)(g) of the UK GDPR (together with paragraph 6 Schedule 1 Data Protection Act 2018) relating to the exercise of a statutory function for reasons of substantial public interest.

How we obtain your personal data

The personal data that we collect and process as part of our work may be obtained from you directly (e.g. if we contact you to ask you specific questions or for further information in connection with our work), or from relevant bodies, including those that we are auditing, through the exercise of the Auditor General's access rights.

Who will see the data?

The AGW and relevant WAO staff, such as the study team, will have access to the information you provide. Your data may be shared internally within Audit Wales for the purposes described in this notice.

Our published report may include some of your information, but we will contact you before any publication of information that identifies you—see also "your rights" below.

We may share information with:

a) Senior management at the audited body(ies) as far as this is necessary for exercising our powers and duties;

b) Certain other public bodies/public service review bodies such as the Office of the Future Generations Commissioner, Care Inspectorate Wales (Welsh Ministers), Health Inspectorate Wales (Welsh Ministers), Estyn and the Public Services Ombudsman for Wales, where the law permits or requires this, such as under section 15 of the Well-being of Future Generations (Wales) Act 2015.

How long we keep the data

We will generally keep your data for 6 years, though this may increase to 25 years if it supports a published report—we will contact you before any publication of information that identifies you—see also "your rights" below. After 25 years, the records are either transferred to the UK National Archive or securely destroyed. In practice, very little personal information is retained beyond 6 years.

Our rights

The AGW has rights to information, explanation, and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006, section 52 Public Audit (Wales) Act 2004, section 26 of the Local Government (Wales) Measure 2009 and section 98 of the Local Government & Elections (Wales) Act 2021. Further information can be found in our Access Rights leaflet available on our website. It may be a criminal offence, punishable by a fine, for a person to fail to provide information that falls within the AGW's access rights, but such an offence does not apply to surveys of the general public, which are not conducted using the statutory access rights above.

Your rights

You have rights to ask for a copy of the current personal information held about you and to object to data processing that causes unwarranted and substantial damage and distress.

To obtain a copy of the personal information we hold about you or discuss any objections or concerns, please write to the Information Officer, Wales Audit Office, 1 Capital Quarter, Tyndall Street, Cardiff, CF10 4BZ or email infoofficer@audit.wales. You can also contact our Data Protection Officer at this address.

You may also contact the Information Commissioner's Office to obtain further information about data protection law, or to complain about how your personal data is being handled at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, or by email at casework@ico.gsi.gov.uk or by telephone 01625 545745.

Audit Wales
1 Capital Quarter, Tyndall Street
Cardiff, CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

1 Capital Quarter
Tyndall Street
Cardiff / Caerdydd
CF10 4BZ
Tel / Ffôn: 029 2032 0500
Fax / Ffacs: 029 2032 0600
Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru

[by-email]

Reference: 4037A2024

Date issued: 5 February 2024

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
Members of the NHS Technical Accounting Group
Hywel Jones – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2023-24

1 We will shortly commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on how we will undertake your 2023-24 audit.

2 Within this letter, we consider the following:

- the proposed audit timetable for 2023-24;
- a review of the 22-23 audit of accounts;
- an update on audit fees; and
- a look forward to key issues impacting on the 2023-24 accounts and other developments.

The proposed audit timetable for 2023-24

3 We wrote to you in March 2023 setting out our proposed timetable for 2022-23 coupled with our rationale. We set out a proposed timetable which reflected:

- the additional resource required to implement our new audit approach driven by ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020);
- the delays we had experienced in completing the 2021-22 Local Government accounts which in some cases ran well beyond 31 March 2023; and
- the global shortage of audit and finance professionals, which impacted on our ability to recruit and retain qualified staff.

4 Taking the above into account, we proposed the following audit certification deadlines:

- Audit of Accounts 2022-23 – certification by 31 July 2023;
- Audit of Accounts 2023-24 – certification by 30 June 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

5 We are grateful for the support of colleagues in all NHS bodies, which enabled all 2022-23 audits except for one Local Health Board (LHB) to be certified by the proposed target date of 31 July 2023.

6 We have now reassessed the position for the 2023-24 audit of accounts. Our position has improved on last year. We have made progress embedding the new audit methodology and are further ahead with our audit of Local Government this year than last. However, we are still contending with recruitment and retention challenges which mean we do not envisage quite being able to meet our original planned audit certification deadline for the 2023-24 audit of accounts of 30 June 2024 (as per above).

7 We are therefore proposing the following revised audit certification deadlines:

- Audit of Accounts 2023-24 – certification by 15 July 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

8 As you can see from the above, our intention is to still try and work to our original timetable for the audit of accounts 2024-25. We believe this is achievable when we take into account it will be our third year delivering audits under our new approach which should generate efficiencies. That said, the achievement of the timetable for 2024-25 is not without its challenges, particularly if market conditions persist in respect of the recruitment and retention of qualified auditors.

9 We recognise that for the forthcoming audit of accounts 2023-24, our deadline is slightly later than many bodies would like but we believe it is important to set realistic timescales given our current position and alert the Service to our proposals as soon as practically possible.

10 We will be working closely with the Welsh Government and NHS finance teams over the next few months to agree the precise timings for submission of draft accounts. There will inevitably be logistical matters to take into account at each body, and we are conscious of the need to factor in Audit Committee, Board and Annual General Meeting (AGM) dates, particularly as Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

11 In respect of the Charitable Funds audit or the independent examination, we intend to complete these by the deadline set by the Charities Commission.

Review of the 2022-23 audit of accounts

12 Our audits of NHS accounts for the year ended 31 March 2023 were carried out under revised Auditing Standard, ISA 315. In planning our audit at individual Health Bodies, we were required to undertake more detailed and extensive risk assessment procedures to identify the risks of material misstatement and to develop an audit approach designed to address those risks.

13 This revised standard had a significant and far-reaching impact on our audit methodology, and we are grateful to Finance Teams for their engagement and the support they provided to our audit teams.

14 All audits except for one Local Health Board (LHB) were certified by the agreed administrative certification date - 31 July 2023. The delay for the final LHB was as a result of issues arising during the audit. All NHS bodies were certified before the NHS statutory deadline which is four months after submission of the draft accounts (early September 2023).

15 With regards to our audit opinions and reports, none of the NHS Trusts or Strategic Health Authorities received any qualifications. All except one of the LHBs had regularity qualifications for breach of break-even duty. In addition, a number of the LHBs had a substantive report for a failure to meet the second financial duty (lack of an approved financial plan). A summary of our NHS opinions and reports can be seen in **Appendix 1**.

16 2022-23 was a technically challenging year due to the quinquennial valuation of the NHS estate and implementation of the new leasing standard - International Financial Reporting Standard (IFRS) 16. As a result, we identified more

adjusted and unadjusted audit adjustments than in previous years. We also continued to see audit adjustments being required to remuneration report disclosures, along with issues relating to the approval of senior officer remuneration. In many cases, we also identified issues with year-end payables balances which increased audit testing. We will continue to work with individual bodies and make recommendations for improvement.

17 We held a number of meetings with key NHS finance groups during the year and we intend to continue with these meetings going forward. In particular, we welcomed our invitation to meet with the Audit and Risk Committee Chairs as a group and would be keen to do so again this year.

Update on audit fees

18 As a result of ISA 315, the revised audit approach applied in 2022-23 required us to employ more experienced, professionally qualified, staff on the audits, resulting in the larger than usual increase in your audit fee last year. We estimated that fee increase required to support the implementation of this new approach would be around 10.2%. In addition, we also applied a 4.8% fee increase last year in respect of inflation resulting in a combined average fee increase of 15%.

19 On the completion of our 2022-23 audits, we initiated a fee review as part of our post-project learning process. In summary, we concluded that the specific uplift of 10.2% to support the implementation of the revised auditing standard was not quite sufficient across all NHS audits. The total amount of further audit cost overrun incurred on NHS audits amounted to 10.1% which is equivalent to £234,000.

20 Recognising the cost pressures prevalent across NHS Wales, we have decided not to invoice for these overruns where there were no significant issues arising during the audit process. This means that we will be absorbing overspends of over £100,000. Our ability to absorb these overruns has been made possible this year by identifying additional 'one-off' efficiencies internally and should not be seen as creating a precedent for future years.

21 In terms of this year, our Fee Scheme for 2024-25 is now available Fee Scheme 2024-25 | Audit Wales. Our fee rates are increasing on average by 6.4% next year. Some further context is provided in the consultation foreword, but we have incorporated the key message into this letter.

22 Like the rest of the public sector, we are facing significant staff cost pressures. As stated above, those are exacerbated by a global shortage of audit and

finance professionals, which we are seeing reflected in our ability to recruit and retain qualified staff.

23 It is important that we do all that we can to address the recruitment and retention challenges if we are to continue to bring audit deadlines forward in accordance with the revised timetable set out above. To help offset increasing staff costs, we are taking difficult decisions to reduce our non-staff expenditure. We have moved to smaller, cheaper offices in both South and North Wales, have significantly reduced our travel and associated costs, and removed financial allowances previously paid to staff.

24 It is worth pointing out that audit fees have increased significantly across the whole audit profession in response to regulatory pressures, new auditing standards (including, but not limited to, ISA 315) and rising staff costs. The table in **Appendix 2** summarises current Public Sector Audit Appointment (PSAA) rates and then compares them to current Audit Wales fee rates. The table illustrates the very substantial change in PSAA rates over the past four years (following the Redmond Review) and highlights the very marked difference between current local government rates in England and those of Audit Wales. Whilst we are focusing on fee rates within the local government arena, this is indicative of the rising audit costs across the border.

25 Legislation requires that the fees we charge may not exceed the full cost of exercising the function to which the fee relates. We set our audit fees based on our estimated cost base, the estimated skills mix for audit work and the estimated number of days required to complete the work. We do not, and cannot, make a profit from our work. Our fees are set at a level to recover the estimated full cost but no more.

26 We are also mindful of us moving into the second year of our new audit approach and methodology. On the basis that we are more familiar with the new approach, we are expecting to see some level of efficiency. As stated above, as our fees are set at a level to only recover the full cost, where the full cost is less than the estimated fee, we will issue a refund to individual bodies. In this context, we remain determined to minimise audit fees whilst ensuring that our audit quality continues to meet rigorous standards.

27 Your Engagement Director will discuss the proposed fee for your audit once the audit commences and the risk assessment for your organisation has been completed.

A look forward to key issues impacting on the 2023-24 accounts audit and other developments

28 As well as reflecting on last year, it is important to have a look at some of the issues that could impact on the 2023-24 accounts.

29 **Projected year-end deficits** – we are mindful of the control total deficit of £123 million set by Welsh Government across the whole of the NHS and how challenging this will be for NHS bodies to meet. Given these expectations, we will focus on certain areas, particularly accruals and expenditure around year-end.

30 In terms of our wider audit responsibilities, the situation has prompted us to remain focused on themes such as financial sustainability, the realism of savings plans and the continued need for NHS to deliver value for money. Alongside these themes, the Auditor General for Wales places significant importance to seeing high standards of governance and financial management and will continue to shine a light and report on weaknesses in these areas.

31 **Executive salary pay points** – this has been a recurring theme for audit over the past few years where executive salaries have been paid over and above the defined salary point determined by the Welsh Government and where Government approval to do so has not been sought or provided. This again will be an area of focus as part of our audit work on the remuneration report. In addition, a disproportionate amount of time is spent seeking to reconcile payments to contracts of employment for senior staff. This is generally an area where health bodies could seek to improve audit evidence.

32 **Other technical changes** – at this point in time, we are not anticipating any new significant issues, but we will continue to liaise with Health and Social Services Group (HSSG) and the NHS Technical Accounting Group (TAG).

33 **Reintroduction of an interim audit** – for 2022-23, we applied little or no interim audit. This was a deliberate decision due to us commencing NHS audits much later than our normal timings. As we aim to recover and potentially bring the timetable back, we are envisaging moving back to an interim audit this year. This will hopefully take pressure off both Finance and audit teams, particularly during the final audit period scheduled for May and June 2024.

34 **Data quality / Analytics Assisted Audit (AAA)** – since the 2020-21 audit cycle, we have been using general ledger data obtained from the NHS Wales Shared Service Partnership (NWSSP) in our Analytics Assisted Audit application to support our audit work. This has realised several benefits with auditors having more accessible and timely access to the data, enhanced risk

assessments and automation of some audit tests. However, we have identified several inefficient processes and barriers to our vision of a more data driven audit, including:

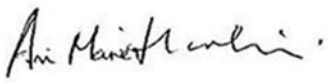
- adjustments cited on working papers not posted through the financial system;
- multiple mapping documents and inconsistent approaches for preparing the individual notes to the accounts; and
- multiple working papers to support individual notes to the accounts.

35 We are initially working with some pilot NHS bodies to try and eradicate these issues with the expectation that it will generate considerable benefits to improving data quality and time saving efficiencies for both audited bodies and auditors. We will engage with the sector on these developments during the early part of 2024.

36 We remain committed to working collaboratively with you to successfully navigate the challenges set out in this letter, building on our shared experiences. We will ensure we attend all the relevant NHS fora to discuss the content of this letter with you and will be arranging meetings with all NHS Directors of Finance and Audit Committee Chairs to provide you with an opportunity to meet with us all.

37 Thank you to you and your teams for working so well with us.

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – A summary of NHS audit opinions and reports for 2022-23

Health Board	Qualification/Subs Report
Aneurin Bevan	Qualified Regularity – breach of first financial duty (break-even)
Swansea Bay	Qualified Regularity – breach of first financial duty (break-even)
Powys	Qualified Regularity – breach of first financial duty (break-even)
Cardiff & Vale	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Cwm Taf	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Hywel Dda	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Betsi Cadwaladr	Qualified True and Fair opinion – impact of uncertainty coming forward from 21-22 (expenditure and payables) Qualified Regularity – payment to interim executive director above WG approved pay scale not properly approved. Substantive Report – failure to agree an approved financial plan (second financial duty) Note – first financial duty (break-even) **unqualified**
Velindre	No qualifications
Public Health Wales	No qualifications

Health Board	Qualification/Subs Report
Welsh Ambulance Services NHS Trust	No qualifications
Digital Health and Care Wales	No qualifications
Health Education and Improvement Wales	No qualifications

Appendix 2 – A comparison of current Public Sector Audit Appointment (PSAA) fee rates with Audit Wales

Grade	Audit Wales Fee Rates	Public Sector Audit Appointments (PSAA) Rate Cards	
	2023-24 £	2023-24 £	2018-20 £
Partner / Director	168	414	132
Senior Manager / Manager	129	228	73
Audit Lead	106	148	47
Other	40 - 85	113	36

Internal Audit Progress Report

Audit Committee

March 2024

Velindre University NHS Trust

NWSSP Audit and Assurance Services

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

Contents

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 Internal Audit Plan for Velindre University NHS Trust to the March 2024 Audit Committee;
- note the reports completed since the last Audit Committee meeting (three reports are included on the Committee's agenda);
- seek approval for one change to the 2023/24 Internal Audit Plan, as listed within Section 5; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2023/24 Internal Audit Plan

There are currently 17 (including one proposed deferral) individual reviews in the 2023/24 Internal Audit.

The table below details progress against the 2023/24 Internal Audit Plan.

Reconciliation of total planned audits	
Number of audits in approved plan	17
Proposed reduction to the plan	-1
Number of audits in current plan	**16**
Status of audits	
Number of audits reported as final	8
Number of audits reported as draft	1
Number of audits work in progress	5
Number of audits at planning stage	2
Number of audits not started	0
Number of audits in current plan	**16**

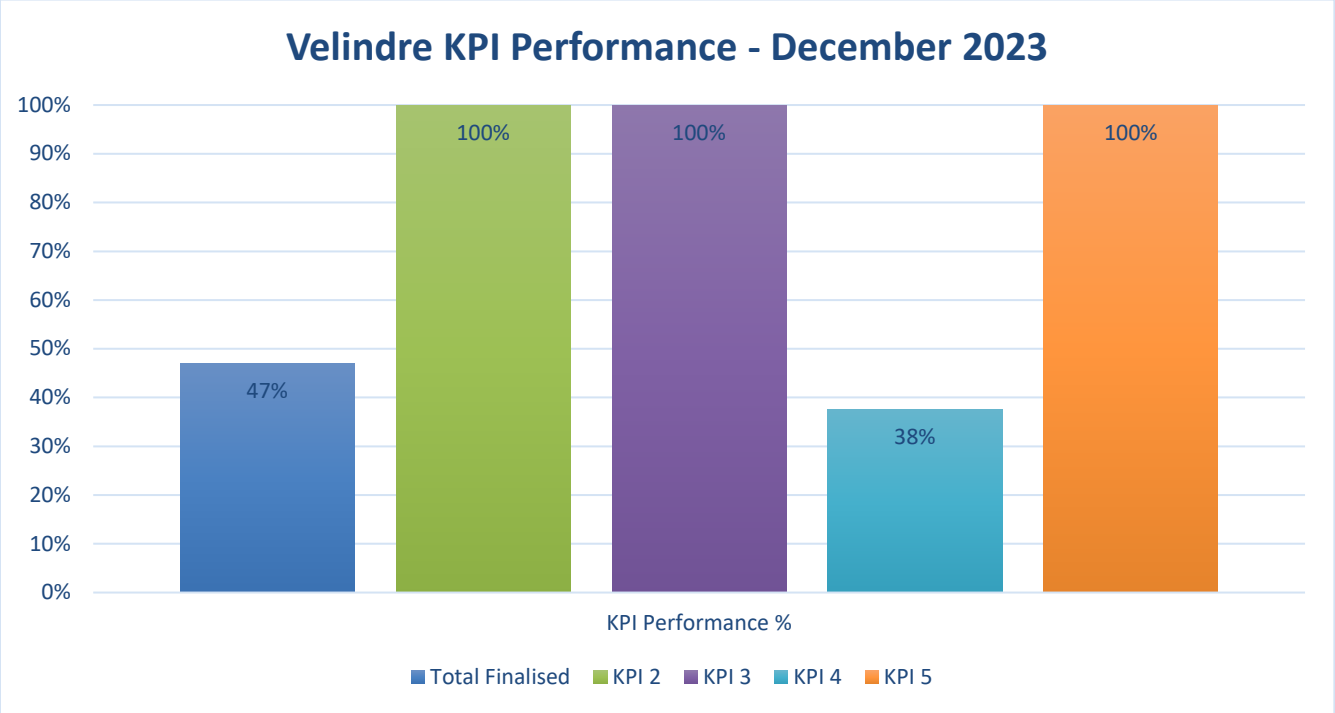
The following 2023/24 final reports have been issued since the meeting of the Audit Committee on 19 December 2023:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Estates Assurance	Limited
Education Strategy	Reasonable
Private Patients	Reasonable

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix B.

3. Key Performance Indicators

The graph below illustrates the latest performance position for the completion of audit reports (47%) and the management response time (KPI 4). The latter of which remains low, with a current performance of 38% of management responses received within 15 working days, against a target of 80%.



KPI 2 – Audits reported versus planned	KPI 4 - Report turnaround management response to draft report [15 working days]
KPI 3 - Report turnaround fieldwork to draft reporting [10 days]	KPI 5 - Report turnaround draft response to final reporting [10 days]

4. Summary of Findings

All audit reports are considered by the Audit Committee as part of the main agenda, giving members of the Committee the opportunity to raise any questions or matters relating to the reports directly with the Auditor. Two of the three reports submitted to this Committee meeting have provided Reasonable assurance. The remaining report has provided limited assurance.

5. Potential Audit Plan Changes

As we progress with our delivery of the 2023/24 Internal Audit Plan, we continue to evaluate risk, the allocation of our resources and the remainder of the agreed plan.

During the planning phase of the Quality and Safety audit, it was apparent that there is significant overlap with the scheduled work completed by Audit Wales, which would result in duplicate assurance being provided. As this offers very little value,

we are proposing a deferral of this audit into a future plan, where more value can be derived from the work. This deferral will not impact the delivery of our Annual Opinion.

As a result, we are asking for the Committee's approval to defer that audit.

6. Other Activity

The following actions have also been progressed during the reporting period:

- monthly meetings with the Executive Director of Finance;
- liaison with senior management on individual audits; and
- planning work in relation to the 2024/25 audit plan.

7. Recommendations

The Audit Committee is invited to:

note and **receive** this progress report;

note and **receive** the three reports referred to in section 3 above and included later in the agenda; and

agree to the deferring of the Quality and Safety 2023/24 audit referred to in section 5 above.

Appendix A: Progress against 2023/24 Internal Audit Plan

No.	Audits	Status
1	Financial & Service Sustainability	Planning
2	Recruitment & Retention	Final – Reasonable
3	Education Strategy	Final – Reasonable
4	Private Patients	Final - Reasonable
5	Business Continuity	Final – Reasonable
6	Decarbonisation	WIP
7	Follow-Up	WIP
8	Governance, Assurance & Risk Management	Planning
9	Medicines Management	WIP
10	Quality & Safety	Deferral request
11	Digital Strategy & Transformation	Final – Reasonable
12	TCS Digital	Draft
13	Integrated Radiotherapy Solution (IRS) Procurement	WIP
14	Estates Condition	Final – Limited
15	nVCC – Enabling Works 2022/23	WIP
16	nVCC – Approvals	Final – Reasonable
17	nVCC – Planning	Final – Reasonable
	Audits deferred or cancelled	
1	nVCC – MIM Design & Change Management	Agreed AC July 2023
2	nVCC – MIM Procurement	Agreed AC July 2023
3	nVCC – Enabling Works 2023/24	Agreed AC December 2023

Appendix B: Audit Assurance Ratings

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

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

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Education Strategy

DATE OF MEETING	12th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	RHIAN GUARD, AUDIT MANAGER,
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The purpose of this report is to present the Education Strategy audit report.
RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

Executive Management Board Run	29/02/2024
EXECUTIVE MANAGEMENT BOARD REVIEWED AND NOTED THE EDUCATION STRATEGY INTERNAL AUDIT REPORT.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

The audit was undertaken as part of the agreed 2023/24 Annual Internal Audit Plan.

2. BACKGROUND

The purpose of this audit was to to provide assurance over the implementation of the Trust's Education Strategy.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Education Strategy was launched in 2019 and just like the People Strategy it is one of a suite of enabling strategies underpinning the Trust's corporate strategy: Destination 2033. The main aim of the Education Strategy is to *"create and maintain an agile workforce in possession of the skills and competencies required to deliver excellence".* The audit reviewed the different components of the strategy and whether they are implemented and embedded throughout the trust.

Whilst reasonable assurance has been provided on this area, this is primarily attributed to the recent progress towards implementing the education aspects of the People Strategy. There are still numerous deliverables to complete, particularly with national partnership work. However, we recognise that the establishment of the People Development and Education Steering Group has begun to ensure partial reporting is underway and the implementation of some key actions. In spite of this, concern remains over how the remaining actions will be completed, together with timeframes and responsible officers.

Consequently, we recommend a follow-up audit in approximately six months' time to provide a further assessment over the assurance levels and progress.

The matters requiring management attention include:

- The lack of robust workplans setting out timescales and responsible officers. Whilst work is underway, this is still required for the remaining actions.
- There has been no evaluation exercise completed by the People Development and Education Steering Group to evaluate where the Trust's Strategy implementation is at or whether objectives have been achieved.
- There is partial reporting taking place, but there is a limited escalation of the position of the deliverables.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below Safe ☒ Timely ☒ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • the Trust is not focusing on the right things to support the delivery of the Education Strategy.
WHAT IS THE CURRENT RISK SCORE	Linked to one high and two medium priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit, as the recommendations relate to actions regarding the effectiveness of plans.
All risks must be evidenced and consistent with those recorded in Datix	

Education Strategy
Final Internal Audit Report

February 2024

Velindre University NHS Trust

Contents

Review reference:	VT-2324-05
Report status:	Draft
Fieldwork commencement:	23rd November 2023
Fieldwork completion:	20th December 2023
Debrief meeting:	17th January 2024
Draft report issued:	8th February 2024
Management response received:	15th February 2024
Final report issued:	20th February 2024
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Interim Deputy Head of Internal Audit Rhian Gard, Audit Manager
Executive sign-off:	Sarah Morley, Executive Director of Workforce & OD
Distribution:	Susan Thomas, Deputy Director of Workforce &OD
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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

Executive Summary

Purpose

To provide assurance over the implementation of the Trust's Education Strategy.

Overview

The Education Strategy was launched in 2019, before becoming fully incorporated into the People Strategy launched during 2022. The People Strategy focuses on maintaining a planned and sustained workforce, with staff training a key element of this.

Whilst we have issued reasonable assurance on this area this is primarily attributed to the recent progress towards implementing the education aspects of the People Strategy. There are still numerous deliverables to complete, particularly with national partnership work. However, we recognise that the establishment of the People Development and Education Steering Group has begun to ensure partial reporting is underway and the implementation of some key actions. In spite of this, concern remains over how the remaining actions will be completed, together with timeframes and responsible officers.

Consequently, we recommend a follow-up audit in approximately six months' time to provide a further assessment over the assurance levels and progress.

The matters requiring management attention include:

- The lack of robust workplans setting out timescales and responsible officers. Whilst work is underway, this is still required for the remaining actions.
- There has been no evaluation exercise completed by the People Development and Education Steering Group to evaluate where the Trust's Strategy implementation is at or whether

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Workplans	Limited
2	Roles and Responsibilities	Reasonable
3	Assurance	Reasonable

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

the objectives have been achieved.
- There is partial reporting taking place, but there is a limited escalation of the position of the deliverables.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Workplans	1	Operation	High
2	Roles and responsibilities	2	Design	Medium
2	Assurance	3	Design	Medium

1. Introduction

1.1 The review of the Education Strategy was completed in line with the 2023/24 Velindre University NHS Trust (the 'Trust') Internal Audit Plan.

1.2 The Education Strategy was launched in 2019 and just like the People Strategy it is one of a suite of enabling strategies underpinning the Trust's corporate strategy: Destination 2033. The main aim of the Education Strategy is to *"create and maintain an agile workforce in possession of the skills and competencies required to deliver excellence".* The audit reviewed the different components of the strategy and whether they are implemented and embedded throughout the trust.

1.3 The key risks considered in this review were:

- the Trust is not focusing on the right things to support the delivery of the Education Strategy;
- insufficient focus to deliver the strategy appropriately; and
- processes, systems, and procedures do not enable staff to achieve their set roles and the implementation of the strategy.

2. Detailed Audit Findings

Management of the implementation of the organisation's development priorities including;

Objective 1: Workplans with achievable deliverables in place

2.1 The Education Strategy (the 'Strategy') was approved in May 2019 and there was a pause in implementation because of the pandemic. The Strategy does not appear to have been communicated across the Trust but has since been superseded. Following this, the People Strategy as part of the enabling strategies underpinning the Trust Strategy: Destination 2033, was launched in May 2022. Our testing shows key components of the Education Strategy are also included in the People Strategy, and overall, there is a strong linkage between the two.

2.2 From our testing we can see that as part of the approval process in 2018/19 the Executive Management Board (EMB) recommended the need for action plans with timescales of implementation and a mapping exercise on resource requirement to be completed. The Education Strategy refers to deliverables and states *"A detailed action plan to support the delivery of the aspirations set out in this strategy will be developed."* We confirmed these are not yet in place, but there is a draft Education Strategy action plan, which is in the process of being completed. However, this has not yet been finalised. There are no timeframes or responsible officers detailed within the draft action plan. As there are no work plans in place, we are unable to see if the deliverables are on track for delivery.

2.3 The draft action plan details the four components from the Strategy, six actions, seventeen objectives and twenty outputs. From the twenty outputs only eight actions are classed as complete, eight are not completed, one is in progress and

three are on hold. We tested the eight outputs classed as complete and found evidence of five of them being complete. Three of the eight we viewed as still work in progress, rather than complete, contrary to what was stated in the draft action plan. The three outputs refer to Performance Appraisal Development Review (PADR) compliance, review of the policy, and the development of the training plan. However, we did confirm that work has taken place and is still underway, but we did not feel that the actions have yet been fully completed.

2.4 The training plan, dated September 2023, is still an evolving document. Once complete it is intended to provide information on all training, education and development opportunities, both internal and external to the organisation. Currently, it captures a wealth of training available, but does not detail responsible officers or timeframes and a lot of the fields are filled in with "tbc".

The above points are included within **matter arising one.**

Conclusion:

2.5 We confirmed that the Education Strategy has been incorporated into the People Strategy. Furthermore, we identified the recent progress of work to compile a draft action plan and training plan, but there are significant gaps to be completed and updated for them to be specific, measurable, achievable, relevant and timely (SMART). The output and actions of these plans are not yet fully implemented. Therefore, we have provided **limited assurance** for this objective.

Objective 2: Management of the implementation of the organisation's development priorities including roles and responsibilities are clearly defined

2.6 According to the Education Strategy *"its implementation will be overseen by the Education and Training Steering Group which reports to the Executive Management Board".* The Education and Training Steering Group has recently been changed to the People Development and Education Steering Group (the 'Group'). We understand that the Group paused during 2022, when the terms of reference were reviewed. However, since 2023 the Group meets quarterly to discuss education, training, and the implementation of the Strategy.

2.7 Highlight reports are completed and discussed on a quarterly basis, which are also provided to the Executive Management Board (EMB). Action and risk logs are also reviewed at each of the meetings and closed out when they are completed. However, these do not detail any risks concerning the Strategy deliverables not being achieved.

2.8 High level metrics such as statutory and mandatory and PADR compliance are discussed at the meetings as part of the implementation of the Strategy. This information is captured from the Electronic Staff Record (ESR) and shared with the respective divisions when necessary.

2.9 The Medical Education Board provides updates into the Group and representatives from both forums attend respective meetings to ensure there is a joined-up approach across the Trust.

2.10 From a review of the minutes in 2023 and from observing the December 2023 meeting we observed high attendance, from across many different specialities and key workforce staff. Key roles are identified to ensure progress is made. We confirmed discussion on the implementation of the components of the Strategy took place, but not in terms of outstanding actions to ensure the deliverables are implemented.

The above points are included within **matter arising two.**

Conclusion:

2.11 We confirmed key roles and responsibilities are defined in terms of the Group. We also observed discussion on the implementation of components of the Strategy together with the actions and risk logs. However, there is no record of the risks, regarding the Strategy implementation delay. Highlight reports and updates are fed into the EMB for noting and discussion. As there are clear roles and responsibilities and these are working to implement the Strategy, we have therefore provided **reasonable assurance** for this objective.

Objective 3: Management of the implementation of the organisation's development priorities including assurance process is in place to escalate any risks or issues when required

2.12 Assurance is provided through to the Group and then onwards to the EMB. Risks and high-risk areas are discussed at the Group along with the necessary actions to resolve them. When necessary, they are then escalated to the EMB.

2.13 Through the assurance route we can see evidence of highlight reports and updates taken to the EMB. Within these reports the high-risk areas are documented, but we are unable to see if any assurance is provided on the Strategy.

2.14 The highlight reports document the high-level metrics; compliance for statutory and mandatory training, PADR compliance and any competencies with low compliance, along with the internal and external training being delivered across the Trust. For November 2023, PADR compliance stands at 72.21% and statutory and mandatory training is 86.24%. The compliance target is 85%. However, as referenced within audit objective one, there are no other metrics or deliverables currently reported.

The above points are included within **matter arising two.**

Conclusion:

2.15 There is a route of assurance and escalation in place, and we have seen evidence of risks and issues being escalated and discussed at the People Development and Education Steering Group with escalation to the EMB if required. We can see highlight reports being reported detailing compliance on high level metrics, but no escalation on the lack of implementation of the Strategy deliverables. Overall, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Implementation (Operational)	**Impact**
Whilst we confirmed that elements of the Education Strategy were being implemented, we did not identify any finalised implementation / action plans to ensure all objectives were completed in a timely manner. We found that a recent, high level draft Education Strategy Action Plan (the 'Plan') has been compiled by the Organisational Development Team and is in the process of being implemented, but these actions do not detail timeframes or responsible officers. Within this Plan we tested eight objectives marked as complete but found that three were still in progress. Overall, we were unable to determine if and when the Plan will be fully completed and the objectives of the Strategy embedded.	Potential risk of: • The Strategy is not embedded in a timely manner. • Staff are not developed or trained within their roles.

	Recommendations	**Priority**
1.1	An Implementation Plan will be developed to track the remaining actions to be completed to embed the Strategy. This should also detail all remaining actions, with responsible owners and appropriate timescales. The progress should be closely monitored via the People Development and Education Steering Group.	**High**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1.1	An Implementation Plan for the Education Strategy will be developed to reflect actions, timescales and responsible officers. This will be signed off by Executive Management Board in April. Monitoring of the plan will be managed by the People Development and Education Steering Group	15th April 2024	Susan Thomas Deputy Director of Organisational Development & Workforce

Matter Arising 2: Monitoring and Assurance (Design)	**Impact**
Roles and responsibilities: The People Development and Education Steering Group formerly known as the Education and Training Steering Group is responsible for the implementation of the Strategy. We observed detailed discussion taking place, however, there is a lack of oversight over remaining deliverables and actions required to embed the Strategy. Furthermore, there has been no evaluation exercise completed to confirm what the Trust has achieved, regarding the Strategy. Assurance: There is partial reporting to the Executive Management Board (EMB) in the form of highlight reports, but there is a lack of escalation over the lack of implementation of the Education Strategy. Whilst we confirmed that progress is underway, status reporting for the remaining actions has not been fully completed since 2019. The lack of progress should be escalated to an appropriate forum / the EMB.	Potential risk of: • The Strategy is not implemented in a timely manner. • Progress is not being tracked and results in delayed action. • A lack of visibility / oversight of current progress.

Recommendations		**Priority**
2.1	An evaluation exercise should be completed to confirm at what stage the implementation of the Strategy is at and whether the objectives are being achieved. In addition, there should be regular oversight of progress made against the Implementation Plan (once introduced). Where progress is slow, this should be escalated to the Executive Management Board or other appropriate forum.	**Medium**
2.2	The reporting should incorporate key metrics and deliverables and be regularly presented to the People Development and Education Steering Group / the EMB. This should be utilised to assist in determining the stage of progress.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	An evaluation framework noting key performance indicators (KPI) to assess and monitor the successful implementation of the Education Strategy Plan and objectives will be presented to the People and Development Steering group in June. An evaluation exercise, using the agreed evaluation framework, will be undertaken from June to September 2024 and presented to the People and Development Steering group in September for discussion and next steps. On agreement the plan will be monitored by the group. Following each Steering group a highlight report is presented to Executive Management Board, any issues to escalate will be noted there.	September 2024	Susan Thomas Deputy Director of Organisational Development & Workforce and Claire Budgen Head of Organisational Development
2.2	The quarterly meetings of the People and Development Steering Group will include progress updates against the plan and will include key metrics and deliverables. This will begin at the September meeting of the Steering Group and reported to EMB via the Steering group highlight report.	September 2024	Susan Thomas Deputy Director of Organisational Development & Workforce and Claire Budgen Head of Organisational Development

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Velindre Private Patients

DATE OF MEETING	12th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	SIMON COOKSON, DIRECTOR OF AUDIT & ASSURANCE, EMMA REES, DEPUTY HEAD OF INTERNAL AUDIT AND LAURA HOWELLS, PRINCIPAL AUDITOR
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
APPROVED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SUMMARY	The purpose of this report is to present the Private Patients Audit report.
RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board Run	29/02/2024
EXECUTIVE MANAGEMENT BOARD REVIEWED AND NOTED THE PRIVATE PATIENTS INTERNAL AUDIT REPORT.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

The audit was undertaken as part of the agreed 2023/24 Annual Internal Audit Plan.

2. BACKGROUND

The purpose of this audit was to review progress against the actions identified within the independent review of the Trust's private patients activity.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Action tracker deadlines should be reviewed and any actions overdue need to be allocated revised timescales for completion.

Overall, actions are monitored effectively and issues arising are escalated through appropriate channels.

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

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☐

	Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • The Trust is unable to recruit and / or retain staff, resulting in insufficient workforce to deliver services in a safe and timely manner. There is also an increased financial risk as temporary staff are appointed to reduce workforce gaps, but at a higher rate.

WHAT IS THE CURRENT RISK SCORE	Linked to two medium and one low priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit, as the recommendations relate to actions regarding the effectiveness of plans.
All risks must be evidenced and consistent with those recorded in Datix	

Private Patients
Final Internal Audit Report

February 2024

Velindre University NHS Trust

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

Review reference:	VT-2324-06
Report status:	Final
Fieldwork commencement:	1st November 2023
Fieldwork completion:	9th February 2024
Debrief meeting:	14th February 2024
Draft report issued:	19th February 2024
Management response received:	28th February 2024
Final report issued:	28th February 2024
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Laura Howells, Principal Auditor
Executive sign-off:	Cath O'Brien, Chief Operating Officer
Distribution:	Rachel Henessey, Interim Director, Velindre Cancer Service Nicola Williams, Executive Director of Nursing, AHPs and Medical Scientists
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Velindre University NHS Trust (the Trust) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To review progress against the actions identified within the independent review of the Trust's private patients activity.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Action tracker deadlines should be reviewed and any actions overdue need to be allocated revised timescales for completion.

Overall, actions are monitored effectively and issues arising are escalated through appropriate channels.

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

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A – first review of area

Assurance summary[1]

Objectives		Assurance
1	Action log	Reasonable
2	Governance	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1.1	Action deadlines	1&2	Operation	Medium
1.2	Action closure	1&2	Design	Medium

1. Introduction

1.1 The review of Private Patients was completed in line with Velindre University NHS Trust's (the 'Trust') 2023/24 Internal Audit Plan.

1.2 Risks considered as part of the audit include:

- Failure to implement the recommendations may result in the original risks materialising.
- Increased financial risk if actions are not implemented effectively.
- Increased reputational risk if actions are not implemented effectively.

2. Detailed Audit Findings

Objective 1: Effective arrangements are in place for monitoring and implementing actions received from the independent review of Private Patients.

2.1 An independent review of private patients was completed by external consultants during 2022. Areas of weakness were identified and actions were raised to assist with the improvement of these areas. The Trust reviewed each action and created the Action Log Tracker (the 'Tracker') for all agreed actions.

2.2 All actions on the Tracker included:

- details of the action;
- a target date and a revised target date, where appropriate;
- a responsible owner for each action completed;
- the status of the action; and
- action progression.

2.3 A sample of 10 closed actions noted on the Tracker was selected for testing. We reviewed each action to determine if they had been appropriately closed / implemented. These include:

Closed Actions

Action reference number	Position on Trust action log	Confirmed as fully implemented	Updated position
PP3	Closed	No	**Action**: Integrate business planning into the Trust's IMTP process. **New Position**: This action is not closed, but was closed in error. However, this error has since been rectified. It was agreed that the Private Patient Strategy will feed into the Trust's IMTP process, which concludes at the end of March 2024. The original deadline for this action was noted as July 2022, an updated deadline was noted as November

			2023. Consequently, the deadline for this action requires amendment.
PP5	Closed	Yes	N/A – Closed
PP30	Closed	Yes	N/A – Closed
PP35	Closed	Yes	N/A – Closed
PP24	Closed	Yes	N/A – Closed
PP38	Closed	Yes	N/A – Closed
PP39	Closed	Yes	N/A – Closed
PP33	Closed	Yes	N/A – Closed
PP1	Closed	Yes	N/A – Closed
PP16	Closed	Yes	N/A – Closed

2.4 All, but one of the 10 selected actions had been closed appropriately, with the necessary evidence in place for closure. As noted above, one was closed in error, but this was also showed as an open action on the Tracker. However, it continues to be effectively monitored. The issue regarding accurate deadline dates is also referenced below. **Matter arising 1**.

2.5 A sample of five open actions from the Tracker was selected for further testing. We tested the actions to determine if they continued to receive appropriate scrutiny:

Action reference number	Confirmed as open action	Updated position
PP19	Yes	**Action**: Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/ outpatient appointment and for marketing. **Current Position**: Leaflet drafted for patients accessing services at Velindre Cancer Centre (VCC).
PP21	Yes	**Action**: Develop a private patient tariff for both self-pay and insured private patients. **Current position**: A new tariff has been created by external provider Liaison. This is awaiting VCC Finance Team feedback.
PP3	Yes	**Action**: Integrate business planning into the Trust's IMTP process. **Current position:** This is a part of an ongoing discussion within the Private Patients Management Group.
PP8	Yes	**Action**: Produce job planning guidance to define NHS and private patient work within consultant job plans. **Current position**: Guidance is currently being compiled, but it is yet to be approved.
PP10	Yes	**Action**: Review patient pathway for private patients to ensure there is equity of service provision. **Current position**: The clinical nurse specialist job description has been developed and is proceeding through the recruitment process. This was identified as a key element of the action. Furthermore, the associated policy is yet to be signed off by the Executive Management Board and Senior Leadership Team.

2.6 We confirmed that all actions marked as open are appropriately categorised, with progress made on each of them. However, the remaining open actions are yet to be closed, two years after first receiving the report. Although justification for this delay has been noted within the highlight reports, there was no evidence that the Trust had undertaken a prioritisation of which actions should be completed first.

This should be determined by the level of risk facing the Trust. However, we were informed that ongoing discussions regarding prioritisation have taken place. As the low level of resources available continues to impede delivery of some of the actions, the Trust should ensure that higher levels of risk are addressed first. **Matter arising 1**.

2.7 The deadlines for the closure of actions are not always updated in a timely manner. We found that for all five open actions tested that the completion deadline had passed. Deadline dates are regularly amended and in reviewing the most recent Tracker, towards the end of our fieldwork testing, we observed that the deadlines for open actions had been updated further. There is a risk that action deadlines are not being allocated an appropriate amount of time and it is reported that the delay has been related, in part, to the absenteeism of three key individuals responsible for action completion. Due to the small team size, there has been no backfill available. **Matter arising 1**.

Conclusion:

2.8 Actions raised as part of the independent review are effectively monitored and closed. Strengthening the process for completing actions by the agreed deadlines would assist in closing the remaining open actions, therefore we have provided this objective with **reasonable assurance**.

Objective 2: Appropriate escalation of actions are reported to the Board or Committee with delegated responsibility and the resolution therein are embedded, including overdue deliverables.

2.9 In response to the independent private patients report, the Trust has created a private patients group: The Private Patient Improvement Group (the 'Group'). This was established to enhance the governance and functioning of the Trust's private patient service in response to the external review's recommendations and to facilitate the implementation of the actions raised within the report.

2.10 The Group meets monthly and is well attended by senior members of the Trust from all necessary areas of the organisation (e.g. Finance, Workforce, Nursing etc.). Our review of the minutes confirmed that actions are discussed in detail and steps are taken at each meeting to close the remaining actions.

2.11 Although the Tracker should be updated for missed deadlines, the minutes detailed that there was a delay in the implementation of some actions. **Matter arising 1**.

2.12 Actions with financial elements have been discussed by the Audit Committee. A highlight report is sent to both the Quality, Safety and Performance Committee and the Executive Management Board, which allows for any necessary issues to be appropriately escalated. Within the highlight reports, the delay in implementing the actions raised within the report are addressed.

2.13 The highlight report notes that the delay was due to operational capacity constraints, the absence of core staff and business intelligence capacity. However,

as raised within objective one there are still actions open for an extended period of time and in excess of their implementation dates. **Matter arising 1**.

Conclusion:

2.14 We found actions are monitored, but in spite of this there are still some that exceed their implementation date by a considerable period of time. The timeliness of completing actions should be reviewed and therefore we have provided this objective with **reasonable assurance**.

Appendix A: Management Action Plan

Matter Arising 1: Deadlines in the Action Tracker (Operation)	**Impact**
The deadlines for the closure of actions are not always updated in a timely manner. We found that for all five open actions tested a completion deadline had passed. Deadline dates are regularly changed and in reviewing the most recent action log tracker, at the end of our fieldwork testing, we observed that the deadlines for open actions had been revised again. There is a risk that action deadlines are not being allocated an appropriate amount of time to complete and / or there is insufficient scrutiny and challenge over actions not completed. Furthermore, a number of actions raised as part of the independent review remain open, two years after first receiving the report. Although justification for this delay has been noted within the highlight reports, the Trust has not undertaken a prioritisation of which actions should be completed first. This should be determined by the level of risk facing the Trust.	Potential risk of: • Actions not being completed in a timely manner. • Most critical actions remain open for an extended period of time period. • Ineffective use of Trust resources.

Recommendations		**Priority**
1.1	The deadlines noted within the Trust's action log tracker should be reviewed for appropriateness and amended where necessary. If deadlines are not met, clear justification for the delay should be noted within the Trust's Private Patient Group's minutes.	**Medium (operation)**
1.2	Review the remaining actions that are open and confirm that they are still relevant and require completion. The remaining actions should be prioritised, focussing on the ones within the higher level of risk first.	**Medium (design)**

Agreed Management Action		Target Date	Responsible Officer
1.1	Deadline dates reviewed at each Improvement Group meeting. 2 closed since review undertaken. 10 remain open. A number of these will be completed by 30th March 2024. The timescale for one action previously agreed to be 2025. ***Action: March Private Patient Group to further review delivery deadlines for actions that remain open and formally report to*** EMB, ***Audit & Quality & Safety Committee. All legacy actions to be transferred onto AMaT Quality & Safety Tracker on improvement Group close down for ongoing monitoring and assurance.***	31st March 2024	Rachel Hennessy, Interim VCC Director & Nicola Williams, Executive Director Nursing, AHP & Health Science
1.2	March Improvement Group to risk rate all remaining open improvement actions and ensure this factors in the prioritisation of completion of open actions.	31st March 2024	Rachel Hennessy, Interim VCC Director & Nicola Williams, Executive Director Nursing, AHP & Health Science

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Estates Condition

DATE OF MEETING	12th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	David Butler, Audit Manager
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The purpose of this report is to present the Estates Condition audit report.
RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

Executive Management Board Run	29/02/2024
EXECUTIVE MANAGEMENT BOARD REVIEWED AND NOTED THE ESTATES CONDITION INTERNAL AUDIT REPORT.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

The audit was undertaken as part of the agreed 2023/24 Annual Internal Audit Plan.

2. BACKGROUND

The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management, condition, and performance of the Estate.

3. ASSESSMENT

Report Assurance Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Key matters arising included:

- A funded plan to address backlog maintenance is not in place.
- The Trust should engage with NWSSP: SES to confirm appropriate derivation and accuracy of published backlog maintenance data at Velindre.
- Appropriate surveys should be undertaken following dialogue with NWSSP: SES, including completion of annual update of specialist / invasive surveys, and the associated adjustment of survey values.
- Management should report progress against prior backlog and Estate investment targets to appropriate forums, including funding and inflationary variances.
- Costed statutory, “High”, and “significant” risk backlog maintenance unaddressed by investment proposals should be appropriately profiled at the Corporate Risk Register and reported to management for acceptance and approval / implementation of mitigating actions.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust’s strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established ‘University’ Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required Not required for Internal Audit reports.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk that: • backlog maintenance is not effectively addressed.
WHAT IS THE CURRENT RISK SCORE	Linked to two high, two medium and one low priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions support risk mitigation, with plans to manage the associated funding risk.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion dates.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit, as the recommendations relate to actions regarding the effectiveness of plans.
All risks must be evidenced and consistent with those recorded in Datix	

Estates Condition
Final Internal Audit Report

February 2024

Velindre University NHS Trust

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

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

Review reference:	SSU-VUT-2324-02
Report status:	Final Report
Fieldwork commencement:	21st June 2023
Fieldwork completion:	13th October 2023
Draft report issued:	26th October 2023
Draft report meeting:	12th December 2023
Revised Draft issued:	26th January 2024
Management response received:	23rd February 2024
Final report issued:	26th February 2024
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Carl James, Executive Director of Strategic Transformation, Planning, Performance & Estates
Distribution:	Matthew Bunce, Executive Director of Finance
	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development
	Jonathan Fear, Estates Manager
	Lauren Fear, Director of Corporate Governance
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Corporate Governance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre NHS Trust no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Velindre University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current Estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable Estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging Estate in Wales.

The latest nationally reported data (2021/22) for the Trust confirmed a total backlog maintenance requirement of £9.7m.

The audit sought to evaluate the arrangements put in place by the Trust to identify and manage key risks associated with the existing Estate and the implementation of resulting strategies to manage/mitigate the risk.

The audit excludes the hosted Welsh Blood Service.

Overall Audit Opinion and Overview

As noted, the Trust has an assessed backlog of circa £9.7m.

Key to understanding the challenge is the accuracy of the baseline data. A six-facet survey was undertaken in 2020. However, the audit identified the need for a targeted programme of surveys to supplement the non-invasive nature of the six-facet survey undertaken. Accordingly, the 2020 survey included numerous key caveats e.g. did not include assessment of asbestos within hospital ducts.

Management have highlighted that backlog maintenance data focusses on functional (useable) Estate, and statutory requirements, and does not include compliance with the standards of Healthcare Technical Memoranda (HTM) (such as required ventilation).

While total backlog has most recently been reported at circa £9.7m, the Trust has separately estimated the value of required Estate maintenance for full HTM compliance over the next 20 years at £200m - £350m - the latter being works required for a "Plan B" in the event of retaining the current hospital. There is therefore significant disparity in the assessment and reporting of associated risks.

Published data also stated that 35% of the Estate did not meet the required physical condition (which

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary [1]

Assurance objectives		Assurance
1	Governance	Reasonable
2	Baseline information	Limited
3	Estates Strategy	Reasonable
4	Funding strategy	Limited
5	Monitoring & reporting	Limited
6	Risk management	Limited

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

Key Matters Arising		Assurance Objective	Priority
1	The Trust should engage with NWSSP: SES to confirm appropriate derivation and accuracy of published backlog maintenance data at Velindre.	*2, 6*	High
2.	Appropriate surveys should be undertaken following dialogue with NWSSP: SES, including completion of annual update of specialist / invasive surveys, and the associated adjustment of survey values.	*2*	High

would also indicate there being a considerably larger sum of backlog than the current reported £9.7m).

Further issues have been raised on the comparability of the published data, given the significantly varied methods of computation by each NHS Wales organisation.

It is recognised that the level of investment in the Velindre Hospital site may have been reduced recognising the progression of the new Velindre Cancer Centre business case.

The Trust's Estates Strategy did not contain targets for the elimination of backlog.

In the short to medium term, the Trust utilises a combination of all Wales capital funding, planned/ reactive maintenance, and discretionary funding to address identified high-priority areas as follows, e.g.:

- £1.2m of Welsh Government project funding to address Fire Safety (including Welsh Blood Service (WBS) buildings); and
- discretionary finance of £1.454m including £153k on ventilation works, and £140k on emergency lighting during 2022/23 (also including further investment in the Welsh Blood Service - WBS, and equipment).

A long-term strategy is required for maintenance, as continued investment at historic levels is likely to result in the Trust's estate being in a further deteriorating position requiring increased levels of capital investment in the future.

Other key matters requiring management attention included the need to monitor and report against targets, as part of clear and effective reporting.

Further recommendations / advisory points are provided within the detail of the report.

In conclusion, the Trust does not presently benefit from a funded strategy to address backlog maintenance.

Limited assurance has therefore been determined. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales Estate. The centrally commissioned surveys have not identified any instances of RAAC within the Trust.

3.	Management should report progress against prior backlog and Estate investment targets to appropriate forums, including funding and inflationary variances.	*3, 4, 5*	Medium
5.	Costed statutory, "High", and "significant" risk backlog maintenance unaddressed by investment proposals should be appropriately profiled at the Corporate Risk Register and reported to management for acceptance and approval / implementation of mitigating actions.	*6*	Medium

1. Introduction

1.1 This audit formed a part of the 2023/24 operational plan agreed with the Trust.

1.2 The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management, condition, and performance of the Estate.

1.3 The effective and efficient management of the NHS Wales Estate is essential for the delivery of quality health care services.

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

- The Board may be unaware and/ or may not be adequately informed to effectively assess and manage the risks associated with backlog maintenance (particularly statutory requirements).
- Appropriate funding may not be in place.
- The status and value of backlog maintenance may not be adequately defined, and the probability and impact may not be fully understood.
- Information may not be interrogated to ensure focus is prioritised on the key risks.
- Performance in addressing identified priorities may not be monitored, potentially impacting organisational objectives.

1.5 The Estates and Facilities Performance Management System (EFPMS) enables the Trust to submit its annual declaration on key data to Welsh Government. The Trust reported position over the last three years, against NHS Wales averages, was as follows:

Table 1

	2019/20	2020/21	2021/22
Trust Cost to eradicate High Risk Backlog (£)	85,103	139,220	139,220
Trust Cost to eradicate Significant Risk Backlog (£)	1,623,329	1,894,312	1,894,312
Trust Total Backlog Cost (£)	8,945,202	9,755,653	9,755,653
NHS Wales average: Total Backlog Cost (£)	78,098,898	97,385,329	113,007,158
Trust Risk Adjusted Backlog Cost (£)	1,875,521	1,875,521	1,875,521
Physical condition %	65	65	65
Trust Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	34.95	26.91	31.33
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	23.9	28.77

1.6 In the case of Velindre, backlog maintenance data excludes the hosted Welsh Blood Service.

1.7 EFPMS data is extensive, and typically across Health Bodies not available until well into the following year. Accordingly, data for 2022/23 had not been submitted at the time of audit, and therefore was not considered within this report.

1.8 Trust reporting did not include commentary on the above. However, it was evident that the Trust had reported no movement in the estimated value of backlog maintenance figures in recent years.

1.9 In considering associated investment, the audit has excluded that relating to the satellite radiotherapy and enabling works for the planned new hospital, as these will not impact on backlog maintenance figures for the Velindre Hospital site.

1.10 Additional Estate performance data across NHS Wales is presented at **Appendix B,** taken from the NHS Estate Dashboard Report for 2021/22 (published by NWSSP: Specialist Estates Services – NWSSP:SES).

1.11 Our audit work was reliant on the above information. We have not sought to provide assurance over the accuracy of supplied information; however, we have commented within the body of this report on the consistency in approach with other NHS Wales Organisations.

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

Governance: *Assurance that robust governance arrangements were applied to ensure the organisation stayed abreast of matters and associated risks relating to the Estates condition.*

2.2 Effective governance structures were in place, including leadership by the Executive Director of Finance & Corporate Services and the Executive Director of Strategic Transformation, Planning and Digital. Reporting and escalation of capital and Estates issues included accountability to the Executive Management Board, Strategic Development Committee, inclusive of specialist independent member scrutiny of capital investments.

2.3 Audits by NHS Wales Specialist Estates Services (NWSSP:SES) had routinely identified the need for specialist staff to deliver the ongoing programme of surveys and associated works. Management were found to have made appropriate appointments and be monitoring associated training provisions. They had also assessed future needs under the scenario of a new Velindre Cancer Centre provision. Accordingly, there was on-going assurance that appropriate Estates expertise was in identified.

2.4 Whilst no issues were identified associated with the specific governance arrangements in place, sound decision-making is predicated upon the quality of management information. Accordingly noting management information issues in

subsequent sections of this report, **reasonable assurance** has been determined in relation to existing governance arrangements.

Baseline information: *The Trust had detailed assessments of the condition of the Estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that were subject to regular review.*

2.5 The extant guidance in relation to assessing backlog maintenance: '*A risk-based methodology for establishing and managing backlog,'* (updated March 2013) describes the steps involved in establishing and managing backlog maintenance, as follows:

2.6 In respect of the detailed condition survey, the guidance recommends that:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis[1]."*

2.7 A six-facet survey of the Estate was conducted in 2020, in accordance with the above guidance. This provided management with a detailed risk-assessed picture of the condition of the Estate and compliance with statutory / mandatory requirements (e.g. fire safety), along with the associated costs in undertaking remedial works.

2.8 This resulted in a significant change in the assessment of the Estate:

	2018/19	2019/20	2020/21	2021/22
% Estate of acceptable Physical Condition	82	**65**	**65**	**65**
Trust Cost to eradicate High Risk Backlog (£)	32,036	85,103	**139,220**	**139,220**
Trust Cost to eradicate Significant Risk Backlog (£)	808,821	1,623,329	**1,894,312**	**1,894,312**
Trust Total Backlog Cost (£)	2,682,993	8,945,202	**9,755,653**	**9,755,653**

2.9 Following the survey, the percentage meeting acceptable physical compliance (Estate backlog) dropped from 82% to 65% (from 2018/19 to 2019/20), with total backlog values more than tripling. This implies that the interim assessment was inaccurate (as highlighted above). EFPMS returns have subsequently published identical data for 2020/21 and 2021/22 i.e. have not been updated (as highlighted).

2.10 Accordingly, there were issues both in relation to published data and interim update, and an associated need for management to review and confirm the accuracy of data derivation (**MA 1**).

2.11 Management commented that the 2020 survey contained a number of caveats e.g. the extent of asbestos within ducts throughout the hospital was not inspected. The surveyors also included major caveats e.g., in relation to mechanical and electrical installations:

> *"this survey was non-invasive and therefore does not include costs on significant 'carcass installations' throughout the hospital except where they can be seen";*

though it is recognised that there have subsequently been various technical surveys providing positive assessments.

2.12 Management also stated that non-compliance with Health Technical Memoranda - HTMs (such as inadequate ventilation or radiation screening) was not included at

the physical condition (backlog) assessment. The Trust has separately estimated that should the present hospital be retained, associated refurbishment, rebuild (and associated decanting), would require at as much as £200m within clinical areas over the next 20 years, and £350m for the whole Estate (to provide appropriate facilities, and functionality for HTM compliance).

2.13 Additionally, noting differences in approach to inflation, surveys, interim updates, and risk categorisation across Wales, there have been inconsistencies in EFPMS figures between different health bodies. To ensure data comparability across Wales, health bodies would therefore benefit both from peer review and consultation with NWSSP: Specialist Estates Services (**MA 1**).

2.14 The guidance also recommends that:

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose."*

A programme of risk-focused surveys should therefore be undertaken on a rolling basis to supplement the full survey. While interim surveys were conducted, these were referenced at the 2020 survey as being incomplete (e.g. in respect circuit boards, deficiencies in heating and hot water systems, and asbestos in underground ducts). Taken together, the issues listed could result in material adjustment to survey values. Accordingly, the survey recommended that associated allowances to the survey results should be made. It was not evident that the survey results had been adjusted in this way. It has also been recommended that there is dialogue with NWSSP:Specialist Estates Services to appropriately support specialist surveys and build knowledge across NHS Wales (**MA 2**).

2.15 While a recent six facet survey had been undertaken (as recommended by best practice guidance), noting the above issues, **limited** assurance has been determined in relation to baseline information.

Estates Strategy: *To obtain assurance that a tailored Estates Strategy was in place including linkage to major investment, Estates condition, statutory compliance, decarbonisation requirements, service needs etc. The strategy also reflected emerging risks.*

2.16 A long-term Estates Strategy was in place (to deliver a fit for purpose Estate), supported by an Integrated Medium-Term Plan.

2.17 The IMTP also provided a profiled capital plan, for which supporting documents showed circa £4.2m of Welsh Government funding investment in the Estate over a four-year period from 2022/23.

2.18 While a longer-term assessment of Estates needs and funding had also been made, it is recognised that more formal documentation is contingent upon the progression

of the new Velindre Cancer Centre. These estimates are further considered within the **Funding Strategy** section.

2.19 It has been recommended that both the Strategy and associated plans could usefully include time profiled backlog targets to facilitate associated reporting (**MA 3**).

2.20 Capital bid forms did require specific reference to backlog risks and values being addressed. Short term priorities were well informed via the Quality and Safety Committee, as supported by the Health, Safety and Fire Sub-committee. As a result, high risks and statutory maintenance relating to key areas such as fire and water safety were found to have been prioritised and addressed.

2.21 Accordingly, **reasonable** assurance is determined in relation to Estates Strategy.

Funding strategy: *Assurance that there was a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the Estates Strategy.*

2.22 There has been historical under-investment across Wales in this area, resulting in a deterioration of the NHS Estate condition.

2.23 Since 2018, total published backlog maintenance had risen from £2.2m to almost £10m, with the total of "high" and "significant risk" backlog rising from £786,840 in 2017/18 to £2,033,532 by March 2022. It is partly deficiencies within the Estate that have driven plans for a new cancer centre.

2.24 However, as of October 2023, while investment plans were in place identifying circa £6m over a four-year period (including EFAB funding), less than £1m of All Wales capital monies had been approved (excluding funding for progressing new cancer centre proposals and off-site satellite radiotherapy services).

2.25 There remains therefore a material risk that the Estates Strategy and capital investment plans are unaffordable, noting the current financial climate and considering total funding requirements across NHS Wales.

2.26 It is recognised that the Trust have assessed the value of a contingency plan (i.e. £200m - £350m). However, should the new cancer centre not progress, funding at these levels has not been subject of application or approval, and therefore may take some time to put in place. While costed, this had yet therefore to be developed into a full proposal. It has been additionally recommended that contingency plans should also include maintenance targets to avoid future deterioration of the estates /escalation of cost estimates (**MA 4**).

2.27 Noting the status of the current investment plans, at the time of audit the Trust did not have a funded strategy to address backlog. Accordingly, there was limited assurance via Trust reporting, that investment plans would address current / high and significant risk backlog (**MA 3**).

2.28 The Estates and Facilities Performance Management System (EFPMS) is an annual return that the Trust makes to Welsh Government; part of this return categorises the "Total Building & Engineering Maintenance Cost per Occupied Floor Area". Over

recent years these figures are as highlighted below (existing Velindre Cancer Centre only).

Table 2

Measure	2019/20	2020/21	2021/22
Trust's Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	34.95	26.91	31.33
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

2.29 While the Trust's maintenance figures remain above the national all-Wales averages in relation to spend per occupied floor area, the average level of investment has been insufficient to prevent a deterioration in the condition of the Estate across Wales (with backlog maintenance increasing in absolute terms across Wales) or within the Trust.

2.30 Over the period 2019-2022 the Trust had also decreased its maintenance costs by £3.62/m^2 p.a. While this is against the context of plans to replace the existing cancer centre, the All-Wales averages represent historic under-investment across Wales resulting in a deterioration of the Estate. In the absence of a new cancer centre therefore, the current level of investment may not represent a sustainable position.

2.31 It is recognised therefore that whilst an appropriate range of funding has been utilised with significant investment plans identified. However, acknowledging the historical underinvestment and material gap in approved levels of investment, there remain significant risks to the Trust in obtaining sufficient funding to address all maintenance requirements. There is also a need to report funding limitations, based on re-assessed data, and an on-going need for a funded plan. **Limited** assurance has therefore currently been determined in relation to the funding strategy.

Monitoring and reporting: *To gain assurance that appropriate management information was presented with regularity on key issues, including the Estate condition and progress to implement the Estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving Estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions.*

2.32 The Estates Strategy and associated capital plans, formed a part of the IMTP submitted to the Trust Board in April 2023, and subsequently approved by Welsh Government.

2.33 A prioritised plan was therefore in place to address the Estate's needs. However Key Performance Indicators, which may be derived from such a strategy, were not defined and monitored (e.g. EFPMS targets as at **Appendix B**).

2.34 The Intermediate Medium-Term Plan (IMTP) (2022-25) including the Estates Strategy and capital investment plans formed a part of the reporting process to the Board.

2.35 Formulation of Estates plans was via a Strategic Capital Board with oversight and approval by an Executive Management Board – and onward accountability and reporting to the Strategic Development Committee (e.g., of the discretionary capital allocations).

2.36 However, as previously noted, the Trust had not published reporting against targets to reduce or eliminate backlog maintenance at the Velindre Hospital site (or Welsh Blood Service properties) (also see **Estates Strategy** section) (**MA 3**).

2.37 The context of the business case being developed to replace the existing Velindre Hospital is recognised. However, pending its approval, noting interim time frames, and the absence of regular reporting against targets for the Trust's key sites, **limited** assurance has currently been determined in relation to monitoring and reporting.

Risk management: *Assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the Trust in relation to Estates condition was clearly reported.*

2.38 The Trust has a defined Trust Assurance Framework, supported by a Risk Management Framework, Trust Risk Register, and operational Risk Registers. These provide guidance on the management of strategic and operational risks within the organisation, as supported by risk assessments and Risk Registers.

2.39 The 2020 survey provided both overall totals for each Estates risk priority, together with backlog maintenance totals for 23 individual areas.

2.40 The risk prioritisation of the backlog maintenance issues was maintained in an on-line system facilitating visual enquiry.

2.41 While a costed and prioritised capital programme was approved (based on capital bid forms), the resultant "high" and "significant" risk backlog maintenance resolved or left un-addressed by such decisions was not reported e.g. to highlight any potential remaining single points of failure (**MA 1** & **5**)

2.42 Noting the limited risk reporting to appropriately inform decisions, **limited assurance** has currently been determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Data consistency – All Wales approach (Design)	**Impact**
It is recommended within the NHS Wales Risk Based Methodology for Establishing and Managing Backlog (as amended in March 2013) that NHS organisations carry out a detailed survey of their assets on a five-yearly basis. In 2004 NHS Wales also published "*A risk-based methodology for establishing and managing backlog*" (mandatory in Wales) as guidance for consistent compilation of EFPMS data. A six-facet survey of the Estate, completed in 2020, resulted in significant changes in the percentage of the Estate meeting acceptable physical compliance, which dropped from 82% to 65% in one year. Additionally, much of the published backlog maintenance data had not changed in recent years including risk adjusted backlog and percentage physical compliance *(**Table 1**).* The percentage compliance remained un-changed from 2019/20 to 2020/21 despite a change in overall backlog (the percentage of the Estate below category "B" – acceptable condition / functionality) indicating an error in its publication (***Table 1***). Backlog maintenance across the Estate was stated at circa £9.7m (***Table 1***). However, 35% of the Estate was stated to fall below "category B" (**Appendix B**). The value of 35% of the Estate would evidently be much higher than the £9.7m figure declared. There was a need therefore to confirm the accuracy of published data. The approach to risk prioritisation varied across Wales, with some organisations assessing matters as high risk, where whole asset classes had reached end of useful life, while others took account of the ability to safely maintain the assets (in accordance with guidance) etc.	Potential risk that: • Sub-optimal investment decisions are made due to inaccurate data. • Backlog maintenance figures are not comparable across Wales.

Current guidance would indicate the prioritisation of single points of failure which cannot be readily recovered as being high risk e.g., High Voltage power, as compared to failure of individual Low Voltage circuits. There is currently no agreed approach across Wales relating to the application of inflationary uplifts e.g., some bodies had not included uplift for inflation while others had utilised professional estimates ranging from 3% to over 10% or applied cost indexes. Uplifts for fees, overheads and profits had similarly varied. This meant that uplifts at some health bodies to works costs was as much as 49%. Issues of consistency across Wales in compiling Key Performance Indicators included physical compliance percentage (as above), and space utilisation (measured as an allocated use or actual occupancy, and consistently recorded by Velindre at 99% utilisation in recent years). Other areas providing scope for differing interpretation included whether functional suitability included appropriate service adjacencies, and compliance with Health Technical Memoranda (HTM). These matters therefore raise questions both as to the robustness of interim assessments, and comparability of figures across Wales at any point in time.	

Recommendations	Priority
1. The Trust should engage with NWSSP: SES to confirm appropriate derivation and accuracy of published backlog maintenance data at Velindre.	High

	Agreed Management Action	Target Date	Responsible Officer
1.	Agreed, engagement with NWSSP will be undertaken once relevant surveys and CAFM system has been updated	August 2024	Executive Director of Strategic Transformation, Planning, Performance & Estates

Matter Arising 2: Annual update (Design)	**Impact**
In 2004 NHS Wales published "*A risk-based methodology for establishing and managing backlog*" (mandatory in Wales). This recommended a six-facet survey every five years, and that "*you should update the findings of your detailed survey on an annual basis*". Across Wales, surveys at some other health bodies were heavily caveated, notably as to their non-invasive nature, meaning that significant sums relating to e.g., mechanical, electrical, and asbestos issues may not have been assessed. In the case of Velindre Hospital, the 2020 survey stated that supporting surveys were incomplete, and that these required checking as "*several issues were noted during the inspections*" recommending that associated "*allowances*" were made. It particularly recommended the follow-up survey of distribution boards and stated that the rolling surveys were incomplete (e.g., the need to check all circuit boards; medical gas plant; energy efficiency, drainage; deficiencies in heating and hot water systems in several areas; and asbestos in underground ducts). In noting that rolling inspections were incomplete, it stated that the "*assumption*" that associated works had been carried out should be checked, as several issues relating to electrical and legionella matters were identified. Accordingly, it recommended that associated allowances to the survey results should be made. It was not evident that the survey results had been adjusted in this way. As such the 2020 survey was not a definitive assessment of backlog maintenance, and reliant upon other pieces of work, not included within its documentation (more invasive surveys) i.e., it could not act as a central and definitive reference (placing increased importance on such interim / invasive surveys and annual updates). On an All Wales basis, there is currently active engagement with NWSSP:SES to support these processes, address issues of cost and resource, and build local knowledge and expertise within the NHS e.g., with potential utilisation of SES specialist support.	Potential risk that: • Backlog maintenance is not appropriately recognised.
Recommendations	**Priority**

2. Appropriate surveys should be undertaken following dialogue with NWSSP: SES, including the completion of annual updates of specialist / invasive surveys, and the associated adjustment of survey values.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
2. Agreed, we are in the process of installing new a CAFM system with up to date asset information, which will link the asset register to surveyed items to ensure comprehensive coverage.	November 2024	Assistant Director of Estates, Environment & Capital Development

Matter Arising 3: Delivery targets (Design)	**Impact**
A key focus of Welsh Government reporting on Estate matters is the cost of addressing backlog maintenance risks within the Estate. Accordingly, Estates strategies and plans should target associated delivery. The Estates Strategy expressed general aims for the Estate (e.g. fit for purpose) and was supported by Estates Plans containing more specific investment targets. While tactical plans were in place to deliver schemes against priorities and reduce backlog, a time phased plan to eliminate "high" and "significant" risk or overall backlog was not identified. In context, it is recognised that the proposed new cancer centre would address all such backlog. However, this proposal had yet to reach financial close, and may take circa 3 ½ years until delivery, if approved. Reporting could also usefully include inflationary adjustments, reductions due to direct/indirect investment, benchmarking information, newly discovered backlog maintenance etc.	Potential risk that: • Targets are not achieved.

Recommendations	**Priority**
3. Management should report progress against prior backlog and Estate investment targets to appropriate forums, including funding and inflationary variances.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3.	Agreed, backlog maintenance targets will be reported to the relevant forums to ensure that there Is a robust plan in place to address High Risk items along with benchmarking data.	November 2024	Assistant Director of Estates, Environment & Capital Development

Matter Arising 4: Estates Strategy – Plan B (Design)	**Impact**
WHBN 00-08 2018 Estatecode outlines that the Estate strategy should represent the vision for the future Estate to deliver and satisfy the current/anticipated business plans and operational services. The present long term Estates Strategy outlined an ambition and associated finance requirements over the next ten years. However, it was based on the assumption that finance for the new cancer centre would be approved. As such it did not presently provide a financial strategy to address backlog maintenance within the Estate should the new hospital not be approved (noting that a quantum of the £7m of medium and low risk backlog has the potential to escalate to higher risk/value over time as the Estate ages). It was also noted that the backlog maintenance figures themselves were undergoing re-appraisal at the time of audit and were thought to be considerably higher than that provided at previously published data. A "Plan B" for on-going maintenance of the current Estate has been professionally assessed (at £200m for clinical areas, and £350m for the whole hospital Estate). However, should the new hospital not progress, funding at these levels has not been subject of application or approval, and therefore may take some time to put in place. While costed, this had yet therefore to be developed into a full proposal. This will be key to providing the Board with an appropriate level of assurance in the management of the Estate condition. Recognising this, in the event of on-going delay in approval of a new Velindre Cancer Centre, the "Plan B" Strategy could usefully be developed to include measures that the Trust would put in place to ensure refurbished buildings are maintained in the future; thus, ensuring that any future backlog maintenance can be managed appropriately.	Potential risk that: • There is no viable strategy to address backlog maintenance.

Recommendations	Priority
Future Assurance 4. Contingency plans for the retention of the current Estate should include reporting of performance indicators linked to reducing High/Significant backlog maintenance, and opportunities linked to space utilisation etc. (in the event of on-going delay or rejection of a new Velindre Centre Centre).	**Low**

Agreed Management Action	Target Date	Responsible Officer
4 Backlog Maintenance data can be developed once relevant surveys have been updated. A recent space utilisation exercise has been completed. These two topics can then be integrated into the Trusts business continuity plans.	3 months post confirmation of future hospital provision	Executive Director of Strategic Transformation, Planning, Performance & Estates

Matter Arising 5: Risk reporting (Design)	**Impact**
The Trust had a defined Trust Assurance Framework, supported by a Risk Management Framework, Trust Risk Register, and operational Risk Registers. These provide guidance on the management of strategic and operational risks within the organisation, as supported by risk assessments and Risk Registers. It is important that management are provided with clear reporting to inform risk assessed decisions. The All-Wales backlog methodology provides a detailed risk assessment methodology, to ensure consistency in reporting across Wales (based on full surveys of the Estate and interim update). The six-facet survey undertaken in 2020, risk assessed the Estate. The resulting information was utilised to inform capital bids to formulate the capital programme. However, these contained narrative, rather than risk ratings. Accordingly, while bids for capital investment were risk appraised (based on narrative within the bid form), management were not sighted on the extent to which "high" or "significant" risk backlog, would be left un-addressed by their decisions. More detailed surveys in specialist areas were also undertaken by NWSSP: Specialist Estates Services in the interim between Trust wide surveys (e.g., Medical Gasses, and Ventilation). However, these typically did not provide values for required works, and the interface to update the backlog maintenance system was not evident. In context, Estates personnel stated that this information was available within an on-line system (with limited print facilities), and that this informed bids that they submitted to address the issues – the on-line system being the de-facto Estates Risk Register. There was therefore no automatic reporting of high and significant backlog un-addressed by investment proposals, or automated linkage between it and the Corporate Risk Register. However, in context, it is recognised that contingent risks of the new Velindre Cancer Centre not being approved had been separately assessed (as a major and particular risk).	Potential risk that: • Management is not sighted on accepted risks.
Recommendations	**Priority**

5. Costed statutory, "High", and "significant" risk backlog maintenance unaddressed by investment proposals should be appropriately profiled at the Corporate Risk Register and reported to management for acceptance and approval / implementation of mitigating actions.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
5 Agreed, all relevant risk items will be profiled and logged on the Trust risk register with the necessary implementation plans.	August 2024	Assistant Director of Estates, Environment & Capital Development

Appendix B: Estates Facilities Performance Management System (EFPMS)

NHS ESTATE DASHBOARD REPORT 2021/2022

HEALTH BOARD / TRUST ESTATE PERFORMANCE BREAKDOWN 2021/2022

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	93	85	98	91
BETSI CADWALADR UNIVERSITY HEALTH BOARD	62	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	78	86	87	66	81
CWM TAF UNIVERSITY HEALTH BOARD	96	89	95	100	97
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	65	91	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	51	47	47	55	97
VELINDRE UNIVERSITY NHS TRUST	65	95	95	88	99
WELSH AMBULANCE SERVICES NHS TRUST	48	90	90	36	99

Backlog Maintenance Costs

...get to be agreed

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	37,754,428	16,518,352	45,488,017	49,807,323	98,296,321
BETSI CADWALADR UNIVERSITY HEALTH BOARD	91,809,773	142,498,091	68,658,155	45,421,260	239,955,528
CARDIFF & VALE UNIVERSITY HEALTH BOARD	32,033,876	85,487,856	28,777,072	5,537,518	101,262,019
CWM TAF UNIVERSITY HEALTH BOARD	31,261,530	31,963,352	22,345,412	1,519,250	64,046,747
HYWEL DDA UNIVERSITY HEALTH BOARD	0	89,509,339	9,432,673	6,802,904	90,679,218
POWYS TEACHING LHB	5,075,437	23,998,187	12,931,568	10,039,954	30,117,985
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,057,000	46,516,759	41,835,883	4,598,390	56,464,069
VELINDRE UNIVERSITY NHS TRUST	139,220	1,894,312	5,002,211	2,719,910	1,875,521
WELSH AMBULANCE SERVICES NHS TRUST	667,486	2,855,208	3,170,304	3,936,411	7,184,233

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

Note – Risk Adjusted backlog = $\frac{\text{Non-critical backlog ("low" and "moderate")}}{\text{Years remaining life of asset life}}$ + Safety critical backlog (i.e. "high" & "significant" risk)

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AUDIT COMMITTEE

Counter Fraud Progress Report

DATE OF MEETING	12/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	GARETH LAVINGTON
PRESENTED BY	Gareth Lavington
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The counter fraud progress report provides a detailed breakdown of the work carried out by the team during the relevant period. The report breaks down the areas of work into the most relevant work streams that align with the NHS Counter Fraud Authority requirements for compliance. These areas are: Infrastructure/Annual Plan Promotion and Awareness and Education

	Prevention Referrals Investigations Fraud Risk National Fraud Initiative Any further information that it is felt that should be presented to the committee is provided in Section 3 - Other

RECOMMENDATION / ACTIONS	It is recommended that committee note the report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS NA	

7 LEVELS OF ASSURANCE	
NA	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
3	NA

1. SITUATION

The purpose of the Counter Fraud Progress Report is to provide the Audit Committee with a breakdown of the work carried out by the Local Counter Fraud team on behalf of the organisation during the relevant time period. The report's style has been adopted, in consultation with the Director of Finance. This report consists of:

a. Counter Fraud Progress Report

2. BACKGROUND

In compliance with the NHS CFA standards Counter Fraud is a standing item at Audit Committee. Regular progress reports are written and presented by the counter fraud manager. The provision is overseen by the Director of Finance within the organisation. The report seeks to highlight all work carried out by the team and breaks this down into proactive and reactive areas.

3. ASSESSMENT

It is proposed that the report is noted.

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. Counter Fraud Progress report – An administrative report only.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosporous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

All risks must be evidenced and consistent with those recorded in Datix

NHS WALES

Counter Fraud Progress Report

02/12/2023-27/02/2024

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Velindre UNHST.

This report relates to activity for the reporting period 02/12/2023-27/02/2024

2. Progress

Infrastructure/Annual Plan

The below activity has taken place -

i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.

ii. Continued maintenance of Counter Fraud digital platform – Members of the Audit Committee are encouraged to visit the site at the link/QR code here. The site can also be accessed via the VUNHST intranet site within the finance share point pages.

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

Newsletters/Publications - A further newsletter has been published via Sway and can be accessed via the Share Point link provided above.

Corporate Induction– Seven (7) joint education and awareness sessions for new starters in conjunction with Information Governance have taken place throughout December and January. These have involved staff from the Velindre Cancer Centre, Welsh Blood Centre and corporate staff.

Bespoke Awareness – one (1) session of awareness was delivered to Health Technology Wales staff at their team building day in December.

E- Learning – The new e-Learning package is now Live on the ESR system and available to staff. Liaison made with WOD to target new starters with an objective of completing the module.

VUNHST staff uptake – 31

NHS Wales staff uptake – 8000+

(since launch 04/23)

Prevention

CFA IBURN (intelligence bulletin) – (1) - relating to serial fraudster obtaining positions in public sector organisations. Full checks made and the subject of the IBURN notice nor any of their aliases has had any interaction with Velindre UNHST or the wider NHS community in Wales.

FPN – (1) – reminder of the risks of mandate fraud during the festive period. Support material and awareness distributed to the relevant staff members throughout the organisation.

Fraud Risk

A further two (2) fraud risk assessments completed in relation to the following subject areas.

- Credit Card use (internal)
- Petty cash procedures

These have been submitted to key stakeholders within finance teams and await response.

An update on all fraud risks will be reported to Audit Committee under separate cover at the meeting at Quarter 1, 2024.

National Fraud Initiative

Work has commenced into the latest NFI data dump. The below table provides the total matches that require investigation by the Counter Fraud Team

Report Type	Total No. of Matches	No. Cleared
Payroll to Payroll - NI	20	20
Payroll to Payroll - Tel. No.	7	7
Payroll to Pension	15	15
Payroll to Company Director/Trade Creditor	6	3
Payroll to Creditor	17	5

3. Referrals & Investigations

NA

AUDIT COMMITTEE

Counter Fraud Annual Plan

DATE OF MEETING	12/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	GARETH LAVINGTON
PRESENTED BY	Gareth Lavington
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	THE COUNTER FRAUD ANNUAL PLAN PROVIDES AN OVERVIEW OF THE WORKSTREAMS TO BE CARRIED OUT BY THE COUNTER FRAUD TEAM ON BEHALF OF VELINDRE NHS TRUST FOR THE YEAR 24-25.

RECOMMENDATION / ACTIONS	It is recommended that committee review the report in order to gain a full understanding of the work that will be carried out by the Counter Fraud team in the year ahead.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS NA	

7 LEVELS OF ASSURANCE	
NA	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
3	NA

1. SITUATION

The NHS Counter Fraud Authority requires that an Annual work plan is created in relation to the counter fraud work to be carried out by counter fraud teams for their organisations. The workplan must directly align with Government Functional Standard GovS 013: Counter Fraud. This plan adheres to that principle and provides an overview of the areas of work that will be carried out on behalf of the organisation for 2024/2025.

2. BACKGROUND

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater

consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services. The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and has a duty to ensure the effective implementation of the NHS Counter Fraud Requirements. Local Counter Fraud Teams must adhere to these requirements and report their work against them. As a result, an Annual Workplan identifying how these requirements will be met is produced and submitted to DoF and Audit Committee for their approval.

3. ASSESSMENT

It is proposed that the report is approved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. Counter Fraud Progress report – An administrative report only.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosporous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item**

	Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].

All risks must be evidenced and consistent with those recorded in Datix

NHS WALES
Velindre University NHS Trust

COUNTER FRAUD WORK PLAN
2024/2025

Gareth Lavington
Manager Counter Fraud

This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Team on behalf of Velindre UNHST to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Executive Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Gareth Lavington

Workplan agreed by:

Executive Director of Finance – Matthew Bunce

Date: 01/03/2024

WORKPLAN 2024-2025

Background

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHS Counter Fraud Authority (CFA) worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales. The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. Deadline for submission of this document in relation to this plan is on or about 31/05/2025. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. The Counter Fraud Manager will provide a grading of compliance in relation to all areas of the functional standards by way of self-assessment. (Green, Amber or Red). This will be supported internally with the completion of the Annual Report that will align with the same methodology.

To achieve the standards, set by the NHSCFA, Velindre University NHS Trust (VUNHST) follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and employs a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS). To ensure that the Trust's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the Counter Fraud Manager that is agreed by Executive Director of Finance and submitted to the Audit Committee for approval at the commencement of each financial year. The Workplan provided below formulates

Local Counter Fraud arrangements for VUNHST for 2024-2025. The tasks outlined will be considered and reviewed throughout the year as the need arises. The plan is intended to provide targets for the year but will remain a living document and subject to change. The effectiveness of the plan will be reported in the end of year Annual Report to Audit Committee and in the NHSCFA Functional Return as referred to above.

This organisation's Work-Plan will directly mirror GovS:13 Standard (Counter Fraud) to maintain consistency with the NHSCFA Counter Fraud Bribery and Corruption Strategy. This in turn supports the objectives set by the Welsh Government.

Taking a risk-based approach to planning local counter fraud work

Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the LCFS.
The counter fraud work-plan should be tailor-made and specific to the NHS organisation, for example, carrying out local proactive exercises identified during investigations, or analysis of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

Meeting key personnel in the health board and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work. Any risks which are identified by the LCFS will be recorded in line with the local Risk Management Policy and nationally via the CLUE case management system, and they will be shared with the Internal Audit department and reported to the Executive Director of Finance and Audit Committee. The aim is to provide assurance that the risk is being suitably managed and is owned. While every effort will be made to identify local risks, it is important that information from outside the organisation is also considered; for example, NHS CFA fraud alerts, and fraud prevention notices, together with identified inherent risks to all NHS organisations. Information received from external sources will be assessed and investigated and any risks identified as pertinent to the organisation will be subject to formal assessment. To help organisations take a risk-based approach to counter fraud work and planning, the NHSCFA has issued

up to date risk assessment advice and training. A dedicated risk matrix scoring system and template have been designed and implemented that comply with Cabinet Office methodology for the purpose of recording and reporting upon fraud risk.

Outcomes/Results

Accurate records of counter fraud work are crucial. They inform upon the effectiveness of work undertaken, assist in the planning of future work and help to identify strengths and weaknesses within the organisation. Accurate records of all work undertaken by the Counter Fraud team for this upcoming year will be kept and updated. These results will be reflected in the quarterly progress reports and end of year annual report.

The Counter Fraud team are aware of the importance of liaison with Internal and External Auditors when planning Local Counter Fraud work to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which Internal and External auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g., Whistle-Blowing arrangements, Declaration of Interests, Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust and the Counter Fraud team will maintain a close working relationship with Wales Audit as required.

Resource Provision

Resource Provision for VUNHST	Days Planned 24/25
Counter Fraud Manager and LCFS provision from CAVUHB	100

Resource by Activity

Activity	Days Planned 24/25
Proactive	70
Reactive	30
Total	100

With the move to the GovS:13 (NHS Requirements) taking place and old 4 standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account now obsolete, the methodology to be adopted in planning resource time by activity area is simplified into Proactive and Reactive areas. Generally *Proactive* work will involve activities such as fraud awareness, corporate induction, creating e-learning modules, local proactive exercises involving risk assessment. Reactive work will involve activities such as, investigation into referrals received, carrying out system weakness analysis because of investigation findings.

NHSCFA states that Proactive work should not be absorbed by Reactive activity or *vice versa* and to this end NHSCFA strongly encourages Proactive work to be 'ring-fenced'. However due to the dynamic nature of the Counter Fraud environment the plan is intended to be flexible to the needs of the service, so may be subject to review and change where service priorities and risk require. If this occurs, then careful consideration will be given to any changes made and they will be discussed with the Executive Director of Finance as soon as is practicable and reported to the Audit Committee. Any changes to the overall days provided or regarding the areas planned for will be reported in the end of year report and through the ongoing Counter Fraud Progress Reports.

Work Plan Objectives

A work plan with matching tasks/objectives is set out below for each NHS requirement area. Each task/objective relates to a specific standard of compliance or fraud risk area; the work plan has been formulated to support the mitigation of the risk of fraud to the organisation and to ensure compliance with the NHSCFA/Gov requirements.

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
1: Accountable individual NHS Requirement 1A: A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for	Counter Fraud Manager (CFM) to hold regular scheduled meetings with Director of Finance (DoF) - objectives to be reviewed and work to date evaluated. During these meetings ongoing work involving investigations, the promotion of fraud awareness, fraud proofing and risk assessments, policy considerations and Counter Fraud communication strategy to be discussed. CFM to produce the VUNHST Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee. CFM to provide quarterly progress reports to DoF and Audit Committee and to present these verbally at Audit Committee.	Q1/2/3/4 Q1 Q1

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
the accountable board member, audit committee chair and counter fraud champion are accurate.	Checks to be carried out by CFM that nominations to NHSCFA are correct, up to date and in order.	Q1
NHS Requirement 1B: The organisation's non-executive directors, counter fraud champion, or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.	Where necessary and appropriate CFM will have access to one-to-one meetings with the Audit Committee Chairperson and Counter Fraud Champion. In addition to this CFM to attend pre-audit committee meetings with Independent Members.	Q1/2/3/4
	Counter Fraud to remain a standing agenda item at Audit Committee. Counter Fraud Manager to provide written and oral reports to this forum, annually and progressively throughout the year.	Q1/2/3/4
The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation.	CFM will address and report to DoF and Audit Committee any matters arising from NHSCFA in relation to thematic assessment exercises, matters arising out of Fraud Prevention Notices and national exercises.	As required
Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility		

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	CFM to liaise with internal partners, including Internal Audit, Workforce & Organisation Development, Communication Department, and other senior management teams as necessary to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision. CFM to complete annual report to Audit Committee and NHS CFA Functional Standard return.	Q2/Q4 And as required Q1 (25/26)
2: Counter fraud bribery and corruption strategy NHS Requirement 2: The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and	CFM to ensure that work planned in the Annual Counter Fraud Plan and work carried out remains aligned to the NHS CFA strategy and that the objectives are being met. CFM to provide assurance that counter fraud provision is resourced by way of qualified, nominated and accredited Counter Fraud Specialists and to ensure that this is maintained.	Q1/2/3/4 Q1

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
resource allocation are aligned to the objectives of the strategy and locally identified risks		
3: Fraud bribery and corruption risk assessment NHS Requirement 3: The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. Locally identified risk to be recorded in line with the organisations Risk Management Policy and entered on to the appropriate risk registers. All risks identified to be assessed and remedial action identified and reported to key stakeholders. All matters arising to be reported to DoF and Audit Committee by way of counter fraud progress reporting. Deputy Counter Fraud manager to maintain the fraud risk profile (live document) and the CLUE case management system (risk module) to effectively	Throughout the year and dynamically as the needs arise Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.	record, evaluate, evidence and measure the effectiveness of counter fraud risk assessment work. Fraud Risk Assessment action plan/timetable (as part of fraud profile) to be maintained targeting all areas of inherent/emerging Fraud Risk to the organisation and providing a timescale of intended work and results of work already completed. To be presented to AC under separate cover Q1. Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year. These will be both locally and nationally informed by CFA Fraud Prevention Notices and national exercises. All risk analysis work to be subject to timed ongoing review to assess if recommendations acted upon. Priorities for LPE work at he time of reporting: 1. Impersonation of Medical Professionals	Q1 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	2. Consultants/SAS vs Declarations of Interest vs Job Planning vs Private 3. IT Stock/Asset Management	
4: Policy and response plan NHS Requirement 4: The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team.	Counter fraud bribery and corruption policy – reviewed amended and updated and approved Q4 22-23: - Counter Fraud (CF) team to promote awareness of the policy at presentations to staff and through newsletters. CF team to utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.	Q1/2/3/4
5: Annual action plan NHS Requirement 5: The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment	CF Manager to complete annual CF fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed action time period.	Q4 (23/24)

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	CF Manager to ensure the plan is agreed by DoF, ratified by Audit Committee. CF manager to provide quarterly reports to Audit Committee and CF quarterly statistics to Counter Fraud Service Wales for onward reporting to Welsh Government. CF manager to provide annual report measuring the effectiveness of the plan.	Q1 Q1/2/3/4 Q1 (24/25)
6: Outcome-based metrics NHS Requirement 6: The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive	The contact, enquiry and reporting methods now in place benefit from the automatic facility of analytical data collection. This will be utilised as an important tool to measure the effectiveness of the actions and work undertaken by the CF Team throughout the year. Where necessary regular review will be used to inform change.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	Maintenance and use of the following resources already successfully implemented will be utilised and improved where necessary: - • CLUE Management System • Interactive feedback forms • Interactive Staff Surveys • Fraud Risk Profile • Risk Management Policy • Locally developed database • Electronic Staff Record • CFS Statistics • Microsoft Share point All investigations will be recorded and Managed on the CLUE case management system and reported to Audit Committee via the quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to Audit Committee via the quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA. Statistical report of work areas drawn from newly implemented local database to be provided in Annual Report. (To provide work benchmarked year on year)	Q1/2/3/4 Q1 (24/25)
7: Reporting routes for staff, contractors and members of the public NHS Requirement 7: The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and	New reporting routes were put into place during 2022/2023 that complement existing national routes of reporting and remain effective. These will be continually 'advertised' and promoted throughout the year and awareness will be drawn to them via all routes available. Continued liaison with the communications team will assist in achieving this.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF team will continue throughout the year promoting their identity and presence. This will be undertaken by way of the continued development of the Share point Intranet Site, and throughout structured awareness and training sessions and pop-up stalls at key locations. Ongoing review of the effectiveness of the work undertaken and where necessary remedial action to take place dynamically throughout the year. Continued promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA.	Q1/2/3/4 As required Q1/2/3/4
8: Report identified loss NHS Requirement 8: The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and	CF team to make full use of the CLUE case management system for recording and managing Investigations, System Weakness reporting, and Local Proactive exercise reporting.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises	CF Manager to ensure that all members of CF team are suitably trained and qualified to access the CLUE case management system. Review of staff competence to be conducted. CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated . CF manager to oversee all investigations acting as Senior Investigating Officer, ensuring that Investigating Officers take timely action and are fully supported with decision making processes. CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting.	Q2 Q1/2/3/4 Q1/2/3/4 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and reported to DoF and Audit Committee at progress updates and at year end in Annual report and NHS CFA Functional Return.	Q1/2/3/4
9: Access to trained investigators NHS Requirement 9: The organisation employs or contracts in an accredited person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of	The organisation currently employs/has access to provision from, four fully accredited, nominated and qualified LCFS. All members work on a full-time basis. All staff members of the CF team are skilled and trained in criminal investigation and fully up to date with their knowledge of relevant legislation such as PACE, CPIA, DPA, HRA, GDPR, offence legislation. All staff will keep abreast of changes and updates to legislation and undertake training as necessary. All CF staff will continue to develop professionally, attending appropriate training sessions provided by	Q1/2/3/4 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.	NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. CF team will undertake continuing professional development opportunities associated with role throughout the year as they become available.	
	All CF staff to maintain full compliance with mandatory training/e learning as measured on the ESR system.	Q1/2/3/4
	CF team to maintain the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role (inclusive of secure access to relevant IT systems). Review of staff awareness to take place.	Q2
	CF team to continue to maintain access to secure office accommodation accessible only by them.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention and storage of evidential data in line with legal requirements. All training and development to be recorded on ESR and referenced during annual staff appraisals that are carried out at year end.	Q4
10: Undertake detection activity NHS Requirement 10: The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into	CF team to undertake national exercise work as it is published by NHS CFA throughout the year. CF team to react appropriately to the issue of FPN's from NHS CFA. CF team to react appropriately to fraud alerts raised by other Trusts, Health Boards and Special Health Authorities. CF team will undertake Local Proactive exercises in response to locally identified risk as identified above and as the need arises.	As required As required As required

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	CF Team to continue undertake the 2023-2024 National Fraud Initiative exercise in relation to Payroll data and to finalise by end Q2 CF team will engage with internal and external partners e.g. internal and external audit, to ensure that any outlying data is reported and acted upon accordingly.	Q2 Q1/2/3/4
11: Access to and completion of training NHS Requirement 11: The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard	CFM to continue to work towards making Fraud Awareness e-Training module mandatory. CFM to continue to work towards ensuring that Fraud Awareness training remains a standing item of agenda at all corporate inductions. CFM to assist with the smooth roll out of the newly developed All Wales Counter Fraud Training module. CF team to maintain a promotion strategy in relation to the new module through effective communication to staffing cohorts.	Q1/2/3/4 Q1/Q2 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	CF team to develop awareness of the Counter Fraud Department team through all available avenues. To include but not limited to • Digital banners on organisation intranet site • Regular publishing of Counter Fraud news items via Counter Fraud Newsletter • Regular messaging across available social media systems • All staff email bulletins to advise of fraud alerts • Ad hoc and bespoke fraud awareness training for different staff cohorts throughout the organisation including primary care • The use of a Counter Fraud Awareness staffed stand at impactive sites around the organisational estate to provide face to face contact with staff and public promoting the work of the team and its function	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	CF team to fully conversant with the use of the NHSCFA 'ngage' tool in accessing materials and literature suitable for dissemination organisation wide and to the public.	
	CF team to fully participate in National Counter Fraud Week initiative.	Q3
12: Policies and registers for gifts and hospitality and COI. NHS Requirement 12: The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested	CFM to liaise with Corporate Governance Team to ensure policies are current	Q1
	CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters.	Q1/2/3/4
	CF manager to provide a presence and input into relevant policy review, and to record and document changes highlighted through Counter Fraud review.	Q1/2/3/4
	CF team to complete National Fraud Initiative exercise in relation to payroll versus Company	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	Director matches to test effectiveness of declarations of interest policy.	

AUDIT COMMITTEE

Private Patient Service Improvement Group Highlight Report

DATE OF MEETING	12th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	GARETH MITCHELL, DIRECTORATE SUPPORT OFFICER, CSMO AND DAVID OSBORNE, HEAD OF FINANCE BUSINESS PARTNERING
PRESENTED BY	DAVID OSBORNE, HEAD OF FINANCE BUSINESS PARTNERING
EXECUTIVE SPONSOR APPROVED	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Improvement Group	15/02/2024	Approved content
EMB		

ACRONYMS

VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is for the Audit Committee to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting held on the 15th February 2024.
- **NOTE** the amended Private Patient Improvement Plan action completion dates.
- **NOTE** the continuance of Liaison Financial Services external expert support for the areas identified in the improvement plan until the conclusion of planned activities under revised specification.

2. BACKGROUND

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements.

The Executive Director of Nursing, AHP and Health Science was asked to provide Executive leadership to the Group and take on the role as Senior Responsible Officer (SRO). The role was accepted on the provision that appropriate delivery support would be allocated as identified by the SRO.

It was agreed that the Audit Committee would have oversight of the Finance and Commercial actions in the improvement plan and the Quality, Safety & Performance Committee oversight of all other actions in the improvement plan.

3. PRIVATE PATIENT IMPROVEMENT PLAN

The Private Patient Improvement Plan was reviewed at the 15/02/2024 Private Patient Improvement Group with an extended deadline given to a number of actions. This gave actions a new delivery date of 30/04/2024 for contractual related activities with externally supported provider.

4. HIGHLIGHT REPORT

The following are additional highlights from the meeting.

ALERT / ESCALATE	None to Raise
ADVISE	<u>Medical Advisory Committee</u> No further progress had been made in relation to the creation of the Medical Advisory Committee. <u>KPIs within the BI workplan.</u> This is currently outstanding due to urgent BI work needed in other areas within the Cancer Centre. <u>Extended Support with External Provider</u> Due to critical absences within the Finance Team and Private Patient Services Team, there has been unfortunate delays to the implementing the improvement plan, necessitating an extension to key deadlines and contracted support provided by Liaison to the end of April 2024. Revised specifications are being concluding with Liaison with associated procurement governance being processed. Funding has been secured to support activities with the extension within the 50% contractual extension option. The ongoing support has been paused temporarily due to the current purchase order being exhausted and delays in notification and remedial renewal. These are anticipated to have been resolved by the time of Audit Committee and concluding activities progressing.

	The elements of the Improvement Plan for delivery by Liaison in relation to contractual negotiations have been reviewed and the majority of actions assigned to them were agreed for delivery by 30/04/24. Liaison have advised that all the preparatory work has been completed for contract negotiations with the main Insurance providers. Based on this preparatory work their assessment is that the Trust should benefit from one-off additional income based on the retrospective review and letters and invoices sent to Insurers of **£487k** raised in this financial year for past services and **£558k** prospective additional income per annum based on the work around ensuring all activity is invoiced and review and update of the Trust prices. The recurrent incomes stream of £558k is comprised of £162k recovery of Pathology and Allied Health Professional service costs, with the balance of £396k in relation to improved data capture ensuring all relevant charges are made. The scope for additional income through wider contract negotiations are presently being assessed as a contribution to the Divisional Savings Plan, at an indicative £150k per annum. Liaison have also revised operational governance and processing, including updated policies, contracts, billing procedures, databases, insight and analysis. • The Commercial & Financial actions concluded or in progress are: ➢ Renegotiate the contracts with insurers – ***Preparatory work prior to negotiation of current insurer contracts is complete. This included reviewing current contract tariffs and services provided compared to invoicing as well as ensuring billing is up to date. Liaison has negotiated and renewed contracts for specific supplies, such as pathology and diagnostics, with the Insurers. Negotiations of the main contracts are planned as concluding activities under revised specification.*** ➢ Develop new professional fee arrangements which provide consistency across disciplines – ***proposed arrangements have been established, requiring the Medical Advisory Committee and associated clinical leadership to negotiate internally and embed.*** ➢ Develop a private patient tariff for both self-pay and insured private patients setting fees at commercial levels – ***work is***

	complete reviewing the current fees and cost of services which has been compared to market intelligence around fees for cancer services in other NHS Private Patient services, leading to the retrospective review income requests to Insurers and anticipated increase recurrent income going forward. ➢ Developed a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure – ***Charging processes and billing methodologies have been enhanced, though not reflective of applying new tariff, application of the tariff has not commenced due to prioritising provision of operational management and insurer contract re-negotiation.*** ➢ Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk – ***Practice policies have been reviewed and updated, these are presently being concluded for discussion with Clinicians, ensuring payment arrangements are reflective of managing the risk equitably.*** ➢ Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service – ***review of the Sciensus contract has been undertaken, Trust agreed suspension of review into 24/25 Financial Year to align with procurement and service specifications of need.***
ASSURE	<u>Practicing Privileges Policy & Private Patients Policy</u> Both the Private Patient Policy & Practicing Privileges policy are currently undergoing EQIA and IQA. The document will be taken to the March SLT meeting wherein they will be taken to EMB Run.
INFORM	<u>Private Patient Leadership Changes</u> Ann Marie Stockdale is stepping down from leading the Private Patient's service due to an internal restructure. Wayne Jenkins will now be leading the service. <u>Aged Debt</u> Through the use of a new version of the Healthcode system, approximately £697k of unallocated cash in the Debtors ledger has been identified as relating to private patient activity and in the process of being transacted.

APPENDICES	***1. Private Patient Improvement Plan***

Improvement Plan - Private Patient Service

Date Updated: 14/02/2024

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date
STRATEGIC BUSINESS MANAGEMENT							
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022. 21/12/2022 - Target date revised to reflect discusions with Liaison Services who are supporting the renegotiation. A target of 31/03/2023 will remain for the preparation work of reviewing current contracts, tarrifs and ensuring Trust billing is up to date. DPIA's will be completed. 18/04/23 - Finance and LIAISON working together on financial resoruce mapping 17/05/23 - Work ongoing but may stall without DO.10/10/23 - Preparatory work prior to negotiation of current insurer contracts is complete. This included reviewing current contract tariffs and services provided compared to invoicing as well as ensuring billing is up to date. Liaison are in the process of negotiating with the Insurers and anticipate this will be concluded during November. **14/02/2024 - Fee Strucutres aligned with cost recovery and market insight have been developed in readiness for negotiation with main insurers. Negotiations to commence following debt recovery focus and procurement extension for final specification of contract. Pathology, Allied Health Professionals and Diagnostic elements of contracts have been concluded resulting in additional income to the Trust.**	COB/MB / External Provider	30/09/2022	30/04/2024
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Finance and LIAISON working together on financial resource mapping 17/05/23 - Work ongoing but may stall without DO. 10/10/23 - Practice policies have been reviewed and updated, these are presently being concluded for discussion with Clinicians, ensuring payment arrangements are reflective of managing the risk equitably. Application of new fees will be concluded following renegotiation of contracts. **14/02/2024 - Proposed arrangements have been established requiring the Medical Advisory Committee and associated Clinical Leadership to negotiate internally and embed.**	VCS SLT	31/07/2022	30/04/2024
MEDICAL GOVERNANCE							
COMMERCIAL							
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Revised processes have been established and are being rolled out. 17/05/23 - Work ongoing but may be disrupted by BI resource issues. 10/10/23 - Charging processes and billing methodologies have been enhanced, though not reflective of applying new tariff, application of the tariff has not commenced due to prioritising provision of operational management and insurer contract re-negotiation. **14/02/24 - New processs embedded, application of new tariffs contingent on contract negotiations with main insurers. Contract updates which have concluded are reflected in practice.**	External provider	31/07/2022	30/04/2024
OPERATIONAL							
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - HCaH contract reviewed and maximised for Blood Testing, but not the wider Chemo service - all contract negotiations aligned to Q1 delivery. 17/05/23 - Issues to be worked up when DO returns. 10/10/23 review of the Sciensus contract has been undertaken, but the assessment was that it required further review and support from procurement services. Work is taking place with Shared Services to clarify the contractual agreement that was agreed with Healthcare at Home. **14/02/24 - Overall use of HCaH under review within Cancer Services, aligned with procurement. This programme of work is scheduled for the Financial Year 24/25.**	VCS SLT	31/07/2022	31/03/2025

Definitions of 7 Levels Framework for Evaluating Delivery of Improvement Plans

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL ASSURANCE

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	12/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	David Osborne, Head of Finance Business Partnering and Wayne Jenkins, Assistant Director of Planning and Performance
PRESENTED BY	David Osborne, Head of Finance Business Partnering
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**

ACRONYMS	
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 A review of the Velindre Cancer Centre (VCC) Private Patient Service debt management process and position was completed as part of an Internal Audit of the Trust's Core Financial Systems.

1.2 Audit Committee raised some questions relating to the spike in the aged debt position and it was agreed that regular position up-dates would be provided.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Team have completed submission of invoices up to December 2023 period, with outstanding invoicing currently being raised, ensuring the 6 month turnaround time for invoicing with insurers is met. There is an inherent lag in invoicing due to the timing of services provided and activity recorded across multiple platforms, this can be up to 2 months.

2.2 The Private Patient Team has been fully recruited for the past 3 months, establishing resilience and addressing the historic capacity issues which resulted in delayed invoicing. Additionally, under a Departmental restructure within the Operational Services Directorate at Velindre Cancer Centre, the Private Patients Team is now led by the Business Planning Manager.

2.3 The services continue to work with Liaison (external consultants) to support delivery of key objectives, including debt recovery. The benefits of this support has been highlighted previously, and is reflected in the increased monthly and overall private patient income. The ongoing support has been paused temporarily due to the current purchase order being exhausted and delays in notification and remedial renewal. These are anticipated to have been resolved by the time of Audit Committee and concluding activities progressing.

2.4 The Private Patient Team in conjunction with Liaison have successfully realised new income streams, for work which has been historically undertaken but not charged for, which increases the total for the Trust. However, there is now a backlog of invoices which have been paid, which remain unallocated within the accounts. To prevent a recurrence of this situation, new processes have been established, for example isolating new clients as a separate category within reporting and enhanced systems controls, such as the Private Patients Team conducting routine client account reconciliations with Accounts Receivable oversight in financial ledger assurance.

2.5 It has been identified that a £697k proportion of aged debt greater than 180 days of £825k (85% of total debt greater than 180 days as at Jan 2024) has been received by the Trust but has not been applied to the Private Patient budget, this issue artificially inflates the issue of aged debt.

2.6 The process of transacting the Unapplied and Unallocated Reports against the aged debt is underway. The process involves calculating "client" statements based on services invoiced and payments received, this is undertaken by the Private Patients Team. The "Client" statements are mapped and corrective transactions are completed within the financial ledger (correcting the aged debt reports) by the Debtors Team as a segregation of duties, validation and processing.

2.7 There are 260 "client" accounts to review, of which approximately 70 have been completed so far by the Private Patients Team, for assessment by the Debtors Team and resulted in £108k of the £697k unapplied cash having been mapped ready for transaction. Each client account requires approximately 45mins to complete on average, therefore, a further 140-145 hours of corrective work required per Team. The Private Patient Team has dedicated and prioritised focus on these activities, with additional temporary recruitment to the Debtors Team to support conclusion. Factoring the time requirements, training, familiarization and balance of the Year-End Accounts preparation, the target date for all actions having being completed is the end of May 2024.

2.8 The Key Performance Indicator (KPI) to monitor and manage the billing process will be the Days of Sales Outstanding (DSO). In order that invoices are raised in a timely manner and are followed up to collect the cash, it is suggest that the KPI for DSO is set at 90 days. The DSO performance since September 2023 is as follows:

Key Performance Indicator	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024
Days Sales Outstanding	144	174	202	235	227

The DSO performance has deteriorated over the past 4 months as the volume and value of invoices raised for private patients has increased. Whilst it is positive that the Trust is now invoicing for the activity that it is delivering for private patients, there is a need to improve the performance of the debt collection. This will be addressed through additional resource being hired on a temporary basis in the accounts receivable team.

2.9 The trend of the last 6 months illustrates that approximately 96% of private patient income will be derived from insurance companies. This is demonstrated for information purposes in the following table:

Debts % by Customer and by Age	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024
% Debts Payable by Insurance Companies	95.3%	95.9%	96.3%	97.1%	96.5%
% Debts Not Payable by Insurance Companies	4.7%	4.1%	3.7%	2.9%	3.5%
% Debts aged 30 days or less	21.5%	14.2%	20.3%	18.4%	8.7%
% Debts aged 31-180 days	28.2%	42.3%	38.6%	45.8%	54.0%
% Debts aged 181-365 days	22.9%	18.4%	15.6%	10.0%	7.6%
% Debts aged 1 year +	27.4%	25.0%	25.6%	25.8%	29.7%

2.10 The full report (Appendix 1) provides the breakdown of debt profile by age, value and customer category.

3.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

4.1 The Committee is asked to **NOTE** the information provided in this report.

Appendix 1 – Aged Debt Report As At Jan 2024

Spreadsheet attached.

Totals of Debt Categories Per Aged Debt Report *(input values in grey shaded cells only)*

Key Performance Indicators (Targets to be agreed)	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022	31/12/2022	31/01/2023	28/02/2023	31/03/2023	30/04/2023	31/05/2023	30/06/2023	30/07/2023	30/08/2023	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024
% Debts Payable by Insurance Companies	95.1%	95.4%	96.0%	95.1%	95.6%	94.7%	94.3%	96.8%	93.4%	97.4%	96.6%	96.9%	97.1%	97.0%	95.7%	95.7%	96.4%	95.8%	93.5%	94.7%	95.3%	95.9%	96.3%	97.1%	96.5%
% Debts Not Payable by Insurance Companies	4.9%	4.6%	4.0%	4.9%	4.4%	5.3%	5.7%	3.1%	6.6%	2.6%	3.4%	3.1%	2.9%	3.0%	4.3%	4.3%	3.6%	4.2%	6.5%	5.3%	4.7%	4.1%	3.7%	2.9%	3.5%
% Debts aged 30 days or less	33.6%	17.0%	44.5%	0.2%	28.0%	12.3%	0.0%	47.0%	43.4%	12.5%	25.2%	25.0%	35.1%	13.5%	0.3%	0.0%	25.4%	0.6%	0.0%	31.5%	21.5%	14.2%	20.3%	18.4%	8.7%
% Debts aged 31-180 days	33.4%	49.7%	25.6%	52.3%	24.2%	33.1%	38.2%	17.1%	20.1%	51.1%	36.3%	38.8%	31.1%	49.8%	52.8%	49.3%	28.0%	44.5%	30.3%	6.9%	28.2%	42.3%	38.6%	45.8%	54.0%
% Debts aged 181-365 days	10.8%	13.0%	15.3%	27.0%	23.3%	27.3%	28.2%	16.5%	13.8%	12.0%	11.1%	10.7%	10.2%	13.1%	15.1%	18.2%	21.9%	27.1%	39.1%	31.2%	22.9%	18.4%	15.6%	10.0%	7.6%
% Debts aged 1 year +	22.2%	20.2%	14.7%	20.5%	24.5%	27.3%	33.6%	19.3%	22.7%	24.4%	27.2%	25.6%	23.5%	23.6%	31.8%	32.5%	24.6%	27.8%	30.6%	30.5%	27.4%	25.0%	25.6%	25.8%	29.7%
Days Sales Outstanding (private patient value divided by the amount of income raised in the last twelve months (rolling year) times 365 days)			126	83	91	78	79	122	52	128	117	116	132	134	107	115	137	135	130	136	144	174	202	235	227

All debts	**31/01/2022**	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**30/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**	**31/10/2023**	**30/11/2023**	**31/12/2023**	**31/01/2024**
Within maturity (0-30 days)	194.349	108.522	389.682	932	163.241	63.800	0	429.597	167.379	118.239	217.211	225.299	392.686	148.938	2.404	0	286.568	6.826	0	409.468	327.771	250.551	414.774	441.141	193.269
31-60 days	44.949	151.954	89.972	141.409	328	89.335	48.263	0	58.168	160.372	33.900	147.878	0	257.513	142.233	0	0	283.819	22.964	0	335.523	315.841	171.729	343.656	241.570
61-90 days	40.168	43.327	46.511	61.064	36.376	328	80.645	48.263	0	241.246	131.489	27.380	201.858	98.580	84.974	142.233	0	0	234.879	22.964	600	335.256	283.416	168.592	292.937
91-180 days	107.874	121.265	87.415	78.248	104.269	81.331	55.854	107.641	19.360	79.954	146.922	174.079	146.254	191.621	222.926	275.546	316.377	217.566	53.871	66.573	93.228	93.188	331.528	584.292	660.207
181-365 days	62.635	82.974	133.660	145.049	135.991	141.214	136.686	150.957	53.004	113.282	95.449	96.078	114.246	143.511	128.431	154.239	247.447	305.621	402.817	406.243	349.653	323.098	317.369	240.295	167.344
1 year +	128.476	128.824	128.579	110.099	142.493	141.203	162.844	176.682	87.363	229.765	234.267	230.611	263.076	259.130	270.969	275.277	277.983	314.077	315.505	396.393	418.244	440.330	521.461	617.440	657.448
Total	**578.452**	**636.867**	**875.819**	**536.803**	**582.698**	**517.211**	**484.293**	**913.140**	**385.275**	**942.858**	**861.497**	**901.325**	**1.118.120**	**1.099.295**	**851.937**	**847.295**	**1.128.375**	**1.127.909**	**1.030.036**	**1.301.641**	**1.525.019**	**1.758.264**	**2.040.277**	**2.395.416**	**2.212.775**
Insured																									
Within maturity (0-30 days)	191.500	102.991	380.725	0	163.241	63.800	0	427.667	166.301	118.239	213.176	224.389	387.311	142.008	2.404	0	281.645	425	0	407.622	318.619	249.053	412.921	439.580	183.460
31-60 days	43.477	151.397	85.044	141.409	0	89.335	48.263	0	58.168	159.294	33.900	143.915	0	257.586	134.484	0	0	278.896	425	0	334.186	307.064	170.231	342.451	240.850
61-90 days	40.018	42.025	46.511	57.174	36.376	0	80.645	48.263	0	241.246	130.411	27.380	197.642	98.580	83.082	134.484	0	0	229.956	425	600	333.919	274.639	167.803	291.732
91-180 days	100.720	116.223	82.333	77.550	99.891	76.538	50.733	106.410	19.359	79.954	146.922	173.001	145.176	187.613	218.819	269.547	306.848	208.614	46.568	62.206	71.064	71.024	308.777	576.914	652.040
181-365 days	62.479	82.648	133.334	139.831	130.889	135.664	131.137	141.686	45.403	108.338	92.573	92.045	114.103	143.368	127.798	153.607	243.285	300.882	393.173	388.850	333.787	306.966	304.367	208.707	139.682
1 year +	111.925	112.273	112.895	94.390	126.653	124.508	146.149	159.817	70.644	211.157	215.484	212.430	241.005	237.059	248.755	253.062	255.768	291.862	293.291	374.179	394.952	417.484	494.735	590.380	626.645
Total	550.120	607.558	840.842	510.355	557.051	489.845	456.927	883.844	359.875	918.230	832.468	873.160	1.085.237	1.066.216	815.342	810.700	1.087.546	1.080.679	963.413	1.233.282	1.453.208	1.685.510	1.965.670	2.325.835	2.134.409
Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)																									
Within maturity (0-30 days)	2,849	5,531	8,957	932	0	0	0	1,193	0	0	4035	910	5374	6929	0	0	4923	6401	0	1,846	9,152	1,498	1,853	1,561	9,809
31-60 days	1,472	557	4,928	0	328	0	0	0	1,078	1,078	0	3,963	0	-73	7,749	0	0	4,923	22,539	0	1,337	8,777	1,498	1,205	720
61-90 days	150	1,302	0	3,890	0	328	0	0	0	0	1,078	0	4,216	0	1,892	7,749	0	0	4,923	22,539	0	1,337	8,777	789	1,205
91-180 days	7,154	5,042	5,082	698	4,378	4,793	5,121	1,231	0	0	0	1,078	1,078	4,008	4,107	5,999	9,529	8,952	7,303	4,367	22,164	22,164	22,751	7,378	8,167
181-365 days	156	326	326	5,218	5,102	5,550	5,550	9,270	7,601	4,943	5,131	4,033	143	143	633	632	4,162	4,739	9,644	17,393	15,866	16,132	13,002	31,588	27,662
1 year +	16,551	16,551	15,684	15,709	15,840	16,695	16,695	16,865	16,718	18,607	18,782	18,180	22,071	22,071	22,214	22,214	22,214	22,214	22,214	22,214	23,292	22,846	26,726	27,060	30,803
Total	28,332	29,309	34,977	26,447	25,648	27,366	27,366	28,559	25,397	24,629	29,028	28,164	32,882	33,079	36,595	36,594	40,828	47,229	66,623	68,359	71,811	72,754	74,607	69,581	78,366
Self payer																									
Within maturity (0-30 days)	0	0	809	0	0	0	0	1,930	446	0	4,035	910	1,805	6,929	0	0	860	0	0	1,337	6,526	406	1,853	1,561	9,204
31-60 days	380	0	0	0	0	0	0	0	0	446	0	3,963	0	(73)	7,749	0	0	860	0	0	1,337	6,151	406	1,205	720
61-90 days	150	210	0	0	0	0	0	0	0	0	446	0	4,216	0	1,805	7,749	0	0	860	0	0	1,337	6,151	406	1,205
91-180 days	260	410	450	360	150	903	903	903	0	0	0	446	446	3,375	4,107	5,912	9,442	8,865	7,303	304	750	750	1,337	7,378	7,784
181-365 days	0	170	170	430	470	580	580	410	1,203	1,053	903	141	143	143	0	0	3,530	4,107	5,849	13,598	12,703	12,969	10,189	9,612	8,499
1 year +	1,098	1,098	231	256	231	1,086	1,086	1,256	1,110	1,491	1,666	726	726	726	869	869	869	869	869	869	1,315	869	4,399	4,733	5,663
Total	1,888	1,888	1,660	1,046	851	2,569	2,569	4,499	2,759	2,990	7,051	6,186	7,336	11,102	14,530	14,530	14,701	14,701	14,881	16,108	22,631	22,482	24,335	24,895	33,075
Top Up																									
Within maturity (0-30 days)	0	5.531	8.148	932	0	0	0	0	632	0	0	0	3.569	0	0	0	4.063	6.401	0	0	2.626	0	0	0	605
31-60 days	338	0	4.928	0	328	0	0	0	0	632	0	0	0	0	0	0	0	4.063	6.099	0	0	2.626	0	0	0
61-90 days	0	338	0	3.890	0	328	0	0	0	0	632	0	0	0	87	0	0	0	4.063	6.099	0	0	2.626	0	0
91-180 days	6.894	4.632	4.632	338	4.228	3.890	4.218	328	0	0	0	632	632	632	0	87	87	87	0	4.063	4.974	4.974	4.974	0	0
181-365 days	156	156	156	4.788	4.632	4.970	4.970	8.860	6.398	3.890	4.228	3.890	0	0	633	632	632	632	719	719	87	87	87	2.810	2.723
1 year +	15.453	15.453	15.453	15.453	15.609	15.609	15.609	15.609	15.609	17.116	17.116	17.454	21.344	21.344	21.345	21.345	21.345	21.345	21.345	21.345	21.977	21.977	21.977	21.977	22.064
Total	22.841	26.110	33.317	25.401	24.797	24.797	24.797	24.797	22.639	21.639	21.977	21.976	25.545	21.977	22.065	22.064	26.127	32.528	32.226	32.226	29.664	29.664	29.664	24.787	25.392
Overseas																									
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	509	0	1,092	0	0	0
31-60 days	754	557	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,440	0	0	0	1,092	0	0
61-90 days	0	754	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,440	0	0	0	383	0
91-180 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,440	16,440	16,440	0	383
181-365 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3,076	3,076	3,076	3,076	2,726	19,166	16,440
1 year +	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	350	350	3,076
Total	3,603	1,311	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19,516	20,025	19,516	20,608	20,608	19,899	19,899

	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024
VALUE OF DEBT RAISED ON A ROLLING 12 MONTHS	2,095,838	2,226,652	2,426,397	2,641,588	2,437,737
ADJUSTMENT OF IDENTIFIED UNALLOCATED	-697000	-697000	-697000	-697000	-697000
TOTAL DEBT PER MONTH ADJUSTED	828,019	1,061,264	1,343,277	1,698,416	1,515,775
DAYS SALES OUTSTANDING	144	174	202	235	227

BASELINE AUDIT SAMPLE AS REFERENCE POINT FOR IMPROVEMENT

Profile of Private Patient Debts As At Each Period End for the Financial Year to Date 30th September 2021							
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Average
Total Aged Debt	£294,641	£453,718	£349,481	£372,708	£449,410	£473,189	£398,858
Debt Due Less Than 180 Days - Value	£51,235	£221,779	£121,817	£189,746	£254,949	£290,437	£188,327
Debt Due Less Than 180 Days - Proportion	17%	49%	35%	51%	57%	61%	45%

Movement between Months (brackets indicate increase in debts)

Key Performance Indicators (Targets to be agreed)	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022	31/12/2022	31/01/2023	28/02/2023	31/03/2023	30/04/2023	31/05/2023	30/06/2023	30/07/2023	30/08/2023	30/09/2023	31/10/2023	30/11/2023	31/12/2023	31/01/2024
Debts recovered in month compared with total debt end of month	7.9%	17.2%	63.3%	20.1%	25.0%	6.8%	0.1%	180.5%	-46.6%	34.9%	20.6%	15.7%	15.3%	29.3%	0.5%	0.5%	0.6%	9.5%	10.6%	6.8%	1.0%	6.5%	3.6%	17.0%

All debts	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**	**30/09/2023**	**30/09/2023**	**30/09/2023**	**30/09/2023**
Within maturity (0-30 days)	85.827	(281.159)	388.750	(162.309)	99.441	63.800	(429.597)	262.218	49.140	(98.972)	(8.088)	(167.387)	243.748	146.534	2.404	(286.568)	279.742	6.826	(409.468)	81.697	77.220	(164.223)	(26.367)	247.872
31-60 days	(107.005)	61.982	(51.437)	141.081	(89.007)	41.071	48.263	(58.168)	(102.204)	126.472	(113.978)	147.878	(257.513)	115.280	142.233	0	(283.819)	260.855	22.964	(335.523)	19.682	144.112	(171.927)	102.086
61-90 days	(3.159)	(3.184)	(14.554)	24.688	36.048	(80.317)	32.382	48.263	(241.246)	109.757	104.109	(174.478)	103.278	13.606	(57.259)	142.233	0	(234.879)	211.915	22.364	(334.656)	51.840	114.824	(124.345)
91-180 days	(13.390)	33.850	9.167	(26.020)	22.938	25.477	(51.787)	88.281	(60.594)	(66.968)	(27.157)	27.825	(45.367)	(31.305)	(52.620)	(40.831)	98.811	163.695	(12.702)	(26.655)	40	(238.340)	(252.764)	(75.915)
181-365 days	(20.339)	(50.686)	(11.389)	9.058	(5.223)	4.528	(14.270)	97.953	(60.278)	17.833	(629)	(18.168)	(29.265)	15.080	(25.808)	(93.208)	(58.174)	(97.196)	(3.426)	56.590	26.555	5.729	77.074	72.951
1 year +	(348)	245	18.480	(32.394)	1.290	(21.642)	(13.838)	89.319	(142.402)	(4.502)	3.656	(32.465)	3.946	(11.839)	(4.308)	(2.706)	(36.094)	(1.428)	(80.888)	(21.851)	(22.086)	(81.131)	(95.979)	(40.008)
Total	**(58.415)**	**(238.952)**	**339.017**	**(45.896)**	**65.488**	**32.918**	**(428.847)**	**527.866**	**(557.584)**	**83.620**	**(42.087)**	**(216.795)**	**18.827**	**247.356**	**4.642**	**(281.080)**	**466**	**97.873**	**(271.605)**	**(223.378)**	**(233.245)**	**(282.013)**	**(355.139)**	**182.641**
Insured																								
Within maturity (0-30 days)	88.509	(277.733)	380.725	(163.241)	99.441	63.800	(427.667)	261.366	48.062	(94.937)	(11.213)	(162.922)	245.303	139.604	2.404	(281.645)	281.220	425	(407.622)	89.003	69.566	(163.868)	(26.659)	256.120
31-60 days	(107.920)	66.353	(56.365)	141.409	(89.335)	41.071	48.263	(58.168)	(101.126)	125.394	(110.015)	143.915	(257.586)	123.102	134.484	0	(278.896)	278.471	425	(334.186)	27.122	136.833	(172.220)	101.601
61-90 days	(2.007)	(4.486)	(10.664)	20.798	36.376	(80.645)	32.382	48.263	(241.246)	110.835	103.031	(170.262)	99.062	15.498	(51.402)	134.484	0	(229.956)	229.531	(175)	(333.319)	59.280	106.836	(123.929)
91-180 days	(15.502)	33.890	4.783	(22.340)	23.353	25.805	(55.677)	87.051	(60.595)	(66.968)	(26.079)	27.825	(42.437)	(31.206)	(50.728)	(37.301)	98.234	162.046	(15.638)	(8.858)	40	(237.753)	(268.137)	(75.126)
181-365 days	(20.169)	(50.686)	(6.497)	8.942	(4.775)	4.528	(10.550)	96.283	(62.935)	15.765	528	(22.058)	(29.265)	15.570	(25.809)	(89.678)	(57.597)	(92.291)	4.323	55.063	26.821	2.599	95.660	69.025
1 year +	(348)	(622)	18.505	(32.263)	2.145	(21.642)	(13.668)	89.173	(140.513)	(4.327)	3.054	(28.575)	3.946	(11.696)	(4.307)	(2.706)	(36.094)	(1.429)	(80.888)	(20.773)	(22.532)	(77.251)	(95.645)	(36.265)
Total	(57.437)	(233.285)	330.487	(46.695)	67.206	32.918	(426.917)	523.969	(558.353)	85.762	(40.694)	(212.077)	19.023	250.872	4.642	(276.846)	6.867	117.266	(269.869)	(219.926)	(232.302)	(280.160)	(360.165)	191.426
Within maturity (0-30 days)	(2,682)	(3,426)	8,025	932	0	0	(1,193)	1,193	0	(4,035)	3,125	(4,464)	(1,555)	6,929	0	(4,923)	(1,478)	6,401	(1,846)	(7,306)	7,654	(355)	292	(8,248)
31-60 days	915	(4,371)	4,928	(328)	328	0	0	(1,078)	0	1,078	(3,963)	3,963	73	(7,822)	7,749	0	(4,923)	(17,616)	22,539	(1,337)	(7,440)	7,279	293	485
61-90 days	(1,152)	1,302	(3,890)	3,890	(328)	328	0	0	0	(1,078)	1,078	(4,216)	4,216	(1,892)	(5,857)	7,749	0	(4,923)	(17,616)	22,539	(1,337)	(7,440)	7,988	(416)
91-180 days	2,112	(40)	4,384	(3,680)	(415)	(328)	3,890	1,231	0	0	(1,078)	0	(2,930)	(99)	(1,892)	(3,530)	577	1,649	2,936	(17,797)	0	(587)	15,373	(789)
181-365 days	(170)	0	(4,892)	116	(448)	0	(3,720)	1,669	2,658	(188)	1,098	3,890	0	(490)	1	(3,530)	(577)	(4,905)	(7,749)	1,527	(266)	3,130	(18,586)	3,926
1 year +	0	867	(25)	(131)	(855)	0	(170)	147	(1,889)	(175)	602	(3,891)	0	(143)	0	0	0	0	0	(1,078)	446	(3,880)	(334)	(3,743)
Total	(977)	(5,668)	8,530	799	(1,718)	0	(1,193)	3,162	769	(4,398)	862	(4,718)	(196)	(3,517)	1	(4,234)	(6,401)	(19,394)	(1,736)	(3,452)	(943)	(1,853)	5,026	(8,785)
Self payer																								
Within maturity (0-30 days)	0	(809)	809	0	0	0	(1,930)	1,484	446	(4,035)	3,125	(895)	(5,124)	6,929	0	(860)	860	0	(1,337)	(5,189)	6,120	(1,447)	292	(7,643)
31-60 days	380	0	0	0	0	0	0	0	(446)	446	(3,963)	3,963	73	(7,822)	7,749	0	(860)	860	0	(1,337)	(4,814)	5,745	(799)	485
61-90 days	(60)	210	0	0	0	0	0	0	0	(446)	446	(4,216)	4,216	(1,805)	(5,944)	7,749	0	(860)	860	0	(1,337)	(4,814)	5,745	(799)
91-180 days	(150)	(40)	90	210	(753)	0	0	903	0	0	(446)	0	(2,929)	(732)	(1,805)	(3,530)	577	1,562	6,999	(446)	0	(587)	(6,041)	(406)
181-365 days	(170)	0	(260)	(40)	(110)	0	170	(793)	150	150	762	(2)	0	143	0	(3,530)	(577)	(1,742)	(7,749)	895	(266)	2,780	577	1,113
1 year +	0	867	(25)	25	(855)	0	(170)	146	(381)	(175)	940	0	0	(143)	0	0	0	0	0	(446)	446	(3,530)	(334)	(930)
Total	0	228	614	195	(1,718)	0	(1,930)	1,740	(231)	(4,060)	864	(1,150)	(3,764)	(3,430)	0	(171)	0	(180)	(1,227)	(6,523)	149	(1,853)	(560)	(8,180)
Top Up																								
Within maturity (0-30 days)	(5.531)	(2.617)	7.216	932	0	0	0	(632)	632	0	0	(3.569)	3.569	0	0	(4.063)	(2.338)	6.401	0	(2.626)	2.626	0	0	(605)
31-60 days	338	(4.928)	4.928	(328)	328	0	0	0	(632)	632	0	0	0	0	0	0	(4.063)	(2.036)	6.099	0	(2.626)	2.626	0	0
61-90 days	(338)	338	(3.890)	3.890	(328)	328	0	0	0	(632)	632	0	0	(87)	87	0	0	(4.063)	(2.036)	6.099	0	(2.626)	2.626	0
91-180 days	2.262	0	4.294	(3.890)	338	(328)	3.890	328	0	0	(632)	0	0	632	(87)	0	0	87	(4.063)	(911)	0	0	4.974	0
181-365 days	0	0	(4.632)	156	(338)	0	(3.890)	2.462	2.508	(338)	338	3.890	(0)	(633)	1	0	0	(87)	0	632	0	0	(2.723)	87
1 year +	0	0	0	(156)	0	0	0	(0)	(1.507)	0	(338)	(3.890)	0	(1)	0	0	0	0	0	(632)	0	0	0	(87)
Total	(3.269)	(7.207)	7.916	604	(0)	0	(0)	2.158	1.001	(338)	0	(3.569)	3.569	(89)	1	(4.063)	(6.401)	302	0	2.562	0	0	4.877	(605)
Overseas																								
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
31-60 days	197	557	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
61-90 days	(754)	754	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	2,292	1,311	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

AUDIT COMMITTEE

Losses & Special Payments Report 2023/2024

DATE OF MEETING	12/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Tracy Hughes, Interim Head of Financial Operations
PRESENTED BY	Tracy Hughes, Interim Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 This paper has been prepared to provide the Audit Committee with an update in relation to debts written off and losses paid in respect of loss or damage of personal property, during the period 01/12/2023 – 29/02/2024. A summary of the 2023/2024 year to date position is also provided.

1.2 This report does not include the NWSSP losses and special payments, such as stock losses, which are reported separately to the NWSSP Audit Committee.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Write-off of the debts summarised below have all been authorised in line with the Scheme of Delegation within the Trust's Standing Orders & Standing Financial Instructions.

Summary	**Trust**	**Hosted**	**Total**
	£	**£**	**£**
Salary Overpayment	0	0	0
Trade & Commercial	0	0	0
Other	-113.21	143.52	30.31
Total	-113.21	143.52	**30.31**

2.2 The total amount of debt written-off to date in this financial year is £12,940.03.

2.2 These debts were included in the 2022/2023 provision for expected credit losses and therefore will not result in an additional charge to the Trust's Income & Expenditure statement for 2023/2024.

2.3 The age range of the debts written off is between the years 2012 – 2020.

2.4 No further items have been agreed through the Losses and Compensation procedure. The total expenditure to date remains at £6,600, consisting of:

2.4.1 Reimbursement for the cost of replacing glasses;
2.4.2 Reimbursement for damage to a car.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Committee are informed that during the period 1/12/2023 – 29/02/2023, there have been: • Debt write-offs totaling £30.31(net) • No payments agreed under the Losses and Compensation Procedure. The 2023/2024 year to date position consists of: • Debt write-offs totaling £12,940; • Two payments under the Losses and Compensation Procedure totaling £6,600.

4. RECOMMENDATION

4.1 The Committee are asked to review and note the report.

AUDIT COMMITTEE

TECHNICAL UPDATE

DATE OF MEETING	12/03/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Tracy Hughes, Interim Head of Financial Operations
PRESENTED BY	Tracy Hughes, Interim Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**

ACRONYMS	
FRAB	Financial Reporting Advisory Board
IFRS	International Financial Reporting Standard(s)
TAG	Technical Accounting Group
LASPAR	Losses & Special Payments Register
DHCW	Digital Health and Care Wales
MFA	Manual for Accounts

FReM	Financial Reporting Manual
PPP	Public Private Partnership
TCFD	Task Force on Climate-related Financial Disclosure

1. SITUATION/BACKGROUND

1.1 This report has been prepared to provide the Committee with an update on technical issues which will affect the financial accounts prepared for 2023/2024 and/or future years.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Losses & Special Payments Register (LASPAR)

2.1 LASPAR was introduced by the Welsh Government (WG) in 2001 as a computerised database for the recording of all losses and special payments. All payments made by the Trust which fell under the WG category of Losses and Special Payments, as defined in the Manual for Accounts (MFA), were recorded on this database and this information would feed into the Financial Accounts and Returns.

2.2 In February 2022, Digital Health and Care Wales (DHCW) who were responsible for the maintenance and support of LASPAR, advised WG and the All-Wales Technical Accounting Group (TAG) that LASPAR would be decommissioned from July 2023.

2.3 An All-Wales Task & Finish Group was set up to identify a new solution for the 2023/24 financial year and it was agreed that NHS Wales would adopt a spreadsheet model, developed and in use by Cardiff & Vale LHB. Both Welsh Government and Audit Wales have been advised accordingly. The Trust's Finance Team have implemented this spreadsheet model to ensure that all losses and special payments are accurately reported in this year's Financial Accounts and Returns.

2.4 For future financial years, NWSSP Legal & Risk Services are leading a project to recommend a permanent solution.

Impact of IFRS 16 on Public Private Partnerships (PPP)

2.5 The Financial Reporting Manual (FReM) deals with the accounting treatment of PPP arrangements. HM Treasury updated the 2022/23 FReM such that the treatment of indexation linked payments in on-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023/24.

2.6 The IFRS 16 approach means the PPP liability must be remeasured if there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments, when this results in a change in cash payments.

2.7 The interim Head of Financial Operations has reviewed the HM Treasury guidance and can confirm that there will be no impact to the Trust's Financial Accounts in 2023/24.

2.8 The HM Treasury guidance has been shared with the Trust's advisors on the nVCC project to ensure that the advice provided on the technical accounting treatment is in line with the guidelines.

Task Force on Climate-related Financial Disclosure (TCFD)

2.9 The TCFD is an advisory body set up to address concerns around insufficient disclosure of climate-related risks and opportunities for entities. To achieve this objective the TCFD has developed a reporting framework for the disclosure of how climate change will affect their entity.

2.10 HM Treasury have included these new climate-related disclosure requirements in the FReM for 2023/24. An update note issued by WG In January 2024 stated that "it's also likely that Welsh Government will apply the phase 1 requirements relating to Governance for 2023-24, although a formal decision for the rest of the wider public sector has not yet been made".

2.11 Although TCFD adoption is not mandatory for NHS Wales, WG requested that all NHS Wales entities identify any issues or concerns they would have if NHS Wales was asked to implement the TCFD phase 1 requirements relating to Governance in the 2023/24 Annual Report disclosures.

2.12 The Governance recommended disclosures for phase 1 of TCFD role out are:

- Describe the board's oversight of climate-related risks and opportunities.
- Describe management's role in assessing and managing climate-related risks and opportunities.

Reporting entities must also prepare an overall statement of the extent of consistency with the TCFD's recommended disclosures (referred to as a 'compliance statement') – covering extent of disclosure, any non-compliance and future plans.

2.13 The Deputy Director of Finance sought views on WG's request to implement TCFD in 2023/24 from Director of Finance, Director of Corporate Governance and the interim Head of Financial Operations. Following this review, the Deputy Director of Finance responded to WG, setting out the Trust's position as follows:

"The Trust has considered the phase 1 reporting requirements relating to Governance and advised WG that whilst the Trust supports the move towards and adoption of TCFD, it is concerned that it has not had sufficient time to prepare for this disclosure requirement and would propose the introduction of Phase 1 for NHS entities in 2024/25. This would allow time for assurance processes to be reviewed and developed within the Trust, if required, before disclosure."

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Committee are asked to review and note the report.

AUDIT COMMITTEE

ANNUAL REPORT 2023/24

Audit Committee
Annual Report 2023/24

1. Foreword

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee. It outlines the coverage and results of the Committee's work for the year.

Martin Veale was appointed as an Independent Member of the Velindre University NHS Trust in April 2017 and has Chaired the Audit Committee since that time with great expertise, knowledge and diligence and provided the Board with assurance around the Trusts systems of governance, risk management and internal control. Martin was supported by Independent Members, Vicky Morris and myself. Since Martin's absence from October '23 and to the end of his tenure on the 31st January '24 I have been acting Chair of the Audit Committeee. I would like to take this opportunity to put on record my sincere thanks to Martin for his leadership as Chair of the Audit Committee and his and Vicky's significant contributions made during the year.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NHS Wales Shared Services Partnership, Local Counter Fraud Services and by Audit Wales.

Meetings have been well attended and have been a hybrid approach of face to face and online. The meetings have been characterised by constructive dialogue and challenge, and the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

Going forward, the Committee intends to continue to pursue a full programme of work as set out in the cycle of business, covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Trust, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Gareth Jones
Acting Chair of the Velindre University NHS Trust Audit Committee
12 March 2024

2. Introduction

This report summarises the key areas of business activity undertaken by the Committee between January 2023 and February 2024 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

This report reflects the Committee's key role in the development and monitoring of the governance and assurance framework within which the Trust operates.

3. Role and Responsibilities

The primary purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Trust's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further.

The Trust operates a separate Audit Committee to provide assurance on the work of the NHS Shared Services Partnership (NWSSP). Whilst the same Independent Members sit on both committees, they are entirely separate, and the NWSSP Audit Committee produces its own Annual Report.

4. Agenda Planning Process

The Chair of the Committee, in conjunction with the Trust's Executive Director of Finance and Director of Corporate Governance, draws up the agenda for Committee meetings, which is based upon an agreed annual programme of work and clearly linked to the Committee's Terms of Reference.

The Trust Governance team aim to disseminate the agenda and papers to Committee members at least five working days before the date of the meeting.

5. Operating Arrangements

The Committee's Terms of Reference are reviewed annually, with the next review being considered at the March 2024 Audit Committee. A copy of the Terms of Reference extant at the point of writing this report is attached at the end.

The Audit Committee Cycle of Business for July 2023 to July 2024 was noted in July 2023 and will next be updated and presented in July 2024. The agenda of each meeting, however, is sufficiently flexible to allow the committee to consider any emerging issues.

6. Membership, Frequency and Attendance

The Terms of Reference of the Committee state that the Committee should consist of a minimum of three Independent members of the Board. One of these members must also be a member of the Quality & Safety Committee.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. During 2023/24 this option was not exercised.

During the year the Committee met on five occasions with attendance as follows:

Name	Audit Committee
Mr Martin Veale JP (Independent Member) Chair	3 out of 5
Mr Gareth Jones (Independent Member)	5 out of 5
Mrs Vicky Morris (Independent Member)	5 out of 5

During the year, the meetings were supported by the following:

- Mr Matthew Bunce, Executive Director of Finance
- Ms Claire Bowden, Head of Financial Operations
- Mrs Tracy Hughes, Interim Head of Financial Operations
- Mr Chris Moreton, Deputy Director of Finance
- Mrs Lauren Fear, Director of Corporate Governance
- Mrs Emma Stephens, Head of Corporate Governance
- Mr David Osborne, Head of Finance Business partnering
- Mrs Zoe Gibson, Interim Head of Quality Safety and Assurance

- Mr Steve Wyndham, Audit Wales
- Mr Darren Griffiths, Audit Wales
- Mr Dave Burridge, Audit Wales
- Mrs Kate Febry, Audit Wales

- Mr Simon Cookson, Internal Audit
- Mrs Emma Rees, Internal Audit
- Stephen Chaney, Internal Audit
- Melanie Goodman, Internal Audit

- Mr Gareth Lavington, Lead Local Counter Fraud Specialist

7. Audit Committee Activity 2023/24

The Audit Committee fulfilled its planned work for 2023/24 covering a wide range of activity. This work can be summarised under the following headings:

7.1 External Audit

- The Committee approved the Audit Wales plan for 2023/24 in July 2023. Updates from representatives from Audit Wales were given at each meeting.
- Audit Wales documentation was provided to the Committee during the year in relation to the:
  - Annual Audit Plan 2023/24;
  - Financial Audit 2022/2023;
  - Structured Assessment 2022: Corporate Governance & Financial Management Arrangements.
  - Review of Quality Governance Arrangements.
  - Reviewing approach to Equality Impact Assessments.
  - Audit of Accounts Addendum.

- Structured Assessment 2023.

- In October 2023, Audit Wales provided the Committee with a report entitled "Review of Workforce Planning Arrangements". Overall, it was found that the Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities.

7.2 Internal Audit

- The Committee received regular progress reports from the Internal Audit team during the calendar year following agreement of an Internal Audit Plan for 2023/2024 in April 2023.
- During the year the Committee considered 16 review and 1 advisory reports completed by Internal Audit: their assurance ratings are shown below, with a full list of the reports shown in appendix 1.

Rating	**Number**
Substantial	2
Reasonable	13
Limited	1
Advisory	1
Total Reports	**17**

- Internal Audit's annual assurance opinion for 2022/2023 was reported to the Committee in July 2023. It stated that "the Final Opinion provides the Board with **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact** on residual risk exposure until resolved".

7.3 Annual Accounts, Annual Governance Statement & Accountability Report

- The Committee meeting in July 2023 received the audited 2022/2023 Annual Accounts, Annual Governance Statement, Letter of Representation and the Trust's response to Audit Wales regarding governance arrangements.
    - The Committee endorsed and recommended the approval of the Trust's Annual Accounts and other documents to the Trust Board.

7.4 Counter Fraud

- The Committee received the Counter Fraud Annual Report for 2022/2023 in April 2023.
- The Committee received the Annual Workplan for 2023/2024 in April 2023, and updates from the Counter Fraud Specialist or Lead at each meeting.

7.5 Internal Assurance & Risk Management Monitoring

- The Committee received details of the changes to the Trust Board standing orders for the updated Terms of Reference and Operating arrangements for the Quality, Safety & Performance Committee, Research, Development & Innovation Sub-Committee and Charitable Funds Committee; and endorsed them for Trust Board approval.
- The Committee received regular updates in relation to the Private Patient Service Improvement Group including progress against the agreed Improvement Plan.
- The Committee were provided with an update following the review of the Trust Assurance Framework, including a refresh of the Strategic Risks.
- Procurement Compliance was reported regularly to the Committee.
- Declarations of Interests, Gifts, Sponsorship, Hospitality & Honoraria were presented in the April and October 2023 meetings.

- The Trust Risk Register was presented at the January, July, October and December 2023 meetings for review by the Committee, noting that more detailed reviews took place in the relevant Committee and Divisional meetings.
- The Audit Action Tracker which monitors the implementation of the management responses and actions to the audit recommendations, was reviewed by the Committee at each meeting.
- The Committee received and reviewed the legislative and regulatory compliance register at their January 2023 meeting.
- The Committee received and reviewed regular reports on Losses, Compensation and Special Payments.
- The Committee received and reviewed reports of Finance Technical Updates during 2023/24.

8. Reporting the Committee's Work

The Chair of the Audit Committee reports to the Board on the key issues discussed at each meeting by way of a written Highlight Report. These reports are supported by the more detailed Committee minutes. Committee papers and committee minutes are routinely published on the Trust's website.

9. Conclusions and Way Forward

The work of the Audit Committee in 2023/23 has been varied and wide-ranging. The Committee's programme of work will continue to be reviewed to ensure that its contribution to governance, risk management, financial management, counter fraud and internal control is maximised.

This report demonstrates that the Audit Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of control in place and that where necessary has recommended improvements to controls.

Appendix 1

Levels of Assurance Assigned by Internal Audit

Substantial Assurance	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk exposure.**
Reasonable Assurance	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited Assurance	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

List of Internal Audits Undertaken and Assurance Ratings - Velindre University NHS Trust

Internal Audit Assignment	Assurance Rating 2023
Managing Attendance at Work	Reasonable
Patient & Donor Experience	Reasonable
Digital Health & Care Record	Substantial
Cyber Security	Substantial
Decarbonisation **Advisory**	N/A
Performance Management Framework	Reasonable
Clinical Audit	Reasonable
Information Governance	Reasonable
Capital Systems	Reasonable
Follow Up: Previous Recommendations	Reasonable
New Velindre Cancer Centre - Contract Management Report	Limited
Trust Priorities	Reasonable
Business Continuity	Reasonable
Recruitment & Retention	Reasonable
New Velindre Cancer Centre - Approvals	Reasonable
New Velindre Cancer Centre - Planning	Reasonable
Digital Strategy & Transformation	Reasonable

SUMMARY (excluding advisory reports)	No. Reports
Substantial	2
Reasonable	13
Limited	1
Total	**16**

Appendix 2

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	January 2023
Approved:	January 2023
Next Review Due:	January 2024

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives,

  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

  - the reliability, integrity, safety and security of the information collected and used by the organisation,

  - the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance

arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external'

members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance and Chief of Staff
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

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

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10 CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

AUDIT COMMITTEE

AUDIT COMMITTEE TERMS OF REFERENCE

DATE OF MEETING	12/03/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	In accordance with the Audit Committee Cycle of Business, the latest version of the Audit Committee Terms of Reference have been brought to the Committee for review.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to **ENDORSE FOR APPROVAL** the Audit Committee Terms of Reference for Trust Board Approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/A	**N/A**

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	Audit Committee Terms of Reference – with track changes

1. SITUATION

In accordance with the Audit Committee Cycle of Business, the latest version of the Audit Committee Terms of Reference have been brought to the Committee for review.

2. BACKGROUND

3. ASSESSMENT

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee Terms of Reference have updated as appropriate since the previous version but today is opened to the Audit Committee members for any comments or recommended changes.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, enduing good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	Click or tap here to enter text. Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:**

	Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required *Not applicable*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. Click or tap here to enter text

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	January 2023
Approved:	January 2023
Next Review Due:	January 2024

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:
  - the organisation's ability to achieve its objectives,
  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses, Compensation and Special Payments;

Deleted: and

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

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

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.
	It is considered best practice that the Vice Chair does not chair the Audit Committee

Attendees

4.2 In attendance:

Chief Executive *(who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance and Chief of Staff
Chief Operating Officer
Head of Internal Audit
Head/individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales
Other Executive Directors / Directors will attend as required by the Committee Chair

By invitation — The Committee Chair may invite:

- the Chair of the Trust
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Commented [MB(DoF1]: Consider replacing the "...should attend once a year….." with Chief Executive "who should be present when the Committee considers the Internal Audit Plan, the Annual Governance Statement, Annual Quality Statement and the Annual Accounts."

Commented [MB(DoF2]: Why is COO specifically included in attendance? I've checked the WG guidance doc for recommended attendees and doesn't include the COO specifically over any other Exec who are all by invitation. What the guide does include is the "Head/individual responsible for Clinical Audit"

Formatted: Indent: Left: 2"

Deleted: organisation

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

Formatted: Indent: Left: 1", No bullets or numbering

5 COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Commented [MB(DoF3]: The WG guidance also states ",,one of whom should be the committee Chair or Vice Chair ". I assume we have removed this requirement from all the Trust Board Committees as it could lead to increased quoracy issues? Do we have Vice Charis agreed for Sub-committees or just for the Board?

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Commented [MB(DoF4]: The WG guidance doesn't include "with the Chair" - the Auditors have the right to meet the Chair of the Audit Committee at any time, this reference is specifically relating to them being able to request an extraordinary Audit Committee meeting. I think we should remove "with the Chair".

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

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

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

Commented [MB(DoF5]: I didn't think Corporate Standards still exist?

Formatted: Highlight

7 REPORTING AND ASSURANCE ARRANGEMENTS

Commented [MB(DoF6]: The Trust ToR have left out the following form the WG guidance "The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility. " Think we should discuss and agree whether required or not

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

Commented [MB(DoF7]: WG Guidance states "Annual Governance Statement and the Annual Quality Statement". The WG guidance is very clear that he Audit Committee has a role around providing assurance on Quality & Safety, but not curtting across or discussing specific quality & safety matters which is the responsibility of the QSP Committee. All refercnes to Quality & Safety have been removed from Audit Committee ToR so think we need to agree if that is going to be the approach or whether the Quality & Safety aspects of Assurance are to be considered by the Audit Committee as per WG guidance

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

Commented [MB(DoF8]: What does this mean?

9 REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10 CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Audit Committee

PROCUREMENT COMPLIANCE REPORT
1st December 2023 – 23rd February 2024
(Reporting Period)

DATE OF MEETING	12/03/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Gemma Roscrow, Assistant Head of Operational Procurement Rachel Evans, Assistant Head of National Sourcing
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 1st December 2023 to 29th February 2024 and whether in accordance with Standing Financial Instructions (SFIs) Chapter 11 Procurement and Contracting for Goods and Services, Procurement Manual, and the Contract Notification Arrangements, included as Schedule 1 of the SFIs.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to **NOTE** the information provided in this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/02/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS EMB Noted the 1st December 2023 – 29th February 2024 Procurement Report	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1.1	Summary Information of Compliant Arrangements
Appendix 1.2	Further Matters / Non-Compliant Arrangements
Appendix 1.3	All Wales Contracts in progress

1. SITUATION

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 1st December 2023 to 29th February 2024 and whether in accordance with Standing Financial Instructions (SFIs) Chapter 11 Procurement and Contracting for Goods and Services, Procurement Manual, and the Contract Notification Arrangements, included as Schedule 1 of the SFIs.

1.2 Schedule 1 of the SFIs sets out the processes for LHBs and NHS Trusts Contract and Interests in Property Exceeding £0.5m Notification Arrangements:

LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal

Business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC (2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts

Whilst formal Ministerial consent is not required for Trusts as detailed above, general Consent arrangements are still applicable in terms of relevant transactions. Detailed requirements

In terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Entering into contracts

Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group

The process which NHS Wales bodies entering into contracts must follow is:

- *All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract*;
- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- ***All eligible NHS Trust contracts >£1m in total to be submitted to the Director General (DG) HSSG for notification prior to award; and***
- ***All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.***

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;

(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;

(iii) Out of Hours contracts; and

(iv) All NHS contracts; that is where one health services body contracts with another health service body.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team: Robert.Eveleigh@gov.wales

1.3 Assurance is also provided regarding compliance with statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102', which are reflected in Section 11.5 of the SFIs and procurement procedures and schedule 2.1.2 Procurement and Contracts Code for Building and Engineering Works of the SFIs.

1.4 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers

[2] in accordance with the requirements set out in SO 11.6, however Schedule 1 of the SFIs as set out in paragraph 1.2 above states "All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award" not for "Consent" i.e. Approval. The table above in SO 11.6 is incorrect for an NHS Trust as it refers to "Approval".

1.4 Advice from the Procurement Services must be sought for all requirements in excess of £5,000

1.5 Single Quotation Application or Single Tender Application (SFI section 11.13)

In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences);
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Trust Scheme of Delegation; and
- An “or equivalent” test has been considered proving the request is justified.

Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

As SQA/ STAs are only used in exceptional circumstances, the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Trust.

The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Trust to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training; or
- Take internal disciplinary action.

No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition is not possible.

For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA's/STA's not endorsed by Procurement or any exceptional matters.

1.6 An explanation of the reasons, circumstances and details of any further action taken is also included.

SFI Reference	SFI Description	Description	Items
11.13	Single Quotation Application or Single Tender Application	Single Quotation Actions	4
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	4
11.13	Single Quotation Application or Single Tender Application	Single Tenders for consideration following a call for an OJEU Competition	0
11.17	Extending and Varying Contracts	Contract Extensions and Contract Change Note (CCN) or Variation of Terms	0
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes)	9

2. BACKGROUND

As above in section 1.

3. ASSESSMENT

As below in section 4.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Compliance Assurance (Appendix 1.1)

Outlines the number and type of Single Quotation Action (SQA) and Single Tender Action (STA) requests that have been submitted to NWSSP Procurement Services for approval. The SFI Reference column identifies the process followed, i.e. SQA or STA, which are dependent upon value excluding VAT that, for clarity, are £5,000 to £25,000 and above £25,000, respectively. The Compliance Comment column confirms Procurement has scrutinised the request, assessed the Value for Money element and has endorsed this approach.

	VCC & Corporate	WBS	Total	Repeat Submission
SQA's	1	3	4	0
STA's	3	1	4	0
Total	4	4	8	0

Repeat Submissions

As requested, previous costs for repeated submissions are now included to highlight the aggregated value of expenditure incurred for the same requirement. The end column 'First Submission or Repeat', now contains the total aggregated value of expenditure incurred to date, excluding the cost of the repeated requirement detailed in this paper.

Further Matters / Non-Compliance (Appendix 1.2)

Highlights other procurement matters that are not SQA's or STA's i.e. Contract Extensions, Change Control Notes (CCNs) and Variation of Terms as well as instances where service areas have engaged with providers to supply goods and/or services with

a value in excess of £5,000 without following the process outlined in SO's/SFI's and without procurement involvement (File Notes).

Whilst it has been common practice for service areas to undertake competition for the procurement of goods and/or services up to £25,000, it is on the basis that the quotations procedure within SFI's is followed. Where service leads have failed to undertake competition or not sought quotations in accordance with SFI'S there is a breach of SO's/SFI's and File Notes are completed and a record maintained.

All Wales Contracts (Appendix 1.3)

Summarises the All-Wales Contracts that are in progress by NWSSP for information purposes only.

Legislative Regulatory Compliance Register

The Trust Legislative Regulatory Compliance Register has been updated to include reference to procurement regulation and also that this report provides assurance through the Audit Committee.

NWSSP has confirmed that it doesn't currently have a register.

4.2 **General Observations Update**

The Procurement department has undertaken a review of the SQA and STA requests that were submitted and approved from 1st December 2023 to 29th February 2024.

Single Quotation Action (SQA) Requests

As part of the strategy to reduce the number of STA/STA's, there are no SQA's to report this period, any requests received were discussed with the service and another route to market sourced, i.e. direct award via framework or quotation exercise via the Multiquote portal.

VCC / Corporate (SQA's)

1 SQA was submitted and approved for this period.

WBS (SQA's)

3 SQAs were submitted/considered for this period.

Single Tender Action (STA) Requests

VCC / Corporate (STA's)

2 STA's were submitted and approved for this period.

WBS (STA's)

1 STA was submitted and approved for this period.

Publication of Contract Awards

In accordance with procurement regulations contract award notices have been published for all contracts awarded above £25,000. There is no guarantee that there will be no risk of challenge from market providers, regardless of the approach adopted from the Public Procurement Regulations 2015.

There are however no associated, perceived or anticipated risks resulting from these award notices and no challenge have been made to date.

Procurement Activity Between £5,000 and £25,000

As part of the NWSSP Integrated Partnership the Velindre Frontline Procurement team has been relocated to the Cardiff and Vale University Health Board Frontline Procurement teams base at Woodland House in Cardiff, we are in the process of reviewing the aggregated expenditure and undertaking a more focused approach in inviting competitive quotations. Previously for procurement between £5k and £25k departments were asked to obtain three quotations directly, we have since requested that they engage with Procurement Services who will undertake the relevant route to market.

4.3 Other Matters of Interest

` Trust Board Approvals Process – Update

A training programme has now been drafted and it has been agreed that this will be delivered to the Senior Finance Team in the first instance, with a plan to engage and deliver this training with the various Divisions.

5 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Click or tap here to enter text

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	Click or tap here to enter text. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	As indicated in Appendices 1.1 (Summary Information of Compliant Arrangements) and 1.2 **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Click or tap here to enter text.All policies are equality impact assessed prior to approval.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6 RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**Choose an item**
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust - Audit Committee Report – 1st December 2023 to 29th February 2024

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division / Department	Procurement Ref No	Period of Agreement / Delivery Date	SFI Reference	Agreement Title / Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason / Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Jason Hoskins	Estates	VEL-SQA (2023/24) 76	One-off Purchase	SQA	Consultant assessment of works	MDA Consult LTD	£5,400	Capability with existing equipment or service	SQA	N/A	First Submission
Cath O'Brien	Medical Physics	VEL-STA (2023/24) 65	One-off Purchase	STA	All Wales Renewal for Secondary Standard Calibration	National Physical Laboratory	£12,409.66	Sole Supplier of Goods or Services	STA	N/A	First Submission
Paul Wilkins	Charity	VEL-STA (2023/24) 81	One-off Purchase	STA	Coastal Path Challenge	Passion In Events	£14,9246.00	Sole Supplier of Goods or Services	STA	N/A	First Submission
Nicola Williams	Nursing	VEL - STA (2023/24) 88	One-off Purchase	STA	Short term lease accommodation for Overseas nurses	True Cardiff	£39,200.00	Sole Supplier of Goods or Services	STA	N/A	First Submission
Carl James	Facilities	VEL-MIN-MULTIRA33 6558	01/01/2024 to 31/12/2027	Quotation Activity Between £5,000 and £25,000	Lease of 3 Beverage Bean to cup machines	Argie's Coffee	£ 18,092.88	Quotation Exercise undertaken	Quotation Exercise	N/A	N/A
Matthew Bunce	Finance	VEL-MIN-MULTIRA33 7084	18/12/2023 to 29/03/2024	Quotation Activity Between £5,000 and £25,000	Provision of Finance Support Officer	Now Careers	£ 10,513.13	Quotation Exercise undertaken	Quotation Exercise	N/A	N/A
Carl James	Digital Health Intelligence	VEL - QUOTE (23-24) - 67	01/02/2024 to 31/01/2026	Quotation Activity Between £5,000 and £25,000	IT Asset Management software	ITHEALTH	£21,000.00	Quotation Exercise undertaken	Quotation Exercise issued via Multiquote	N/A	N/A
Nicola Williams	Nursing	VEL-DCO-23-24-75	12/02/2024 to 11/02/2025	Quotation Activity Between £5,000 and £25,000	VCC Bed Replacement Programme	Hill-Rom	£22,082.4	Quotation Exercise undertaken	Quotation Exercise issued via Multiquote	N/A	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 1st December 2023 to 29th February 2024

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division / Department	Procurement Ref No	Period of Agreement / Delivery Date	SFI Reference	Agreement Title / Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason / Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Carl James	Digital Health Intelligence	VEL-DCO (23-24) 165	24/01/2024 to 24/01/2025	Quotation Activity Between £5,000 and £25,000	Production support & Subscription for VMware vSphere 8 Enterprise Plus	Trust Marque	£12,892.80	Quotation Exercise undertaken	Quotation Exercise issued via Multiquote	N/A	First Submission
Loren Fear	Corporate Governance	VEL-DCO-23-24- 81	12/02/2024 to 08/04/2024	Quotation Activity Between £5,000 and £25,000	Call off for Executive Assistant Staff Member for 41 days	REED SPECIALIST RECRUITMENT LIMITED	£5928.60	Quotation Exercise undertaken	Quotation Exercise issued via Multiquote	N/A	First Submission
Carl James / Jason Hoskins	Capital Planning Estates and Facilities	VEL-DCO (23-24) 100	18/12/2023 to 30/04/2024	Direct Award	Gleeds Appointment Environmental Consultancy	Perfect Circle	£35,859.26	Direct Award	Direct Award via Framework	N/A	First Submission
Cath O'Brien	Radiotherapy	VEL-DCO(23-24) 76	01/01/2024 to 31/12/2024	Direct Award	Provision of Agency Staff for Radiotherapy (1 staff member)	RIG MEDICAL RECRUIT LTD	£44,850.00	Direct Award	Direct Award via Framework	N/A	First Submission
Carl James	Digital Health Intelligence	VEL-DCO (23-24) 118	01/01/2024 to 31/12/2026	Direct Award	ITSM Business Tool	HaloITSM	£72,200.00	Direct Award	Direct Award via Framework	N/A	First Submission
Carl James	Digital Health Intelligence	VEL-DCO (23-24) 141	03/01/2024 to 02/01/2029	Direct Award	The Provision of Switches & Firewalls	HPE Aruba	£179,069.70	Direct Award	Direct Award via Framework	N/A	First Submission
Carl James	Digital Health Intelligence	VEL-DCO (23-24) 172	06/02/2024 to 05/02/2025	Direct Award	Purchase of computer equipment and support services	Dell Corporation LTD	£432,723.40	Direct Award	Direct Award via Framework	N/A	First Submission
Carl James	Digital Health Intelligence	VEL-DCO (23-24) 158	12/02/2024 to 31/03/2025	Direct Award	Telephone System and Maintenance	DAISY	£47,000.00	Direct Award	Direct Award via Framework	N/A	First Submission
Cath O'Brien	Radiotherapy	VEL-DCO-(23-24) 159	01/02/2024 to 31/03/2024	Direct Award	Provision of Agency Staff for Radiotherapy (2 band 6)	RIG MEDICAL RECRUIT LTD	£21,924.00	Direct Award	Direct Award via Framework	N/A	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 1st December 2023 to 29th February 2024

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division / Department	Procurement Ref No	Period of Agreement / Delivery Date	SFI Reference	Agreement Title / Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason / Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Matthew Bunce	Finance	VEL-FTS-50178	22/12/2023 to 21/12/2027	OJEU Tender	Provision of Investment Agent for Velindre NHS Trust	ABRDN	£136,413.00	OJEU Tender	Open OJEU Tender	N/A	First Submission
Nicola Williams	Nursing	VEL-DCO (23-24) 86	01/12/2023 to 30/11/2025	Direct Award	Provision of the Oncotype DX® Assay - Exact Sciences	EXACT SCIENCES UK LTD	£854,550.00	Direct Award	Direct Award via Framework	N/A	First Submission
Nicola Williams	Nursing	VEL-ITT-PROJECT543752	01/01/2024 to 31/12/2024	Non-OJEU Tender	Resuscitation Training & Audit Services	First Response Medical Training	£27,800.00	Non OJEU Tender	Open Non-OJEU Tender	N/A	First Submission
Alan Prosser	WBS/ RCI TESTING	WBS-RFQ-RA337554	15/01/2024 TO 31/03/2024	Quotation	RCI LABORATORY REVIEW	MED LAB PARTNERS	£15,644.00	One-off Purchase	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS/ COMPONENT DEVELOPMENT	WBS-RFQ-RA338079	One-off Purchase	Quotation	MICROFLUIDICS EQUIPMENT	CELLIX	£11,345.78	One-off Purchase	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS/RCI TESTING	WBS-RFQ-RA338081	One-off Purchase	Quotation	FETAL CELL COUNT KIT	CALTAG-MEDSYSTEMS LTD	£5,100.00	Low value requirement	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS/ COLLECTIONS	WBS-RFQ-RA338151	Not Awarded	Quotation	CUSTOMER SERVICE CONFLICT RESOLUTION TRAINING	NOT AWARDED	No responses received	One-off Purchase	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS/QUALITY ASSURANCE	WBS-RFQ-RA338448	Not Awarded	Quotation	VIRUSOLVE + CONCENTRATE 2.5LT	NOT AWARDED	No responses received	Low value requirement	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS/RCI TESTING	2324/004/ WBS	01/01/2024	SQA	6 Month Maintenance Contract for Flow Cytometer	Becton Dickinson	£8,156.35	Only original equipment manufacturer can maintain equipment	SQA	No further action required	First Submission
Alan Prosser	WBS/ MANUFACTURING AND DISTRIBUTION	2324/005/ WBS	One-off Purchase	SQA	Purchase of PCM Packaging and Racks for transport of	Va-Q-Tec Ltd	£10,067.60	Compatibility with existing Va-Q-Tec transport boxes	SQA	No further action required	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 1st December 2023 to 29th February 2024

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division / Department	Procurement Ref No	Period of Agreement / Delivery Date	SFI Reference	Agreement Title / Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason / Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
					frozen materials						
Alan Prosser	WBS/ADVANCED THERAPIES	2324/006/ WBS	One-off Purchase	SQA	3 Day Clinimacs Prodigy Acc Training	Miltenyi Biotec Ltd	£16,621.20	Only company that provide this training in UK as the training is specific to their equipment.	SQA	No further action required	First Submission
Alan Prosser	WBS/QUALITY ASSURANCE	2324/007/ WBS	To be confirmed	STA	Lease of ABL824M Flex Analyser	Radiometer	£30,000.00	Lease arrangement is not available on any Framework without reagent commitment, which is not possible due to sporadic use of the machine by WBS.	STA	No further action required	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 1st December 2023 to 29th February 2024

Appendix 1.2 - Further Matters / Non-Compliant Arrangements

Executive / Director Responsible	Division / Department	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Carl James / Carl Taylor	Digital Health Intelligence	VEL-FN-065	One off	File Note	Recruitment Agency Finders Fee	ISR RECRUITMENT LTD	£10,474.97	Retrospective requirement and no procurement involvement. No further requirement going forwards.	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Carl James / Jason Hoskins	Capital Planning Estates and Facilities	VEL-FN-066	One off	File Note	SUPPLY AND INSTALL DAB COLD WATER PUMP SET TO MAIN PLANT ROOM	Lorne Stewart PLC	£10,385.93	Unforeseen/unplanned circumstances, emergency order required to be processed. One off requirement therefore no further actions required.	Competition not sought in accordance with SFI'S	Ability to utilise Cardiff and Vale framework from 1st March for any unplanned and emergency works	First submission
David Powell	TCS	VEL-FN-067	August - November 2023	File Note	nVCC Design Advisor VEL-FN-067	Phil Roberts	£26,618.89	No Procurement Involvement	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Sarah Morley	Workforce & OD	AC (VEL 2023-24) 145	One off	File Note	IN-COUNTRY INTERNATIONAL RECRUITMENT EVENT (PSYCHIATRY) ANCIPS RECRUITMENT STAND- TO BE RECHARGED TO HEIW	ANCIPS 2024	£11,275.88	No Procurement Involvement	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Cath O'Brien / Rachel Hennessy	Radiology, Medical Physics / Clinical Engineering	AC (VEL 2023-2024) -147	One off	File Note	MSc Physics and Engineering in Medicine	University College London	£7,600.00	No Procurement Involvement	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Cath O'Brien / Rachel Hennessy	Radiology, Medical Physics / Clinical Engineering	AC (VEL 2023-2024) -148	One off	File Note	Master of Science course for four students	Swansea University	£29,400.00	No Procurement Involvement	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission

Executive / Director Responsible	Division / Department	Procurement Ref No	Period	SFI Reference	Agreement Title / Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason / Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Nicola Williams	Nursing	AC (VEL 2023 -24)-157	December 2023	File Note	Wales Interpretation and Translation Service – December invoice	Cardiff County Council	£7,127.03	No Procurement Involvement	Competition not sought in accordance with SFI'S	Working towards compliant arrangement	Repeat
Nicola Williams	Nursing	AC (VEL 2023 - 24) - 158	November 2024	File Note	Wales Interpretation and Translation Service – November invoice	Cardiff County Council	£7,127.02	No Procurement Involvement	Competition not sought in accordance with SFI'S	Working towards compliant arrangement	First submission
David Powell	TCS	AC(VEL2023-2024)163	15/12/2023 - 07/02/2024	File Note	nVCC FBC Transition Planning	Arcus	£62,171.00	Delays with procurement advice on compliant route to market.	Competition not sought in accordance with SFI'S	Improved working relationships and education with TCS to ensure all requirements are managed appropriately	First submission

Velindre
Total Value of Non-Compliant Spend to be reported £172,180.72

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 1st December 2023 to 29th February 2024

Appendix 1.3 - All Wales Contracts in progress

During the period **1st December 2023 to 29th February 2024**, activity against 35 contracts have been progressed. This includes 17 contracts at the briefing stage and 10 contracts at the ratification stage. In addition to this activity, 8 extensions have been actioned against contracts. A summary of activity for the period is set out in **Appendix 1.3**.

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
1.	Disinfectants These include Alcohol wipes, Chlorhexidine Gluconate solutions, Chlorhexidine Gluconate sprays, Chlorhexidine Gluconate scrubs, Chlorine releasing tablets, Industrial Methylated Spirit, Isopropyl Swabs and Povidone Iodine Solution. 1st February 2021 to 31st January 2025	Extension	£ 3,831,098	28/09/2023	original approval applies 31/12/20	28/09/2023	28/09/2023
2.	AW Blood collection The supply of evacuated and non-evacuated blood collection products including all blood collection tubes, safety needles, and holders. It also includes product training as required throughout the life of the contract. April 24 – 4+2 years	Briefing	£ 12,500,000	28/09/2023	29/09/2023	NA	NA
3.	Oxygen therapy & inhalation Oxygen therapy devices fall into two categories, variable performance and fixed performance, both of which are catered for on the contract. Variable performance devices administer uncontrolled oxygen therapy, as the patient creates the inspired mixture by the act of breathing. Examples of these are nasal catheters, nasal cannula and masks with and without a re-breathing bag. Fixed performance devices allow controlled oxygen dosage. 1st July 2024 – 30th June 2028	Briefing	£ 1,799,751	04/10/2023	24/11/2023	NA	NA
4.	All Wales Taxi Services The contract is for the supply of Taxi, Private Hire and Light Courier Services to NHS sites in South Wales, encompassing taxi service requirements for HDDA, SBU, CTM, CVU, ABU, Vel, PHW and WAST. The service requirements are the conveyance of staff, patients, light goods, and medical/pathological specimens to or from either their place of residence, to locations within these Health	Extension	£ 5,267,843	05/10/2023	original approval applies 5/2/18	sent to NF 5/10	

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
	Board sites or to other NHS locations. This is on a routine and an ad hoc basis. 01/02/2018 to 30/09/2023 extension 01/10/2023 to 31/12/2023 (3 months)						
5.	Healthcare Planning Services The framework agreement is a means of supporting NHS Capital Estates and Facilities department to call off a wide range of healthcare planning services in a timely, cost effective and efficient manner to enable their future strategic direction and to support the preparation of business cases. 1st May 2024 to 30th April 2028	Briefing	£ 6,000,000	10/10/2023	13/11/2023	NA	NA
6.	Practitioner Training programme (PTP) Four education Programmes comprising of: • BSc Healthcare Science (Audiology) • BSc Healthcare Science (Clinical Engineering • BSc Healthcare Science (Pathology) • Standalone Modules to achieve PTP through Degree Assessment. 1st December 2023 to 31st July 2024 Services commencement: 1st August 2024 to 31st July 2029 with the option to extend in three, 12-month tranches up to 31st July 2032.	Ratification	£ 9,415,526	17/10/2023	18/10/2023	19/10/2023	19/10/2023
7.	e-scheduling caseload management E-Scheduling software must be a clinically safe intelligent scheduling system for managing community services and its distributed domiciliary workforce in Wales. The system must automate the caseload scheduling process to ensure visits are optimally appointed. Provide domiciliary employees with a mobile digital solution to schedule their visits. 01/04/24 3 years with options to extend for up to 3 years, in whole or in part.	Briefing	£ 3,000,000	12/10/2023	24/11/2023	NA	NA
8.	Fresh Frozen Meat, Poultry, Cooked Meat, Bacon & Sausage The contract scope for Fresh & Frozen Meat, Poultry, Cooked Meat & Bacon & Sausage is for a variety of fresh and frozen, raw, cooked, and processed meat and poultry products for the purpose of patient feeding or Health Board or Trust income generation. 01/03/2024 3 years with an option to extend for up to a further 12 months	Briefing	£ 11,696,950	13/10/2023	17/11/2023	NA	NA
9.	Motor Fleet Insurance This includes an overview of the current contract and its performance outlines the proposed differences and areas of improvement for the new contract with a focus on the policy costs and risk profile against the background of an inflationary market. Due to the nature of the Motor Fleet Insurance, being dynamic with changes to vehicles numbers, drivers and risk profile, the competition for Insurance must take place close to the contract start date to ensure that risk profiles are as up-to-date and accurate as possible 1st December 2023 – 30th November 2026 plus an option to extend for up to a further 12 months	Briefing	£ 4,947,307	13/10/2023	26/10/2023	NA	NA
10.	Monaco Treatment Planning System Hardware & Software Maintenance & Support Maintenance & Support including upgrade of Treatment Planning System (TPS) including hardware & Software from Pinnacle to Monaco. As the existing Pinnacle TPS product is now End of Life. The scope of the upgrade includes support for the transfer of legacy	Ratification	£ 590,691	17/10/2023	27/10/2023	NA	NA

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
	patient data from Pinnacle system to a standard DICOM data platform 19th December 2023 – 18th December 2028						
11.	Distance part time learning nursing Four education Programmes comprising of: • Adult Nursing • Child Nursing • Mental Health Nursing • Learning Disability Nursing Implementation from 1st January 2024 – 31st July 2024, Service Delivery Commencement 1st August 2024 to 31st July 2025, with the option to extend in two 12-month intervals up to 31st July 2027	Ratification	£ 12,636,000	20/10/2023	24/11/2023	24/11/2023	24/11/2023
12.	Pulp Medical Products Medical pulp products are sustainable, single use products such as kidney dishes and wash bowls designed to have a multitude of functions. These include carrying instruments, dressings, needles, and liquids such as urine, vomit, and can be used for bedside washing of patients. Pulp products are made from 100% recycled materials, are biodegradable and can be commonly found in a variety of clinical environments. 01/08/2024 – 31/07/2028 with the option to extend for 12 months	Briefing	£ 7,956,382	24/10/2023	15/11/2023	NA	NA
13.	Professional blood glucose testing Blood glucose monitoring refers to testing the concentration of glucose in the blood to aid in the management of Diabetes types 1 and 2. Similarly, monitoring the presence of ketones in the blood is also important as high levels can result in complications such as Ketoacidosis. November 2023 + 1 + 1 + 1 + 1 Years (maximum 9 years)	Briefing	£ 10,879,067	03/11/2023	na direct award	NA	NA
14.	Meat & Poultry (bacon & sausage, raw fresh frozen meat/chicken, cooked meats) The contracts consist of a variety of fresh and frozen raw meat, poultry, cooked meats and bacon and sausage products delivered on a direct delivery basis to Health Boards. 01/04/2020 - 28/02/2022 Extended to 30/11/2023 > 01/12/2023 to 30/04/2024	Extension	£ 13,014,870	sent to JI 25/10	NA Framework		
15.	Heparins & Anticoagulants Commonly known as blood thinners, are chemical substances that prevent or reduce coagulation of blood, prolonging the clotting time. Anticoagulants interfere with the proteins in your blood that are involved with the coagulation process 01.07.2024 – 30.06.2027 (with the option to extend for a further 12 months to 30/06/2028)	Briefing	£ 26,900,372	06/11/2023	20/11/2023	NA	NA
16.	Influenza vaccine This contract is for Seasonal Influenza Vaccine purchased by hospital Pharmacy Departments for occupational Health. 1st March 2023 to 31st January 2024 extension 1st February 2024 to 31st January 2025	Extension	£ 2,010,866	13/11/2023	original approval applies 8/3/23	17/11/2023	21/11/2023
17.	Enteral Feeding Service The Enteral Feeding Service contract provides critical products and services for both adult and paediatric patients, consisting of Enteral Feeding products, ancillaries, and consumables along with associated equipment (pumps). There is also a demand within Secondary Care and a Home Delivery Service.	Extension	£ 4,696,927	17/11/2023	original approval applies 2017	22/11/2023	22/11/2023

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
	01.02.2018 to 31.01.2022 with option to extend 12 + 12 months - Additional 9 months to 31.10.2024						
18.	Generic Drugs – Injection/Infusions All products tendered on this contract will be Generic and as such will have the potential for competitive bids to be offered, this level of competition will vary across the various lines which are tendered 01/07/2024 to 30/06/2026 (with option to extend for a further 24 months to 30/06/2028)	Briefing	£ 30,764,269	16/11/2023	17/11/2023	NA	NA
19.	Health Courier Service – Vehicle Replacement Programme HCS vehicle replacement programme covers a total of 15 vehicles Thirty Six (36) Months + Twelve (12) months + Twelve (12) months Optional Extensions.	Ratification	£ 1,536,322	15/11/2023	07/12/2023	08/12/2023	11/12/2023
20.	Sterilisation and Decontamination Consumables Sterilisation is the process of removing or killing all viable organisms. Decontamination is a process that destroys or removes all microbial contamination to render an item or the environment completely safe. Achieving disinfection and sterilization through the use of disinfectants and sterilization practices is essential for ensuring that medical and surgical instruments do not transmit infectious pathogens to patients 01/08/2024 – 01/08/2027 (With option to extend for 24 months)	Briefing	£ 12,250,000	30/11/2023	19/12/2023	NA	NA
21.	HEIW Single platform HEIW have embarked on a programme of work to discover and procure the help, knowledge and skills of a 'partner' that can work alongside HEIW Digital. Contract Start & Discovery: 17th January 2024, Implementation & Build: 22nd February 2024, Go-Live date:1st April 2025, End date: 16th January 2026 (option to extend until 16th July 2026	Ratification	£ 1,222,200	17/11/2023	awaiting wg form from GR, chased 6/12		
22.	Patient and ECG Monitoring Systems and consumables Items on the ECG Electrodes & Defibrillator Pads agreement are vital for detecting heart problems within patients and helping to restore or correct a heartbeat. The current Patient Monitoring contract covers the areas of blood pressure cuffs, patient monitoring consumables, and pulse oximetry. These items are required for the monitoring and observation of patients and to detect any health issues early on 01/09/2024 – 30/08/2028	Briefing	£ 16,000,000	24/11/2023	sent to WG 24/11		
23.	WHAIS LIMS WHAIS requires replacement of its existing 'end of life' legacy IT applications / infrastructure to enable the laboratory to modernise its services and improve quality and efficiency. 5 year contract with an option to extend for a further 1 + 1 year.	Ratification	£ 549,520	27/11/2023	Query sent to team 30/11 response sent 09/01/24		
24.	Systemic Anti-Cancer Therapy (SACT) Compounding and Nursing Service The main aspects of the contract include third party medicines compounding and associated nurse administration by LPCH and the use of the Tenovus mobile facility as a SACT administration facility. 1st April 2024 to 31st March 2027 (option to extend up to 2 years to 2029)	Briefing	£ 7,500,000	01/12/2023	sent to WG 1/12		
25.	Printed Forms There are 40 All-Wales HMR's available throughout the Trusts, these include consent forms and patient medical charts, amongst many other health-related forms. The purpose of these forms is to record patient data, which is a fundamental component to the	Briefing	£ 960,000	01/12/2023	NA as below £1M	NA	NA

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
	successful operational services that NHS Wales provide to the Welsh public. 01/04/2024 – 31/03/2026						
26.	Skin & Wound closure Provision of products used to for skin and wound closure. The current contract includes provisions for the following products: Absorbable and Non-Absorbable sutures (Braided and Monofilament), Mesh (Flat, Devices, Composite, and Biological) Skin Staplers, Skin Adhesives (Surgical and Minor), Mesh Fixation Devices (Absorbable and Non-Absorbable) and Accessories for NHS Wales. This is a multi-supplier framework to ensure that the Health Boards are able to meet a diverse range of requirements and preferences with the products available to them. 01/09/2019 – 31/08/2023 extended until 28/2/24	Extension	£ 5,237,501	07/12/2023	original approval applies 18/9/23	sent to NF 7/12	
27.	Generic Drugs Tablets & Capsules This contract is for the re-tender of the current Generic Tablets & Capsules , Proprietary Drugs 2 Extension and Transitional Drugs which are due to end on the same date 31st January 2024. They will be combined into one larger contract in order to utilise greater economies of scale and streamline the contract management process 1st February 2024 to 31st January 2027 (with an option to extend for up to a further period of 12 months to 31st January 2028)	Ratification	£ 18,736,925	12/12/2023	19/12/2023	19/12/2023	20/12/2023
28.	Fresh fruit & vegetables Extension Fresh Non-Prepared & Prepared Fruit, Vegetables and Salad 01/12/2020 to 31/03/2024	Extension	£ 813,520	12/12/2023	Original approval applies 29/4/21	13/12/2023	NA
29.	Provision of Taxi & Light Goods Transportation Services for South & West The service requirements are the conveyance of staff, patients, light goods, and medical/pathological specimens and other items, to or from either their place of residence to locations within these Health Board & Trust sites or to other NHS locations. This is on a routine and an ad hoc basis Total Contract period is 3 years with one optional 1 year extension	Ratification	£ 10,526,488	15/12/2023	sent to WG 15/12		
30.	Wigs A Framework Agreement to cover Health Boards and Trusts in Wales for the supply and fitting of wigs. 3 years with the option to extend for a further year, from 1st February 2024.	Ratification	£ 737,200	15/12/2023	sent to WG 15/12		
31.	NWSSP Legal & Risk Case and Document Management System The Case Management System will be aligned to a standard and efficient business administration processes. This will take the administration burden away from the lawyers so they can focus on their legal skills and legal work. The new solution will offer task management of each legal areas end to end lifecycle. This will aid the rapid training of new and junior lawyers, reducing time and effort. It will allow the opportunity to rebalance and reassign tasks to less costly administrators and free up lawyers to do the high value work. 5 years with options to extend for up to 5 years in whole or in one or more parts	Briefing	£ 1,595,304	03/01/2024	sent to WG 3/1		
32.	IV & Irrigation solutions This contract is for all parenteral preparations for fluid and electrolyte imbalance and irrigations solutions that are purchased by hospital pharmacy departments in Wales. 1st February 2022 to 31st January 2025	Extension	£ 5,454,851	20/12/2023	original approval applies 18/1/22	20/12/2023	20/12/2023

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
33.	Orthotics Provision of stock orthotic items including a range of Upper Limb orthotic products (such as wrist braces and slings), Lower Limb orthotic products (such as knee braces, hip braces and ankle supports) and Head, Neck and Abdominal orthotic products (such as cervical collars and spinal supports). 1st April 2024 – 30th March 2028	Ratification	£ 7,571,622	02/01/2024	sent to WG 2/1		
34.	Suction Canister and Liners Suction Canisters & Liners are used as a temporary storage container for secretions or fluids removed from the body. These fluids or secretions may come from the patient's lungs, stomach, or wounds. The suction canister may be seen attached to the wall of the patient's room or resting on the floor next to the patient's bed. The liners are disposable and sit inside the canister. The liners can contain or have a gelling agent inserted that solidifies the liquids for disposal purposes. Suction Canisters & Liners are also placed onto trolleys or stands known as carousels for use in Theatres. 01/08/2024 – 31/07/2028 (with the option to extend up to 24 months).	Briefing	£ 2,763,922	02/01/2024	sent to WG 2/1		
35.	Home Parenteral Support (HPN) The contract encompasses the provision of parenteral nutrition support for patients with acute or chronic intestinal failure. Parenteral nutrition is the means of delivering bespoke fluids and nutrients via intravenous access to patients via a central line or peripherally inserted catheters. This contract is specifically for patients receiving this therapy within their own homes, administered either by themselves or with the support of family or a third-party provider's homecare nursing team. 01/04/2024 to 31/03/2027 (with option to extend for a further 12 months to 31/03/2028)	Briefing	£ 32,355,516	02/01/2024	sent to WG 2/1		

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Non-Compliant Activity / Contract Breach Summary

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

Year		July'23		August '23		September '23		October '23		November '23		December '23		January '24		February '24	
Division / Department	**Executive / Director Responsible**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**
Corporate																	
Nursing	Nicola Williams	1								1				2			
Finance	Matthew Bunce	1						2		1							
Corporate Governance	Lauren Fear	1			1		1		1								
Estates	Carl James					1						1					
People & OD						1						1					
Digital Health Intelligence												1					
RD&I																	
Research & Development	Jaz Abraham			1		1											
nVCC																	
nVCC Project	David Powell	2		1		4		4				1				1	
VCS																	
Therapies	Rachel Hennessy	2															
Outpatients																	
Operational Services	Rachel Hennessy									1							
Utilities																	
VCC Planning																	
Private Patients																	
Medical Physics	Rachel Hennessy					1								2			
Service Improvement																	
Radiation Protection																	
Radiotherapy																	
Radiology																	

Nuclear Medicine																	
Pharmacy																	
Charity/Fundraising																	
Charity/Fundraising	Paul Wilkins					1		1		1							
WBS																	
Corporate Services	Alan Prosser		1														
Facilities	Alan Prosser					1											
Molecular Genetics	Alan Prosser									1							
TOTALS		**7**	**1**	**2**	**1**	**10**	**1**	**7**	**1**	**5**	**0**	**4**	**0**	**4**	**0**	**1**	**0**