Bundle Public Audit Committee - Velindre University NHS Trust 3 May 2022

1.0.0 STANDARD BUSINESS

Led by Martin Veale, Chair of the Audit Committee

1.1.0 Apologies

Led by Martin Veale, Chair of the Audit Committee

1.2.0 In Attendance

Led by Martin Veale, Chair of the Audit Committee

1.3.0 Declarations of Interest

Led by Martin Veale, Chair of the Audit Committee

1.4.0 Action Log

Led by Martin Veale, Chair of the Audit Committee

1.4.0 Master Copy Audit Committee Action Log January 2022 Meeting updates Updated April 2022.docx

2.0.0 CONSENT AGENDA

Led by Martin Veale, Chair of the Audit Committee

2.1.0 FOR APPROVAL

Led by Martin Veale, Chair of the Audit Committee

2.1.1 Draft Minutes from the Public Part A Audit Committee meeting held on 11 January 2022

Led by Martin Veale, Chair of the Audit Committee

2.1.1 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 11 January 2022 -LFMV Final Updated.docx

2.1.2 Draft Minutes from the Private Part B Audit Committee meeting held on 14 October 2022

Led by Martin Veale, Chair of the Audit Committee

2.1.2 Draft PART B Private Audit Committee Minutes _14 10 2021.docx

2.2.0 FOR NOTING

Led by Martin Veale, Chair of the Audit Committee

2.2.1 Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

2.2.1 Audit Report Apr 22 v1.0.docx

2.2.2 Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

2.2.2 DOI Gifts, Sponsorship, Hospitality and Honoria.docx

2.2.3 Audit Committee – ISO Paper

Led by Rhiannon Freshney, Environmental Development Officer

2.2.3a ISO14001 EXTERNAL AUDIT REPORT COVER PAPER SLT AUDIT COMMITTEE 03.05.22.docx

2.2.3b APPENDIX 1 - Velindre NHS Trust - Recertification Audit Report - 03-12-2021 - Updated.pdf

2.2.4 Losses and Special Payments Report

Led by Claire Bowden, Head of Financial Operations

2.2.4 MB Review Losses and write offs paper May 2022.docx

3.0.0 PRIVATE PATIENT SERVICE REVIEW

Led by Matthew Bunce, Executive Director of Finance

3.0.0a AUDIT COMMITTEE MAY 2022- Private Patient Service External Review Report.docx

3.0.0b Appendix 2 - PP Action Plan February 22.xlsx

4.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

4.1.0 Trust Risk Register

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

4.1.0a AUDIT COMMITTEE - Risk Paper MAY 2022- LF.docx

4.1.0b PUBLIC RISKS - MARCH 2022 - Appendix 1 - V14 Data.pdf

4.1.0c PUBLIC RISKS - MARCH 2022 - Appendix 2 - V12 Data.pdf

4.2.0 Trust Assurance Framework

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

4.2.0a Audit Committee - 03.05.2022 - Trust Assurance Framework-LF.docx

4.2.0b - Appendix 1 TAF DASHBOARD 28.03.2022.pdf

4.2.0c - Appendix 2 TAF DASHBOARD 28.03.2022.xlsx

4.3.0 Audit Action Tracker – Overdue and Completed Recommendations

Led by Matthew Bunce, Executive Director of Finance

4.3.0a Cover Paper - Red and Green Audit Action Tracker May 2022 Meeting.docx

4.3.0b For May AC loading - Master Audit Action Tracker Overdue and Completed recommendations - May 2022 updates.pdf

5.0.0 EXTERNAL AUDIT

Led by Katrina Febry, Steve Wyndham and Clare James (Audit Wales)

5.1.0 Audit Plan 2022

Led by Clare James (Audit Wales)

5.1.0 VUNHST Velindre Audit Plan 2022 - Final.pdf

5.2.0 Audit Position Update

Led by Katrina Febry and Steve Wyndham (Audit Wales)

5.2.0 VUNHST Audit Position Statement 2022 05 May.pdf

5.3.0 Taking Care of the Carers

Led by Katrina Febry (Audit Wales)

5.3.0a Audit Committee Cover paper Taking Care of The Carers Mgt Response 03.5.22.docx

5.3.0b Taking-care-eng.pdf

5.3.0c VUNHST Response - Taking Care of the Carers19.4.22.docx

6.0.0 INTERNAL AUDIT

Led by Simon Cookson, Director of Audit & Assurance and Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)

6.1.0 2021/22 Internal Audit Progress Update

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

6.1.0 VUNHST 2122 - Internal Audit Update Report - May-22 - Trust issue.pdf

6.2.0 Internal Audit Report: nVCC MIM Governance

Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services)

6.2.0 Velindre_nVCC_2122_MIM Governance_Final Report_issued.pdf

6.3.0 Internal Audit Report: nVCC Contract Management

Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services)

6.3.0 Velindre_nVCC_2122_Contract Management_Final Report.pdf

6.4.0 Internal Audit Report: Financial Systems

Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)

6.4.0 VT 2122-05 - Final Internal Audit Report - Financial Systems.pdf

6.5.0 Internal Audit Report: Scrutiny of Expenditure

Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)

6.5.0 VT 2122-07 - Final Internal Audit Report - Scrutiny of Expenditure - for Trust issue.pdf

6.6.0 Internal Audit Report: DBS Checks

Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)

6.6.0 VT 2122-03 - Final Internal Audit Report - DBS Checks - Trust issue.pdf

6.7.0 Internal Audit Report: Charitable Funds

Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)

6.7.0a VT 2122-08 - Charitable Funds Final Internal Audit Report.pdf

6.7.0b VT Charitable Funds - PAQ.docx

6.8.0 Draft 2021/22 Internal Audit Opinion

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

6.8.0a VT 21-22 Initial Draft Opinion - cover paper.pdf

6.8.0b VT 21-22 HIA INITIAL DRAFT Annual Report and Opinion - Trust issue.pdf

6.9.0 Draft 2022/23 Internal Audit Plan

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

6.9.0a VT 22-23 Proposed Internal Audit Plan - cover paper.pdf

6.9.0b VT_2022-23_Draft Internal Audit Plan_for Audit Committee.pdf

7.0.0 COUNTER FRAUD

7.1.0 Counter Fraud Progress Report

Led by Gareth Lavington, Lead Local Counter Fraud Specialist and Nigel Price, Local Counter Fraud Specialist

7.1.0 ULHB Audit Committee CF Progress Report 05.04.22 (002).doc

7.2.0 Counter Fraud Approval of Annual Plan

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

7.2.0 VEL Annual Plan FINAL.docx

8.0.0 ADMINISTRATION

8.1.0 Audit Committee Effectiveness Survey

Led by Led by Claire Bowden, Head of Financial Operations

8.1.0a Covering paper AC Effectiveness Survey Findings May 2022.docx

8.1.0b Appendix 1 Summary of responses.xlsx

8.1.0c Appendix 2 Audit Committee Effectiveness Survey Findings 2021- LFdocx.docx

9.0.0 FINANCE

9.1.0 Charity Annual Accounts 2020/21 Lessons Learned

Led by Matthew Bunce, Executive Director of Finance

9.1.0 Updated Charity Annual Accounts 2020_21 Lessons Learned 11.04.22.docx

9.2.0 Private Patients Debt Position

Led by Ann Marie Stockdale, Head of Medical Records and Cancer Services Management

9.2.0a Private Patient Service - Audit Committee Paper May 2022.docx

9.2.0b New PP1.pdf

9.2.0c Letter Head PP1A form.docx

9.2.0d Consultant top Up Check List.doc

10.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

11.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

12.0.0 ANY OTHER BUSINESS

By prior approval of the Chair of the Committee

13.0.0 DATE AND TIME OF THE NEXT MEETING

Confirmed Final Accounts – Audit Committee -13 June 2022, 10:30 – 11:30
Public Audit Committee – 19 July 2022, 10:00 – 12:30

14.0.0 CLOSE

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 8 October 2020 Meeting			
01/2021 4.1.0	**Audit Action Tracker** **VCC Control and Governance** The Datix form is complete and going through the divisions. **Action: Lauren Fear** **11/01/2022 UPDATE:** **ACTION:** Emma Stephens, on behalf of Lauren Fear, to share the specific details of the DATIX training, with the Committee outside of the meeting, including the version of the training being implemented and the percentage completed so far.	**ACTION:** Lauren Fear	**OPEN** **UPDATE APRIL 2022:** Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.	LF
	Actions from 22 March 2021 Meeting			
03/2021 4.2.0	**ACTION:** Cath O'Brien, Claire Bowden, and Matthew Bunce to work on a breakdown of Private Patient Debts by Sectors and age of debt, to give assurance on the payment element. This information to be brought to May 2022 Audit Committee. (Nigel Price happy to assist in recovery of funds).	**ACTION:** Cath O'Brien / Claire Bowden / Matthew Bunce	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** A paper setting out the breakdown of the private patient debt by sector and age is included on the agenda	COB / CB / MB
03/2021 10.1.0	**11/01/2022 UPDATE:** **ACTION:** Matthew Bunce to ensure the Response by Shared Services to the Future Generation Commissioners report on 'Procuring Well-Being in Wales is circulated	**ACTION:** Matthew Bunce	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:**	MB

	outside of Committee to enable this action to be closed.		Response by Shared Services to the Future Generation Commissioners report on 'Procuring Well-Being in Wales circulated 14.04.2022	
07/2021 3.1.0	**Legislative & Regulatory Compliance Register** **ACTION: Lauren Fear and Matt Bunce to discuss the inclusion of procurement compliance in this document.**	**ACTION:** Lauren Fear and Matt Bunce	**OPEN** **UPDATE APRIL 2022:** **Report to be received in July 2022 Audit Committee.**	LF/MB
07/2021 3.5.0	**Private Patients' Debts** Gareth Jones requested a breakdown analysis of the dates of the debts, in order for us to be aware if there are any debts we cannot collect due the age of them. **ACTION: Break down the debt in terms of a date analysis to ascertain if there are old debts we cannot claim due to the length of time they have been outstanding.**	**ACTION:** Ann Marie Stockdale	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Template has been developed and will be the proposed mechanism for consideration to support aged debt reporting going forward and will enable monthly progress to be monitored.	AMS
	Actions from 14 October 2021 Meeting			
10/2021 4.5.0	**Update on review of Private Patients debts (Verbal Update)** Matthew Bunce as mentioned will do piece of work on age debt and can have a discussion with Martin Veale and Gareth Jones and share	**aCTION:** Matthew Bunce	**OPEN** **UPDATE APRIL 2022:**	MB

	the information with the committee when ready. Gareth Jones raised concerns to the Committee that age debt analysis should be relatively available and was worried about bad publicity and wants to avoid that. Martin Veale noted a meeting will be scheduled with Matthew Bunce this year. This will be firmly on agenda with written update for the January 2022 meeting. **ACTION: Meeting to be arranged between Martin Veale and Matthew Bunce to discuss Private patient debts.**			
10/2021 7.2.0	**Counter Fraud Staffing** **ACTION:** Matthew Bunce, Nigel Price and Andy Butler to have a conversation about resources more widely in figures in this report 110 for Velindre Trust and 75 for Shared Services, whether those numbers are appropriate and what that might look like going forward.	**ACTION:** Matthew Bunce	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** MB met with Gareth Lavington (GL) Lead Local Counter Fraud Specialist on 20.04.22 to discuss the 22-23 Counter Fraud Plan and whether the 110 days are sufficient to deliver the plan. GL view was that the 110 days are sufficient on basis that the majority of work is proactive, with some risk based work and awareness work. Some contingency days are kept back for unplanned work such as a major investigation. The resource requirement will be kept under review.	MB
	Actions from 11 January 2022 Meeting			
01/2022 3.1.0	**Trust Risk Register**	**ACTION:** Lauren Fear	**PROPOSE TO CLOSE**	LF

	ACTION: Lauren Fear to include in the paper for the May 2022 Audit Committee meeting relating to the Risk Register, detailing the role of each Committee within the risk framework		**UPDATE APRIL 2022:** Included in risk paper agenda item	
01/2022 3.2.0	**Trust Assurance Framework** **ACTION: Lauren Fear to take forward the points raised at the Committee to incorporate a way to keep clear sight of the risks against the strategic objectives.**	**ACTION:** Lauren Fear	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Included in Trust Assurance Framework paper agenda item	LF
01/2022 3.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** **ACTION: Matthew Bunce will chase all the actions outstanding in the relevant sections of the Action Tracker to give revised date of expected completion and a short commentary of why this won't be completed until this date, giving people until the end of January 2022 to respond.**	**ACTION:** Matthew Bunce	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Matthew Bunce sent emails to chase all Audit Action Tracker Red and Green Actions needing clarification giving a deadline for responses by 11 February 2022. Responses have been updated on the Audit Action Tracker.	MB
01/2022 3.4.0	**Losses and Special Payments Report** **ACTION: Claire Bowden to go back through and categorise the private patient debts, where able to, and will then share this information with the committee.**	**ACTION:** Claire Bowden	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Private Patient Debt information shared with Independent Members via email.	CB

	ACTION: Regarding private patient debts, Claire Bowden will liaise with Anne Marie Stockdale to clarify what steps are in place going forward to ensure we are sighted on who the debtors are.	**ACTION:** Claire Bowden	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Private Patient Debts Paper submitted on agenda 03/05/2022 that will include the proposed format for future reporting for consideration and approval by the Committee.	CB
	ACTION: Cath O'Brien will continue to work on the Private Patient Services piece of work and bring to the Audit Committee once complete.	**ACTION:** Cath O'Brien	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Private Patient Service Review being brought to the Audit Committee 03/05/2022.	COB
01/2022 4.1.1	**EXTERNAL AUDIT** **Structured Assessment 2021 (phase 2) final report (and management response incorporated)** **ACTION: Katrina Febry to change the wording Exhibit 7, Page 17, list of clinical audits with recommendations, to reflect 'haven't looked and therefore we have a neutral view, instead of we consider them to be outstanding.**	**ACTION:** Katrina Febry	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Report changed to: 'We have not considered these recommendations as part of our Structured Assessment work. We will consider them as part of our review into quality governance arrangements.'	KF
01/2022 4.1.2	**EXTERNAL AUDIT** **Audit Wales Audit Committee Update** **ACTION: The next Audit Committee is not until May 2022, so 2021/2022 account audit plan document to be circulated by Steve Wyndham out of committee as soon as available to address any issues.**	**ACTION:** Steve Wyndham	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** The draft Audit Plan was circulated to senior management (Steve Ham, Matt Bunce and Lauren Fear) 13/04/2022 for	SW

			comment and the final Plan will be included in the papers for the May 2022 Audit Committee.	
01/2022 4.1.3	**ACTION: Emma Stephens to ensure the Taking Care of the Carers Report is circulated across EMB to have sight of it.**	**ACTION:** Emma Stephens	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Report and self-assessment as part of Executive Management Board 27th April papers	ES
01/2022 5.1.0	**INTERNAL AUDIT** **2021/22 Internal Audit Plan progress update** **ACTION: Due to the next Audit Committee not being until May 2022. As soon as the final papers are ready, Simon Cookson to circulate to the Committee outside of the meeting.**	**ACTION:** Simon Cookson	**PROPOSE TO CLOSE** **UPDATE APRIL 2022:** Circulated as part of May Audit Committee papers as not ready previously	SC
01/2022 5.2.2	**INTERNAL AUDIT** **Internal Audit Report: Board Committee Effectiveness** **ACTION: Emma Stephens/ Lauren Fear to look at the benefits of realisation Matters arising/Recommendation tool to address the scope intention with regards to the comprehensive training programme.**	**ACTION:** Emma Stephens / Lauren Fear	**PROPOSE TO CLOSE** **UPDATE APRIL 2022: Independent Member input incorporated into the Paper Writing training programme**	ES / LF

MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE

VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS

TUESDAY 11 JANUARY 2021 AT 10:00AM

PRESENT:	
Martin Veale	Chair and Independent Member
Gareth Jones	Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Emma Stephens	Head of Corporate Governance
Claire Bowden	Head of Financial Operations
Carl James	Director of Strategic Transformation, Planning and Digital
Katrina Febry	Audit Wales
Clare James	Audit Wales
Steve Wyndham	Audit Wales
Nigel Price	Local Counter Fraud Specialist
Simon Cookson	NWSSP (Audit and Assurance Services)
Emma Rees	Audit Manager, NWSSP (Audit and Assurance Services)
Martyn Lewis	ICT Audit Manager, NWSSP (Audit and Assurance Services)
Christine Thorne	Head of Procurement
Alison Hedges	Business Support Officer

1.0.0	**Standard Business** Led by Martin Veale, Chair, and Independent Member	**Action**
1.1.0	**Apologies** Led by Martin Veale, Chair, and Independent Member Apologies were received from: • Lauren Fear, Director of Corporate Governance • Steve Ham, Chief Executive Officer • James Quance, Head of Internal Audit, NWSSP (Audit and Assurance Services) – James has gone on a temporary secondment to Powys UHB and Simon Cookson covered today's meeting on his behalf. Cath O'Brien, Chief Operating Officer needs to leave the meeting to attend Covid Cell for a short period. Gareth Jones, Independent Member, noted he need to leave the meeting slightly early.	
1.2.0	**In Attendance** Led by Martin Veale, Chair, and Independent Member Attendance was **NOTED** as above. Martin Veale welcomed Vicky Morris to the Committee as the newest Independent Member on the Board, the Chair of the Quality Safety and Performance Committee and member of the Audit Committee. Martin Veale also welcomed Clare James, Katrina Febry and Steve Wyndham, from Audit Wales, Simon Cookson, Emma Rees and Martyn Lewis from Internal Audit, and Nigel Price from Counter Fraud to the Audit Committee Meeting.	
1.3.0	**Declarations of Interest** Led by Martin Veale, Chair, and Independent Member	

	No Declarations of Interest were declared.	
1.4.0	**Action Log** Led by Martin Veale, Chair, and Independent Member **01/2021 4.1.0 Audit Action Tracker** **VCC Control and Governance** DATIX Form/Risk Register the last update says training agreed by end of January 2022, but now looking at March 2022. Emma Stephen noted to the Committee that after a conversation with Lauren Fear, a training programme was agreed, this has changed pace and could not be introduced by the end of December 2021. Now working toward a provisional timetable of March 2022. Vicky Morris highlighted to the Committee that it would be helpful to state if this is initial DATIX training or the version upgrade training and what percentage has been completed of the original training. Emma Stephen agreed to take this information back and noted these details are available which can be shared with the Committee. ****ACTION: The Audit Committee were concerned that DATIX training is not taking place until March 2022. Emma Stephens to share the specific details of the DATIX training, with the Committee outside of the meeting, including the version of the training being implemented and the percentage completed so far.** Gareth Jones highlighted the importance in future to ensure action updates are worded in as a clearer way. Emma Stephens agreed this is important and she has been working with the team to give the actions a good clean up and get more transparency. Martin Veale agreed and asked for this to be kept in mind for future actions. **03/2021 4.2.0 Private Patient Report** Matthew Bunce noted an initial report was received in July 2021 which the Executive Team reviewed and had some questions in terms of the statements within the report. Further evidence has been requested. Feedback was provided to the independent Consultant and revised report had been sent back to the Trust at the end of November 2021. Been reviewed and Matthew Bunce has pulled together an action plan in relation to recommendations. Working with Cath O'Brien and taking through Velindre Cancer Centre Senior Leadership Team. Hopefully to share then prior to the next Committee, which will include the management response ****ACTION: Cath O'Brien and Matthew Bunce to circulate the Private Patient Report to the Audit Committee outside of the meeting, once it has been through the Senior Leadership Team for approval.** Gareth Jones noted to the Committee that he thought we had agreed this item would be a standard agenda item on the Audit Committee Agenda and would like to see a breakdown of debts by sectors and how old the debts are. Martin Veale agreed and confirmed the next Audit Committee will have this item on the agenda. **ACTION: Cath O'Brien, Claire Bowden, and Matthew Bunce to work on a breakdown of Private Patient Debts by Sectors and age of debt, to give assurance on the payment element. This information to be brought to May 2022 Audit Committee. (Nigel Price happy to assist in recovery of funds).**	**Emma Stephens** **Cath O'Brien / Matthew Bunce** **Cath O'Brien / Claire Bowden / Matthew Bunce**

	Matthew Bunce wanted to reinforce the fact to the Committee that Anne Marie Stockdale and the Team are reviewing and chasing private patient debts and there is an up-to-date position that could be shared. Matt Bunce noted he urgently wants to get a Procurement process in place to get some expert help, including with debt collection and ways we could improve. Martin Veale requested an update from Ann Marie-Stockdale for the May 2022 Audit Committee meeting. **03/2021 10.1.0 Response by Shared Services to the Future Generation Commissioners report on 'Procuring Well-Being in Wales** Christine Thorne noted that the response has been provided on several occasions, but not circulated to the wider committee. Christine Thorne has re-sent this to Matthew Bunce, who will ensure this is circulated outside of Committee to enable this action to be closed. ****ACTION: Matthew Bunce to ensure the Response by Shared Services to the Future Generation Commissioners report on 'Procuring Well-Being in Wales is circulated outside of Committee to enable this action to be closed.** **07/2021 3.1.0 Legislative & Regulatory Compliance Register** The Committee noted that this has understandably been pushed back to next Audit Committee. ****ACTION: Change Section of the January 2022 Update 'This work will continue in background, for presentation to Audit Committee in April 2022' to read 'May 2022'.** **07/2021 3.5.0 Private Patient Debts.** The Breakdown has been circulated so it was agreed that this part of Private Patient Debts has been actioned, but it has been replaced with new actions today, so this section should be changed back to open. **10/2021 4.5.0 Update on review of Private Patients debts (Verbal Update)** The Committee decided this item will remain open on the action log and is not closed and should be changed back to open and be superseded with the new actions from today Committee meeting. **10/2021 7.2.0 Counter Fraud Staffing.** It was noted to the Committee that Craig Greenstock's post has been advertised and is closing next week. Matthew Bunce highlighted the need to understand how the current resource is utilised and understand where we need to direct our resource. Seems to be low numbers coming forward. Question of, is there any benchmarking, is there different mechanisms in different organisations that generate more referrals? Nigel Price responded that in relation to getting the message wider, this links back into the Audit Wales Report 'Making Our Game', making Counter Fraud awareness mandatory for new starters and targeting departments that may benefit from it, such as Procurement and Payroll. This is being considered by Shared Services at the moment. The Audit Committee **AGREED** and **NOTED** all the **CLOSED** actions, with exception of the Private Patient Debt actions noted above.	**Matthew Bunce** **Alison Hedges**
2.0.0	**CONSENT AGENDA** Led by Martin Veale, Chair, and Independent Member	
2.1.0	**FOR APPROVAL** Led by Martin Veale, Chair, and Independent Member	
2.1.1	**Draft Minutes from the Audit Committee meeting held on 14 October 2021**	

	Led by Martin Veale, Chair, and Independent Member The AUDIT Committee **AGREED** the notes from the meeting held on the 14 October 2021 were an accurate record.	
2.2.0	**For Noting** Led by Martin Veale, Chair, and Independent Member	
2.2.1	**Procurement Compliance Report** Led by Matthew Bunce, Executive Director of Finance Martin Veale invited Christine Thorne to give a brief update on the Procurement Compliance Report. Christine Thorne noted that the report covers the period 29 September 2021 – 01 December 2021. And highlighted the following: • Slightly lower numbers than normal. • 4 single tender actions to report and 2 file notes. • Overall, no major concern. • WBS-STA-836 - Provision of historical and technical information. Including reviewing documents and assisting with responses to the Welsh Infected Blood inquiry - Need to liaise with service to see if can anticipate any further expenditure in that area. • VCC-STA-837 - Provision of an Independent healthcare facilitator – If linked to reports influenced externally, there isn't anything can do to influence the position. • WBS-STA-851 - Clinical rooms for stem cell collection – No Concerns. Linked to something Procurement is already involved in. Certain things must be done before removing those clinical rooms over. Classed as an essential need. • WBS-STA-860 - Purchase of 12 Blood donor chairs - Standardisation compatible with existing chairs. • Cath O'Brien provided assurance to the Committee that NHSBT had these chairs specifically designed and there is no other supplier of blood chairs. • VEL-VCC-FN-118 – Supply of a Temporary marquee to provide comfort to patients during the COVID-19 Pandemic and support the vaccination process – Due to Covid marquees were in short supply . • VEL-WBS-FN-114 - Various venues for Blood collection. Has been challenging to keep donor and clinics going. On an individual basis most venues form separate contract, so don't go over £100,000 individually. Christine Thorne assured the Committee that items that are repeat submission cover the additional value only. Gareth Jones noted that it would be helpful to have the aggregate value with the extension. Matthew Bunce confirmed with Gareth Jones that going forward need to show the original value, plus additional and the aggregate value. Vicky Morris noted the need to be compliant with the budget and that it would be helpful to put in the summary. Christine Thorne confirmed she will pick this up with Matthew Bunce outside of the meeting. This report was **NOTED** by the Audit Committee.	
	Christine Thorne left the Committee at 10:41am.	
2.2.2	**Review of Standing Orders, SFIs and Scheme of Delegation** **Amendment to Velindre University NHS Trust Standing Orders – Schedule 3** Led by Emma Stephens, Head of Corporate Governance	

	Emma Stephens noted this was created in line with the annual review process. The Charitable Funds Committee, Strategic Development Committee, Quality Safety and Performance and Audit Committee have untaken a review as part of the Annual Governance Cycle as Terms of Reference. Each Committee have already reviewed and endorsed for Board approval the changes that have been summarised. Audit Committee asked Endorse today. Gareth Jones asked whether copies with track changes be available for these examples and as standard practice in going forwards. Emma Stephens agreed for future meeting a clean copy and a copy with track changes noted will be available. ****ACTION: Emma Stephens to circulate a copy of the all the Review of Standing Orders, SFIs and Scheme of Delegation Appendices (a-d) to the Audit Committee with track changes sighted.** The Audit Committee **ENDORSED for Board Approval** the amendments to the Trust Board Standing Orders – Schedule 3 as outlined in section **3** of this report and included in ***Appendices 1-4.***	**Emma Stephens**
3.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
3.1.0	**Trust Risk Register** Led by Emma Stephens, Head of Corporate Governance Emma Stephens noted this is a journey the organisation is on in terms of assuring of the risk register. There is a training programme that will support this. Emma Stephens outlined as below: Section 3.1 - This extract of Risk Register was taken in December 2021, highlighting there will be a further iteration that will be taken to Quality, Safety and Performance Committee next week to reflect the changing position regarding current Covid-19 related risks. Section 3.2 – Previously reported November 2021, with 119 risks reported, increased to 152. The reason for increase is due to the fact impacts of 5 are now included and were not previously. Martin Veale highlighted the need to understand that each of these risks is flagged to an individual risk owner and asked whether risks are divided up between Committees in order to clarify the role of audit committee as having oversight of process rather than individual risks? Emma Stephens responded that each Committee has a different role in this respect. Martin Veale requested that for the next Audit Committee a paper to be brought back to include which risks go to which Committee and who's the owner. ****ACTION: Emma Stephens / Lauren Fear to include in the paper for the May 2022 Audit Committee meeting relating to the Risk Register, detailing the role of each Committee within the risk framework** Gareth Jones highlight a point of detail in paragraph 3, reference to development of a paper-based risk form, given it's a digital solution. Emma Stephens confirmed that she will raise that query and will provide clarity. Emma Stephens will also address the question, if Independent Members will at some point have access to DATIX and have training provided? Vicky Morris noted that the report could be clearer in terms of rationale where risks were closed and also the detail on the actions being taken, to ensure appropriate assurance for the Committee.	**Emma Stephens / Lauren Fear**

	The Audit Committee **NOTED** the Report as below, considering the changes to be actioned: • **NOTE** the risks level 20, 16, 15, 12 and impact of 5 reported in the Trust Risk Register and highlighted in this cover paper. • **NOTE** that a project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust. • **NOTE** the further work in January to update the profile in light of the recently changing covid risk profile.	
3.2.0	**Trust Assurance Framework** Led by Emma Stephens, Head of Corporate Governance Emma Stephens highlighted to the Committee that the original Trust Assurance Framework that was developed in September was a paper-based system and wanted to go into dashboard reporting, so started to put in an Excel Platform. Vicky Morris noted there are lots of benchmarks with a well-established Board Assurance Framework in place. Katrina Febry agreed. Suggested that the link to strategic objectives could be built on further in the reporting. Emma Stephens agreed with these points and that this could be a good way to take further forward. Vicky Morris stated she is happy to support in discussions outside the Committee. ****ACTION: Emma Stephens to take forward the points raised at the Committee to incorporate a way to keep clear sight of the risks against the strategic objectives.** The Audit Committee **NOTED** the direction and the suggestion of some development work for the Board and **NOTED** below: I. **NOTE** the progress to date and **DISCUSS / REVIEW** the next iteration of the Trust Assurance Framework included at ***Appendix 1***. II. **NOTE** the next steps in the development pathway to support further operationalisation of the Trust Assurance Framework.	**Emma Stephens / Lauren Fear**
3.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce noted to the Committee the standard format report with 26 red actions. The majority asking for extensions as a result of the impact of Covid-19 delivery. Matthew Bunce wanted to raise the issue to the Committee on how we ensure when actions are closed out there is assurance what action was taken and when this happened. Martin Veale noted the items of concern are where closure has been delayed but an updated date for closure has not been provided. To be completed by the end of January 2022. ****ACTION: Matthew Bunce will chase all the actions outstanding in the relevant sections of the Action Tracker to give revised date of expected completion and a short commentary of why this won't be completed until this date, giving people until the end of January 2022 to respond.** The Audit Committee **NOTED** the contents of the report. The Committee **AGREED** that all Green Actions could be closed and removed from the Action tracker. The red actions were **NOTED** as written with the additional action being implemented before by the end of January 2022.	**Matthew Bunce**
3.4.0	**Losses and Special Payments Report (Verbal Update)** Led by Claire Bowden, Head of Financial Operations	

	Claire Bowden noted that up until the end December 2021, the Trust has written off approximately £90,000 of aged debt, of which the vast majority, £83,000 were aged private patient debts. Martin Veale stated that £83,000 loss on private patients is a significant concern. Claire Bowden noted that the debts are very old and about £58,000 of that amount was pre-October 2016. Gareth Jones asked if we know who the debtors are, but Claire Bowden said that information isn't readily available as all debts go on the system under the patients' names; and sometimes there is no information available as in some cases patients have passed away. ****ACTION: Claire Bowden to go back through and categorise the private patient debts, where able to, and will then share this information with the committee.** Gareth Jones confirmed if the debts are written off, don't want to go back on old ground of work, just need assurance to not have this lack of clarity going forward. Claire Bowden will liaise with Anne Marie Stockdale what steps are in place going forward. ****ACTION: Regarding private patient debts, Claire Bowden will liaise with Anne Marie Stockdale to clarify what steps are in place going forward to ensure we are sighted on who the debtors are.** The Committee agreed this needs some work to review how can we assure ourselves, as well as the records we need to bill. Noted there has been improvement in record keeping since new member of staff has started. Cath O'Brien noted that we have got a new form of wording for patients to sign that enables us to make sure that we can chase back through for the payment, which will put us on a firmer legal footing. Cath O'Brien gave a level of assurance that it is under scrutiny and in development. Can review again with all the actions to review with the Audit Committee. Cath O'Brien noted she has a level of confidence that we are not in a position where we should be stopping our private patient service. Gareth Jones highlighted a system needs to be in place so we know who's paying and a system where we can recover payments that are due to us. Cath O'Brien noted that she is still in the process of doing this piece of work. ****ACTION: Cath O'Brien will continue to work on the Private Patient Services piece of work and bring to the Audit Committee once complete.** The Audit Committee **NOTED** the Losses and Special Payments Report (Verbal Update) with a view to bringing this as an agenda item in the next Committee to address some of the issues raised again.	**Claire Bowden** **Claire Bowden** **Cath O'Brien**
	Cath O'Brien left the meeting at 11:26am.	
4.0.0	**EXTERNAL AUDIT** Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales	
4.1.0	**Progress Reports**	
4.1.1	**Structured Assessment 2021 (phase 2) final report (and management response incorporated)**	

	Led by Katrina Febry and Clare James, Audit Wales Karina Febry took the Committee through this second piece of work covering Corporate Governance and financial management arrangements over the previous 12 months, following the phase 1 operational planning arrangements that was brough to the March 2021 Audit Committee. Overall the Trust is well governed with clear affective arrangements. Missing Board and Committee papers and Board recordings are now available on the website to address actions more work to be done to ensure staff are trained to put that process in place. Recommended more granularity when setting strategic priorities and plans. Recommended strategic priorities are supported by SMART actions to aid the scrutiny of progress made to deliver those actions. Katrina Febry also wished to highlight another point of scope, which is to review some of the detail in Committee papers (probably aimed more at Quality and Safety Committee). Martin Veale raised the section that suggests that the Trust may wish to consider published unconfirmed minutes and he expressed he wasn't comfortable with that. Katrina noted HEIW do this but it's not widespread, and that it is not a recommendation. Emma Stephens confirmed no other Health Boards operate this. Martin Veale raised a query on Exhibit 7, Page 17, list of clinical audits with recommendations, not comfortable with the wording, should read "haven't looked at and therefore we have a neutral view", instead of "we consider them to be outstanding". Katrina Febry agreed to amend the wording. ****ACTION: Katrina Febry to change the wording Exhibit 7, Page 17, list of clinical audits with recommendations, to reflect 'haven't looked and therefore we have a neutral view, instead of we consider them to be outstanding.** The Audit Committee **NOTED** the report.	**Katrina Febry**
4.1.2	**Audit Wales Audit Committee Update** Led by Katrina Febry and Steve Wyndham, Audit Wales Steve Wyndham noted that in terms of financial audit work, largely completed 2021 work, apart from two areas: • He gave an update to Charitable Funds Committee in December meeting on the completion of the audit of the charitable funds accounts, and extended testing needed to be completed and still awaiting information, relating to this. He said that he was confident this will be completed by Charity Commission deadline 31 January 2022. • Audit of S1 and S2 forms regarding the transition NWIS from the Trust to DHCW is still ongoing. Martin Veale asked Steve Wyndham to keep in touch with Matthew Bunce in terms of progress and if at any point think can't complete by 31 January 2022 to let the Committee know. Martin Veale noted the next Audit Committee is not until May 2022, so would like the 2021/2022 account audit plan document circulated out of committee as soon as available to address any issues. ****ACTION: The next Audit Committee is not until May 2022, so 2021/2022 account audit plan document to be circulated by Steve Wyndham out of committee as soon as available to address any issues.** Katrina Febry then presented to the Committee the 2020 planned quality governance piece of work, an extensive review on quality governance arrangement, which they are in the process of reinstating. They had intended	**Steve Wyndham**

	to do interviews in January 2022, but the Trust have asked to stand interviews down now and hoping to do in February. . Highlighted report called 'Taking Care of the Carers' piece of work on wellbeing of staff. Report has several recommendations for NHS bodies to consider and do a self-assessment. ****ACTION: Emma Stephens to ensure the Taking Care of the Carers Report is circulated across EMB to have sight of it.** The Audit Committee are **REVIEWED** and **NOTED** the report.	**Emma Stephens**
4.1.3	**Update on the Audit Wales Approach to the Audit of Inventories for 2021-22** Led by Steve Wyndham, Audit Wales Steve Wyndham noted the purpose of this paper is to keep the Committee abreast on the approach and keep assurance on the Trust inventory stock balance: • Held discussion with Senior Officers of the Trust, Shared Services, and internal audit to help shape approach and gather information. • Requirements auditing standards ISA501 require to attend physical stock counts where inventory balance is material. • Will be attending stock counts at several store locations and undertake audit procedures as well. Martin Veale asked about arrangements if restrictions continue to end March 2022. Clare James reassured the Committee that the team is also able to do stock accounts post year end and track back, so have window of opportunity to May 2022. She reiterated that Audit Wales staff must attend stock sites to complete, and that she will look at both risk assessments (Audit Wales and Velindre) and look at best opportunity to attend. Aim to work with Matthew Bunce and Andy Butler to look at risk assessments. Martin Veale requested the Committee be kept updated. The Audit Committee **NOTED** the report.	
	Clare James left the meeting 12:03pm.	
5.0.0	**INTERNAL AUDIT** Led by James Quance, Head of Internal Audit/Audit & Assurance and Emma Rees (NWSSP – Audit and Assurance Services)	
5.1.0	**2021/22 Internal Audit Plan progress update** Led by Simon Cookson, NWSSP (Audit and Assurance Services) Simon Cookson noted that of the 19 audits that are done at Velindre, 11 have been done – either final or in draft, 2 are work in progress, with 6 to complete. Simon Cookson wanted to note his thanks to officers across the Trust for their continued support. Martin Veale requested as soon as papers available and final reports are done share around before May 2022 meeting. ****ACTION: Due to the next Audit Committee not being until May 2022. As soon as the final papers are ready, Simon Cookson to circulate to the Committee outside of the meeting.**	**Simon Cookson**
5.2.0	**Receipt of Individual Reports**	
5.2.1	**Advisory Review Report: Use of Technology - Fit for the Future** Led by Martyn Lewis, NWSSP (Audit and Assurance Services) Martyn Lewis gave an overview of the report to the Committee. Martyn Lewis noted that this is an advisory piece of work, assessing the Trust position and	

	preparedness for maximising the use of digital technology in the future and noted the content as below: • Looked at the 6 key questions noted in the report to assess the organisational readiness for digital and provide recommendations for actions which will improve the organisations position and looked at some of the known barriers, • Overall, the Trust is well positioned to take forward digital technologies and there are opportunities for digital transformation within transforming cancer services and the Velindre Futures Programme and the up-and-coming Lab Modernisation process in Welsh Blood Service. • Digital strategy not been fully articulated. Funding position not fully secure and everything on a case-by-case basis. Digital culture hasn't been fully embedded within the service. Carl James noted that Velindre commissioned this as an advisory to take stock of where we are at, transitioning from IT to Digital and to start to understand how we seek out and create different types of value. Carl James highlighted the key is how we take it forward. Encompasses themes around: • Board leadership - Strategy how and where going, bringing something to Board March 2022. • General knowledge and skills. • Investment how do we spend the money we have got wisely and investment. Advert for New Chief Digital Officer. Carl James highlighted to the Committee that Velindre spends about 1.9% of its budget on digital but should be looking to increase this to about 5%. Need to look at how we can progress over next few years. Will be feeding the recommendations into the strategy and the education programme. The Audit Committee **NOTED** the report.	
	Carl James left the meeting 12.16pm.	
5.2.2	**Internal Audit Report: Board Committee Effectiveness** Led by Emma Rees, Audit Manager, NWSSP (Audit and Assurance Services) Emma Rees highlighted this report is to review the new Committee Structure looking at giving reassurance. Report came out as reasonable assurance with two medium and three low priority matters arising. Emma Rees noted this report looked at: • Structure, flow of information • Alignment of cycle of business with strategy and risk actual reports themselves and triangulation of business activity • How the trust has assured itself over benefits and realisation. Emma Rees highlighted the key areas to be brought to the Committees attention: • Ensuring clear alignment of the Committee Cycle of Business and Agendas. Taking advantage of TAF and Trust Risk Register. • Ensuring a robust process that all required reports are included in Committee Agendas. • Recommended clearly defining what success looks like. Martin raised the question around the Matters arising/Recommendation tool around the benefits of realisation. Already got in training not doing anything else. Emma Stephens responded is more in terms of reflection of what is in training wanted to reflect the conversation on the comprehensive training programme and some of work being taken forward. Need to look again at the scope intention.	

	****ACTION: Emma Stephens/ Lauren Fear to look at the benefits of realisation Matters arising/Recommendation tool to address the scope intention with regards to the comprehensive training programme.** Gareth Jones highlighted that Management responses don't specifically say recommendation accepted. Can you ask people when write responses to say yes or no at the beginning? Emma Rees agreed it would be good for clarity so can work that into the reports. The Audit Committee **NOTED** the report.	**Emma Stephens Lauren Fear**
5.2.3	**Internal Audit Report: Trust Assurance Framework** Led by Emma Rees, Audit Manager, NWSSP (Audit and Assurance Services) Emma Rees highlighted this report looked at given the state of development whether what was in place is robust and whether the Trust is managing its principal risks? Emma Rees noted this report is reasonable assurance with one high and two medium priority matters arising. The high priority matter is more about the importance of ensuring that you get the Trust Assurance Framework completed on a timely basis. Making sure where there are slippages and decisions made to step down and slow down work that those decisions are clearly recorded, through discussion at Board level or documented in a report, so the independent Members are clear on why things aren't happening to plan and reassurance clear and in the public domain. The Audit Committee **NOTED** the report.	
6.0.0	**COUNTER FRAUD**	
6.1.0	**Counter Fraud Annual Report 2020/21** Led by Nigel Price, Local Counter Fraud Specialist Nigel Price highlighted that the Counter Fraud service did continue through the Covid year despite a large, reduced capacity due to Covid illness and secondments and people leaving for other jobs. Nigel Price noted that now the resources have increased, role of Manager out for advert, with closing date end January 2022, and by the start of the new financial year should be up to full capacity. Well on track to fulfilling commitment for allocated days for Velindre Trust. The Audit Committee **RECEIVED** and **DISCUSSED** the report.	
6.2.0	**Counter Fraud Progress Report for the period 1st October 2021 to 30th December 2021** Led by Nigel Price, Local Counter Fraud Specialist Nigel Price highlighted and noted below to the Committee: • Two open investigations linked directly to Velindre Trust. Completed 90 days of allocated 110. • Resources have increased. Previously one person in administration role, replaced role with an accredited Investigator, appointed and will do NHS Fraud Training. Will then have three investigators and a manager. Gareth Jones expressed that it would be helpful to understand the sorts of values involved. Nigel Price agreed to include this in the next reports. .	

	The Audit Committee **RECEIVED** and **DISCUSSED** the report.	
	Cath O'Brien re-joined the meeting at 12:30pm.	
7.0.0	**ADMINISTRATION**	
7.1.0	**Production of Audit Committee Annual Report** Led by Claire Bowden, Head of Financial Operations and Martin Veale, Chair of the Audit Committee Martin Veale noted that the report covers the calendar year rather than financial year. Claire Bowden confirmed this could be moved to financial years if required. Claire Bowden highlighted it has a forward by Martin Veale as Chair. The Committee are asked if happy with the report to note at Trust Board. Martin Veale noted he has had the opportunity to comment. The Audit Committee **NOTED** the report.	
	Gareth Jones left the meeting at 12:31pm	
8.0.0	**FINANCE**	
8.1.0	**Receipt of Finance Technical updates** Led by Claire Bowden, Head of Financial Operations Claire Bowden stated to the Committee that this relates to an international financial reporting standard (IFRS 16, leases) that was meant to brought in a few years ago. Information in report very similar to what was reported over the last two years. Will impact on our financial statements from 2022-2023 onward. Working with colleagues across NHS Wales and Welsh Government to make sure we are ready for implementation of the standard. Claire Bowden noted she is not currently aware of any issues that need to be brought to the Committees attention. Martin Veale requested that at an appropriate time, the Committee should be informed of what the impact is likely to be. The Committee **REVIEWED** and **NOTED** the report.	
8.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	The Audit Committee were asked that if they have not yet completed the Audit Committee Annual Effectiveness Survey, please could they kindly do so.	
9.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting 27 January 2022.	
10.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 3 May 2022 at 10:00am via Microsoft Teams	
11.0.0	**CLOSE**	
	The Committee was 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 PRIVATE PART B AUDIT COMMITTEE

VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS

THURSDAY 14 OCTOBER 2021 AT 12:30PM

PRESENT:	
Martin Veale	Chair and Independent Member
Gareth Jones	Independent Member
ATTENDEES:	
Matthew Bunce	Director of Finance
Lauren Fear	Director of Corporate Governance
Steve Ham	Chief Executive Officer
Claire Bowden	Head of Financial Operations
Katrina Febry	Audit Lead, Audit Wales
Claire James	Audit Wales
Nigel Price	Local Counter Fraud Specialist
James Quance	Head of Internal Audit, NWSSP (Audit and Assurance Services)
Felicity Quance	Senior Audit Manager, NWSSP (Audit and Assurance Services)
Emma Rees	Audit Manager, NWSSP (Audit and Assurance Services)
Martyn Lewis	ICT Audit Manager, NWSSP (Audit and Assurance Services)
Alison Hedges	Business Support Officer

1.0.0	**Standard Business** Led by Martin Veale, Chair, and Independent Member	**Action**
1.1.0	**Apologies** Led by Martin Veale, Chair, and Independent Member Apologies were received from: • Cath O'Brien, Chief Operating Officer • Steve Wyndham, Audit Wales • Craig Greenstock, Counter Fraud	
1.2.0	**In Attendance** Led by Martin Veale, Chair, and Independent Member Attendance was **NOTED** as above.	
1.3.0	**Declarations of Interest** Led by Martin Veale, Chair, and Independent Member No Declarations of Interest were declared.	

2.0.0	**CONSENT AGENDA** Led by Martin Veale, Chair, and Independent Member	
2.1.0	**FOR APPROVAL** Led by Martin Veale, Chair, and Independent Member	
2.1.1	**Draft Minutes of the Private Part B Audit Committee meeting held on 08 July 2021** Led by Martin Veale, Chair, and Independent Member The Committee **NOTED** the following changes to be made: • Apologies Ann-Marie Harkin should be Claire James. The Audit Committee **AGREED,** apart from the above amendment, the notes from the meeting held on the 08 July 2021 were an accurate record.	
2.2.0	**For Noting** Led by Martin Veale, Chair, and Independent Member	
2.2.1	**Velindre University NHS Trust – Accounts Qualification** Led by Martin Veale, Chair, and Independent Member Martin Veale noted to the Committee that these letters were shared with the Committee, as an accurate record. The letters have not been shared publicly and there are no issues following. These items were **REVIEWED** and **NOTED** by the Audit Committee.	
2.2.2	**All Wales NHS Chairs of Audit Meeting Minutes** Led by Martin Veale, Chair of the Audit Committee Martin Veale noted to the Committee that the Minutes were shared in terms of understanding collective discussions. Martin Veale meets with all the other Chairs of the NHS Wales Audit Committes on a reasonably regular basis and wanted members to understand what is discussed. This item was **REVIEWED** and **NOTED** by the Audit Committee.	
3.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	The Chair and Committee **NOTED** there was no other business.	
4.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 11 January 2022 at 12:30pm via Microsoft Teams	
5.0.0	**CLOSE**	

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT
2nd December 2021 – 31st March 2022
(Reporting Deadlines)

DATE OF MEETING	03/05/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Helen James, Head of Procurement
PRESENTED BY	Matthew Bunce, Executive Director of Finance
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**
N/A	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
	• VEL – Velindre UNHS Trust • SQA - Single Quotation Actions • STA - Single Tender Action

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with an update in relation to procurement activity undertaken during the period 2nd December 2021 – 31st March 2022 and in accordance with reference 1.2 (Schedule 2.1.2 Procurement and Contracts Code for Building and Engineering Works) of the Standing Financial Instructions.

1.2 An explanation of the reasons, circumstances and details of any further action taken is also included.

SFI Reference	Description	Items
3.5	Single Quotation Actions	18
4.2	Single Tender Actions	17
5.3	Single Tenders for consideration following a call for an OJEU Competition	0
10.8	Contract Extensions	0
14.2	Award of additional funding outside the terms of the contract (executed via Contract Change Note (CCN) or Variation of Terms)	6

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Optional Appraisal/Analysis

Not applicable.

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	No (Include further detail below)
	All policies are equality impact assessed prior to approval.
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)
	As indicated in Appendices 1.1 (Summary Information) 1.2 (Further Matters)

4. RECOMMENDATION

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

Velindre University NHS Trust - Audit Committee Report – May 2022

Appendix 1.1 – Summary Information

Trust	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
VEL	Corporate	VCC-SQA-853	01/12/21 – 30/11/22	Single Quotation Action	Purchase of software package to support estates compliance	BESA (Building Engineering Services Association)	£11,565	Industry standard set of documentation provided by BESA, there are no alternatives	Endorsed	No further actions required.	First Submission
VEL	Corporate	VCC-SQA-886	01/11/21 – 31/10/24	Single Quotation Action	Fire safety software to track project and FM Fire related works	Bolster systems	£20,900	Technical reasons	Endorsed	No further actions required.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-905	01/04/22 – 31/03/23	Single Quotation Action	Software support for the Encoding licence	3M Medicode	£23,484.62	Sole OEM	Endorsed	Longer term STA to be provided	Repeat Submission last reported in October 2020
VEL	TCS	VCC-SQA-908	01/01/2022 – 31/03/2022	Single Quotation Action	Erection of Barriers	Raynes Scaffolding and Groundworks Ltd	£ 9,930	Supplier has knowledge of the site, land requirements, and specific protestor action to be aware of and to be taken into account in supply the services.	Endorsed	No further actions.	First Submission

VEL	Velindre Cancer Centre	VCC-SQA-917	28/02/2022 – 27/02/2023	Single Quotation Action	Programme for a senior clinician in a leadership position	Kings fund	£ 9,930	Only course meets the trusts needs	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-SQA-921	20/02/2022	Single Quotation Action	Provision of Human Platelet Antigen antibody test kits	IBG Immucor Ltd	£ 7,044	Sole OEM	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-RUPS-922	01/02/2022	Single Quotation Action	Replace UPS batteries	Power control Ltd	£ 9,376.20	Existing maintenance supplier	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-SQA-923	09/02/2022 – 08/02/2023	Single Quotation Action	New telephony equipment to enable a SIP service	Daisy Communications	£12,000	Existing maintenance supplier for WBS telephony system	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-926	01/01/2022 – 31/03/2022	Single Quotation Action	Technical support, advice, works and feedback on the RiTTA Chabot assistant project	IBM	£ 9,600	Sole OEM	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-932	01/03/2022 – 08/04/2022	Single Quotation Action	Provision of a temporary pharmacy dispensary	Portakabin Ltd	£6,155	Urgent need and value for money	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-SQA-944	03/03/2022	Single Quotation Action	Replacement parts for Donor chairs	Renfrew	£6,750	Sole OEM	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-948	24/03/2022 – 23/01/2023	Single Quotation Action	Science Manufacturing Technician Level 3 course	West Suffolk College	£5,750	Only provider of this course	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-951	01/02/2022 – 28/02/2022	Single Quotation Action	Installation of Oxygen Pipework and alarm cables	M & M Medical Ltd	£ 17,642.60	Extension of existing pipework completed by supplier	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-957	16/03/2022 – 15/03/2025	Single Quotation Action	Maintenance of ultrasound system	BK Medical UK Limited	£ 21,126.60	Sole OEM	Endorsed	No further actions.	First Submission

VEL	Welsh Blood Service	WBS-SQA-965	01/04/2022 – 31/03/2023	Single Quotation Action	Social customer care (multiple interactions)	Spark Central (Hootsuite)	£ 6,305	Sole OEM	Endorsed	No further actions.	First Submission
VEL	Health Technology Wales	VEL-HTW-SQA-961	15/03/2022 – 31/03/2024	Single Quotation Action	Renewal of subscription for Outnav software	Matter of Focus	£17,400	HTW procured the unique, cloud-based software tool, OutNav from Matter of Focus, via open competition in 2018.	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-STA-973	31/03/2022 – 26/12/2022	Single Tender Action	Varian Spare parts	Varian Medical Systems	£ 120,000	Sole OEM	Endorsed	Procurement process to be completed upon expiry of maintenance agreement	Repeat Submission - previously reported in January 2021
VEL	Welsh Blood Service	WBS-STA-976	01/04/2022 – 31/03/2023 (option to extend for a further 12 months)	Single Tender Action	Clinical Oversight to collection of blood stem cells for patients in Wales	Dr Hushni Habboush	£56,000	Business continuity	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-977	01/04/2022 – 31/03/2023 (option to extend for a further 12 months)	Single Tender Action	Clinical Oversight to collection of blood stem cells for patients in Wales	Dr Keith Wilson MD	£56,000	Business continuity	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-SQA-978	30/03/2021 – 19/03/2026	Single Quotation Action	Software support contract	Oncology Systems Limited	£21,164	Sole OEM	Endorsed	No further actions.	First Submission
VEL	TCS	VCC-STA-862	01/10/2021 - 30/11/2021	Single Tender Action	Felling and clearance of mature trees and scrub vegetation	Walters UK Ltd	£129,117.97	Identified supplier after no bids in Tender exercise.	Endorsed	No further actions.	First Submission
VEL	TCS	VCC-STA-911	01/01/2022 – 30/03/2022	Single Tender Action	Site security manager and manned site security	Nexus Security Ltd	£246,048.60	Identified supplier after no bids in	Endorsed	Procurement to investigate suitable	First Submission

								Tender exercise.		Framework agreements.	
VEL	Welsh Blood Service	WBS-STA-870	01/11/2021 – 30/10/2022	Single Tender Action	Room hire	Welsh Wound Innovation Centre	£54,001.44	Currently utilising room and have granted MHRA Licence	Endorsed	No further actions.	Repeat submission – previously reported in January 2021
VEL	Welsh Blood Service	WBS-STA-881	01/12/2021 – 30/11/2022	Single Tender Action	Purchase of unlicensed Medicines - Kybernin P500 iu	CSL Behring	£99,000	Sole supplier	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-882	01/12/2021 – 30/11/2022	Single Tender Action	Purchase of unlicensed Medicines - factor X1	Bioproducts Laboratory	£99,000	Sole supplier	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-883	01/12/2021 – 30/11/2022	Single Tender Action	Purchase of unlicensed medicines - pentgoblin	Biotest	£99,000	Sole supplier	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-884	01/12/2021 – 30/11/2022	Single Tender Action	Purchase of unlicensed medicines - factor 8y	Bioproducts Laboratory	£99,000	Sole supplier	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-909	02/02/2022	Single Tender Action	Purchase of Agilent Seahorse XF HS Mini Analyzer	Bios Analytique Ltd	£30,454.80	Purchase of existing leased equipment / Value for money	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-938	28/02/2022	Single Tender Action	Replacement of 2 x Hot Water Heaters	Lorne Stewart	£40,496	Nominated supplier that will be undertaking the larger Talbot Green Infrastructure (TGI) works	Endorsed	No further actions.	First Submission
VEL	Welsh Blood Service	WBS-STA-954	14/12/2021 – 14/12/2023	Single Tender Action	Room hire for Welsh blood collections	Various	£750,000	Business continuity	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-STA-958	01/03/2022 – 28/02/2023	Single Tender Action	Faculty of Medical Leadership & Management (FMLM) both FMLM Affiliation and a bespoke medical leadership programme.	Faculty of Medical Leadership & Management (FMLM)	£41,200	Only provider available that meets the Trust requirements	Endorsed	No further actions.	First Submission

VEL	Velindre Cancer Centre	VCC-STA-967	24/03/2022	Single Tender Action	Purchase of Varian Multi-leaf Collimators (MLC)	Varian Medical Systems	£136,275.52	Sole OEM	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-STA-971	25/03/2022	Single Tender Action	Purchase of a X-ray Tube	Varian Medical Systems	£35,136.39	Sole OEM	Endorsed	No further actions.	First Submission
VEL	Velindre Cancer Centre	VCC-STA-981	04/04/2022 – 03/09/2023	Single Tender Action	Storage of VUNHST records as defined in Section 46 Information Management Records code of Practice 2021	Harwell Restoration	£27,525	Urgent emergency measure	Endorsed	No further actions.	First Submission

Velindre University NHS Trust - Audit Committee Report – May 2022

Appendix 1.2 - Further Matters

Trust	Division	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
VEL	Velindre Cancer Centre	VEL-VCC-FN-118	01/01/2021 – 31/12/2022	File Note	Library Journal Subscription Renewal	Ebsco	£29,000	Initial 2 year contract awarded, paperwork incorrectly only covered year 1, file note to cover second year.	Other	Procurement to ensure initial term contract value is covered in approval.	First time submission
VEL	Velindre Cancer Centre	VEL-VCC-FN-124	01/10/2021 – 30/09/2022	File Note	Resuscitation training and audit services	First response Medical training Ltd	£21,250.00	Due to urgent requirement, service signed contract with supplier without following	Competition not sought in accordance with SFI'S	Procurement to run session with service on SFI's	First Submission

								procurement process.			
VEL	Welsh Blood Service	VEL-WBS-FN-142	28/01/2022 – 27/01/2023	File Note	Offsite Donor Sampling Archiving service	UK Biostores & Services Ltd	£171,022.80	Due to the infected blood inquiry, samples require storage for longer than initially expected. Service requested 12 month extension beyond term to allow adequate time to assess the requirement. Procurement was not able to extend within time to due to staff absences. Contract now extended for 12 months but back dated to 28th January 2022	Extended in excess of SFI allowable limits	Procurement to run a formal Tender exercise.	First Submission
VEL	Velindre Cancer Centre	VEL-VCC-FN-143	01/01/2022 – 30/06/2022	File Note	Contract for the provision of a SACT Compounding and Nursing service VEL/ITT/38356a	Lloyds Pharmacy Clinical Homecare	£325,000	Contract expired 30th December 2021. Due to capacity issues and staff absences in Procurement, there has been a regrettable delay in the new Tendering process. The supplier has continued to	Extended in excess of SFI allowable limits	Procurement to run a formal Tender exercise.	First Submission

								provide the service at the agreed existing rates beyond December 2021, therefore, an extension is required to cover the period 1st January 2022 to 30th June 2022 to allow adequate time to complete the Find a Tender exercise			
VEL	TCS	VEL-VCC-FN-144	15/02/2022 – 17/05/2022	File Note	To provide further technical PM support for the new Velindre Cancer Centre Project.	PB Project Management (Wales) Limited	£8,580	Due to service staff absences, there was a delay in submitting STA.	Extended without appropriate authorisation	No further actions	First Submission
VEL	TCS	VEL-VCC-FN-145	15/02/2022 – 17/05/2022	File Note	To provide further legal support for the New Velindre Cancer Centre	Mills and Reeve	£8,580	Delay in submitting an STA for legal advice sought from Mills and Reeve.	Extended without appropriate authorisation	No further actions	First Submission

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AUDIT COMMITTEE

DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY & HONORARIA (04 OCTOBER 2021 – 19 APRIL 2022)

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Not applicable.	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
nVCC	New Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 In line with the requirements of the Trust Standing Orders and the Trust Standards of behaviour Framework Policy, a report from the Trust register is required to be received by the Audit Committee, which detail any Gifts, Sponsorship, Hospitality & Honoraria activities that have been approved, together with any amendments / additions to the interests that have been declared.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The form in the Standards of Behaviour Framework policy should be used to seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is sent to the Trust Headquarters.

2.2 The appendices include the new entries received for the period **04/10/2021 – 19/04/2022.**

- There has been **5** new entries on the Gifts, Hospitality and Sponsorship Register this period.
- There have been **6** amendments /additions to the Declarations of Interest this period.
- There have been no new entries to the nVCC Project this period.

2.3 The declarations received this period have been completed in accordance with the Standards of Behaviour Framework Policy and authorised by the appropriate Trust Officer.

2.4 All declaration forms are reviewed and checked by the Head of Corporate Governance and any queries addressed prior to entry on the register.

2.4 Please refer to the register for the Declaration of Gifts, Hospitality and Sponsorship included at **Appendix 1** and the Declarations of Interest Register at **Appendix 2**.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Register and Declaration of Interests is the method by which the Trust safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur.

	The Trust must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times.
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)
	Please refer to the detail within the registers at Appendix 1 and 2.

4. RECOMMENDATION

4.1 The report is open to the Audit Committee for **NOTING**.

Appendix 1 – Gifts, Sponsorship, Hospitality and Honoraria Register (Additional Entries: 04/10/2021 – 19/04/2022)

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
17/11/2021	Dr Simon Waters	Consultant	Velindre Cancer Service	Novartis Pharmaceuticals UK Ltd	05/11/2021	UK Breast Cancer Steering Committee Advisory Board - Virtual	Advisory Board meeting	Honorarium - £210	Trust Time	Tax and NI Declaration Form.	Eve Gallop-Evans, Clinical Director	*17/11/2021 *Applicant acknowledged & apologised for retrospective application*	Accepted
17/11/2021	Dr Simon Waters	Consultant	Velindre Cancer Service	Novartis Pharmaceuticals UK Ltd	23/11/2021	Evening Meeting (6-9pm): Post ESMO review, Village Hotel, Whitchurch and virtual platform	Post ESMO review,	Honorarium - £917	Own Time	Tax and NI Declaration Form.	Eve Gallop-Evans, Clinical Director	17/11/2021	Accepted
17/11/2021	Dr Simon Waters	Consultant	Velindre Cancer Service	Novartis Pharmaceuticals UK Ltd	26/11/2021	UK Breast Cancer Steering Committee Advisory Board - Virtual	Advisory Board meeting	Honorarium - £1155	Own Time: Annual Leave	Tax and NI Declaration Form.	Eve Gallop-Evans, Clinical Director	17/11/2021	Accepted
14/03/2022	Cath O'Brien	Chief Operating Officer	Corporate	Tom Pugh Williams TPW Consulting	N/A - declined	Invitation to a staff Christmas party, which was declined. This included food and Travel Lodge accommodation.	Hospitality Offer	Hospitality – Accommodation: £60 Meals / Refreshments: £50	Trust Time	N/A	N/A	N/A	Declined

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
05/04/2022	Dr Simon Waters	Consultant	Velindre Cancer Service	Daiichi Sankyo UK Ltd,	07/04/2022	Daiichi Sankyo UK Ltd, Virtual - UK Advisory Board	Advisory Board meeting	Honorarium - £900	Trust Time	Tax and NI Declaration Form.	Eve Gallop-Evans, Clinical Director	05/04/2022	Accepted

Appendix 2 – Trust Declarations of Interest Register (Amendments / Additional Entries: 04/10/2021 – 19/04/2022)

Date Entry Received for Register	Name	Designation	Division	Details
15/10/2021	Bethan Tranter	Chief Pharmacist	Velindre Cancer Service	• Interest in Companies and Securities: Spouse owns Crest Ceilings and Partitions Ltd - Over 30 Years • Personal or Departmental Sponsorship: Personal - No personal involvement. Current joint working arrangement with Ipsen Pharmaceuticals at Departmental level.
08/11/2021	Professor Donna Mead OBE	Chair of Velindre University NHS Trust	Corporate	• Member of the external advisor board to the Wellcome funded GW4-CAT PhD Programme for Health Professionals. This is a £7million fund to support 5 fellows (intakes 2022-2027). • No longer a Governor of Neath Port Talbot College Group.
04/04/2022	Chris Moreton	Deputy Director of Finance	Corporate	• Trustee and Director: Cynnal Cymru – Sustain Wales - Nov-21 to current - No Financial Transactions or Benefits in Kind
04/04/2022	Vicky Morris	Independent Member	Corporate	• Local Authority School Governor- St Mary's RC Primary School, Newtown, Powys - February 2022 to date
06/04/2022	Professor Andrew Westwell	Independent Member	Corporate	• Scientific Advisory Board member for Prostate Cancer UK (review and decisions on competitive grant applications) - 2017 - present (Non-remunerated)
14/04/2022	Dr Susan Myles	Director of Health Technology Wales	Host	• Nil Interests (re-confirmed)

nVCC Project – Declarations of Interest Register: Nil interests received during the reporting period.

AUDIT COMMITTEE

ISO14001:2015 – EXTERNAL AUDIT

DATE OF MEETING	03.05.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rhiannon Freshney, Environmental Development Officer
PRESENTED BY	Rhiannon Freshney, Environmental Development Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Cyenfin	27.02.2022	NOTED
SLT WBS	09.02.2022	NOTED
SLT VCC	FEBRUARY 2022	NOTED
EMB	MARCH 2022	NOTED

ACRONYMS

EMS	Environmental Management System

1. SITUATION/BACKGROUND

1.1 Welsh Government sets a requirement for all NHS bodies to be credited by the ISO14001:2015 standard, an environmental management system. Velindre University NHS Trust has successfully obtained the ISO 14001:2015 standard for the last five years for all sites.

1.2 The purpose of the annual audit is to evaluate the Trusts conformity with the standard. The Trusts current ISO14001:2015 was due to expire on the 16th December 2021. Following the assessment, the Trust successfully obtained recertification.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Normally, the audit would be held onsite, however, due to the pandemic, it was held virtually. The five day audit was split between November and December.

2.2 Each year, a different selection of sites are chosen to be reviewed. As the audit was a recertification rather than a surveillance audit, more sites were under the scope of audit.

2.3 The following sites were under review -

- Velindre NHS Trust Headquarters (1 day)
- Velindre Cancer Centre (2 days)
- Welsh Blood Service Talbot Green (1 day)
- Welsh Blood Service, Pembroke House (half a day)
- Welsh Blood Service, Unit 30, Llandegai Industrial Estate (half a day)

2.4 The Trust received no non conformities raised. Following ratification from BM Trada, the auditing body, the formal report has been received (Appendix 1).

2.5 The auditor noted;

"The organisation have continued to maintain an effective Environmental Management System which is proactive in maintaining compliance with evolving processes to meet and exceed requirements set by regulators and governmental requirement. A plethora of information was discussed and evidenced by functional levels of the Management Team which was wholly delivered by an enthusiastic and competent personnel."

2.6 Once the updated certificate is received, it will be displayed on all Trust sites that are included under the scope.

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)
	There is an annual fee for accreditation.

4. RECOMMENDATION

4.1 The Audit Committee are asked to **NOTE** the recertification audit of the ISO14001:2015 audit.

Management Systems Certification Audit Report for:

Velindre University NHS Trust.

Client address:	Velindre NHS Trust Headquarters, Nantgarw, CF15 7QZ.
Certificate Number	EMS - 2578, expires 16 December 2021
Report author:	William Lemon
Report issue date:	3 December 2021
Date(s) of next audit:	TBC

Number of major NCRs issued at this audit:	0	Number of minor NCRs issued at this audit:	0

Note: As a result of this audit the client is to be issued with a new / revised certificate. Please refer to the section 'Confirmation of Certificate details' towards the back of this report for the certificate details to be specified on the certificate of registration.

Audit & Company Information

Audit Criteria

ISO 9001:2015 ☐	ISO 14001:2015 ☑	(BS) OHSAS 18001:2007 ☐	ISO 22301:2014 ☐
ISO 50001:2011 ☐		SSIP ☐	ISO 27001:2013 ☐
ISO 50001:2018 ☐	ISO 44001:2017 ☐	ISO 45001:2018 ☐	NHSS ☐

Audit Information

Audit Type:

Surveillance ☐	Recertification ☑	Scope Extension / Special Audit ☐	
ISO 50001:2018 Transition ☐	ISO 45001:2018 Migration ☐		
Onsite / Remote Audit:	On-site audit ☐	Remote Audit (Covid-19) ☑	
Integrated / Combined / Single system?	Integrated systems audit (IMS) ☐	Combined systems audit ☐	Not applicable (single standard / system) ☑
Audit conducted at?	Central Office (multi-site certification) ☑	Participating / Temporary Site Multi-site certification) ☑	Single Site Certification ☐

The audit deviated from the audit plan? (if yes please provide further details in the auditor comments and conclusions field in the executive summary)	No
The organisation outsources activities / functions / processes included in the scope of certification?	Yes

Covid-19 Remote Audit Feedback

Client representative who facilitated this remote audit:	Rhiannon Freshney.

Remote Platform(s) / Technology used to facilitate the audit:	• ICT for document sharing: **Emails & MS Teams.** • ICT for staff interviews: **MS Teams.** • ICT for site tours: **MS Teams.** • ICT for process and operational control evaluation: **MS Teams.**
Details of any technological issues which precluded the sharing of essential information by electronic means:	Nil
Details of any special security or confidentiality issues which precluded the sharing of essential information by electronic means?	Nil
Details of any part(s) of the audit that could not be completed remotely as planned for example any processes, standard requirements not evaluated temporary site activities not audited:	Nil
As a result of this remote audit is there any further action required by BM TRADA?	Nil

Sites Audited and Audit Dates

+ -

Site Address Audited	Audit date(s)
Remote Audit - Velindre NHS Trust Headquarters, Nantgarw, CF15 7QZ.	23 Nov 2021
Remote Audit - Velindre Cancer Centre, Whitchurch, Cardiff, CF14 2TL.	24 Nov 2021
Remote Audit - Velindre Cancer Centre, Whitchurch, Cardiff, CF14 2TL.	25 Nov 2021
Remote Audit - Welsh Blood Service Headquarters, Talbot Green, CF72 9WB.	26 Nov 2021
Remote Audit - Welsh Blood Service, Pembroke House, Wrexham, LL137YT.	3 Dec 2021
Remote Audit - Welsh Blood Service, Unit 30, Llandegai Industrial Estate. Bangor, LL574YH	3 Dec 2021

Audit Attendees

Name	Role
William Lemon	Lead Auditor

Company Information

Contact Person:	Rhiannon Freshney	Contact telephone number:	+44 (0)29 2031 6296
Contact email address:	rhiannon.freshney@wales.nhs.uk		
Total number of employees:	1266	Total number of sites included in the scope of certification:	6
Number of shifts operated by the organisation:	2		

Please provide a brief summary below of the activities conducted by the organisation and site specific conditions seen at the sites audited and as required any further details regarding employee numbers, shifts, sites etc.

The Velindre NHS Trust was established in 1994 as a specialist provider of cancer services in Wales. It operates the Velindre Cancer Centre and the Welsh Blood Service. The organisation provides non-surgical treatment of cancer, including non-surgical clinical, laboratory and office based support and the provision of Welsh Blood Transfusion Services, with a staffing level of approximately 1266 personnel.
The Trust is operated from its HQ based at Nantgarw, CF15 7QZ, and the Velindre Cancer Centre, Whitchurch, Cardiff, CF14 2TL, whilst the Welsh Blood Transfusion Services are located at their HQ based at Talbot Green, with several satellite offices throughout North and South Wales.

Scope of Certification

The provision of non-surgical treatment of cancer including non-surgical clinical, laboratory and office based support. Provision of Welsh Blood Transfusion Services.

Details of any Changes to the Client Organisation

Have any of the client organisation details changed since the last audit? (e.g. Name, address, employee numbers, sites)?	Yes
Has the clients scope of certification above changed since the last audit?	No

Does the client require a new certificate as a result of this audit and/or changes? (If yes please ensure that you complete the confirmation of certificate details section reflecting the new certificate details)	Yes

If yes please specify details of all changes below

Minor drop in staffing numbers.

Updated certificate should be issued upon a successful audit report reviewed by the BM TRADA Technical Team.

Confirmation of Changes Required to Future Audits / Audit Programme

Do future audits for this client need amending / adjusting based upon: • any new / changes to production / service activities conducted at temporary locations? • any seasonal activities operated by the client for example laying of asphalt, agricultural activities? • changes to the clients determined IS security controls? - **ISO 27001 only** • other reason(s) not listed above?	No

If yes please specify details below and ensure that the audit programme is updated accordingly

No.

Areas for consideration to be covered during the next audit

Please specify and specific processes, activities, departments, specific sites temporary or fixed, specific requirements, and/or outstanding issues that must be assessed during the next audit.

As detailed within the audit plan.

Following the recertification audit planning review results, confirm below any trends, focus areas of the organisation, areas of significant change that were specifically covered during the recertification audit

No specific trends identifed.

Executive Summary

Nonconformities identified at this Audit

Number	NCR Type	Standard(s)	Area NCR identified (process / department)

Opportunities for Improvement

1. It may benefit the organisation to more specifically record the dates identifed for areas of improvement in order to ensure that set KPI's are met.

Status of any Previous Audit Findings

Are there any outstanding nonconformities identified and issued at previous audit(s) for follow up and verification and closure at this audit?	No

Audit Summary and Conclusions

The audit objectives have been fulfilled?	Yes
The clients management system documented information demonstrates conformity with the requirements of the applicable standard(s), and supports implementation of the management system?	Yes
The audit evidence demonstrates that the organisation continues to implement a **environmental management system** which is consistent with the environmental policy and have demonstrated their ability to enhance environmental performance, fulfil applicable compliance obligations and have established, communicated, planned and monitor actions to achieve environmental objectives	Yes
All major and minor nonconformities from all previous audits in this certification cycle have been verified and closed?	Yes
The recertification audit has confirmed the continued conformity and effectiveness of the organisations management system as a whole, and continued relevance and applicability for the scope of certification	Yes
Over the most recent certification cycle the organisation has demonstrated commitment to maintain the effectiveness and improvement of the management system in order to enhance overall performance?	Yes

Over the most recent certification cycle the organisations management system has been effective with regard to achieving their objectives and the intended results of the respective management system?	Yes

Auditor comments and conclusions

The organisation have continued to maintain an effective Environmental Management System which is proactive in maintaining compliance with evolving processes to meet and exceed requirements set by regulators and governmental requirement. A plethora of information was discussed and evidenced by functional levels of the Management Team which was wholly delivered by an enthusiastic and competent personnel.

The EMS evidenced commitments to Environmental processes upon service delivery through environmental hazard reduction measures and ongoing pollution prevention, demonstrating conformity with the requirements of the audit Standard and provided sufficient structure to support the implementation and maintenance of the Management System.

Key objectives and targets were evidenced to be regularly reviewed for progress and performance overseen by steering groups attended by the leadership team.

Compliance with legal obligations was evidenced through both Environmental Aspects and Legal Compliance Registers.

A solid internal performance evaluation process through departmental inspections and audits with the Management Review Process being assessed to be effective and the main organisational analytical performance and communication tool, with the internal and site-based audits & inspections ensuring that commitment to the Management System was being maintained and communicated through the senior leadership team.

The organisation are recommended for recertification to ISO14001:2015.

Surveillance / Recertification Recommendation

Based upon the results of this audit and objective evidence seen to substantiate the level of implementation of the management system, the auditor / audit team:

Recommends Continued Certification - No Nonconformities Raised

Audit Findings

Persons Interviewed

In the field below please confirm the persons interviewed during this audit.

Note: For OHSMS audits the audit team shall interview the following personnel:

a) the management with legal responsibility for Occupational Health and Safety,
b) employees' representative(s) with responsibility for Occupational Health and Safety,
c) personnel responsible for monitoring employees' health, for example, doctors and nurses. Justifications in case of interviews conducted remotely shall be recorded,
d) managers and permanent and temporary employees.

These people shall be clearly indicated in the field below.

Environmental Development Officer.
Welsh Blood Service Quality Assurance Officer.
Velindre Corporate Estates Manager.
Operational Services Compliance Manager.
Asst Director of Estates.
Industrial Placement Student.
Trust Fire Safety Advisor.

Covid-19 Management System Impact Assessment

Is the organisation functioning normally? If **no** confirm after Covid-19 related restrictions are lifted - how soon would the organisation be able to operate reasonably as normal?	Yes
Is the organisation manufacturing / shipping product / performing all services defined within the scope of certification? If **no** provide details.	Yes
Has the organisation been required to use alternative manufacturing and/or distribution sites? If **yes** please provide details and confirm that these sites are covered under the current certification?	No
Does existing client inventory still meet customer specification or has the certified client contacted its customers regarding possible concessions. Please provide details:	Yes
Has some of the processes and/or services performed been subcontracted to other organisations? If **yes** please provide details including a summary of how the other organisations activities are controlled by the certified client.	No

Has the client conducted any impact assessment related to Covid-19?	Yes ✔	No ☐

Did the audit identify any significant risks to maintenance of certification? If **yes** provide details	No
To what extent has implementation and maintenance of the management system been affected by the pandemic?	To some extent
Please confirm any elements of the clients management system that have not been maintained during the pandemic (if applicable):	None
Is evidence available to demonstrate that the management system been effectively maintained throughout the pandemic?	Yes
If the certified organisation is certified to a management system that requires a disaster recovery or emergency response plan (e.g. ISO 27001)/ If **yes** has the organisation implemented the plan and was it effective?	No
Does the certified organisation have any equipment that requires calibration? If **yes** provide details of the equipment and evidence to demonstrate that the equipment been calibrated in accordance with requirements or if any permitted extensions have been granted or if the equipment has been taken out of use*	No

Details of accidents / incidents, regulatory investigations and prosecutions (environmental / health & safety / information security as applicable)

Important: Please remind the client that they are to inform BM TRADA, without delay, of the occurrence of a serious incident or breach of regulation necessitating the involvement of the competent regulatory authority.

Has the organisation had any environmental / health & safety / information security reportable accidents / incidents that have occurred in the previous 12 month period?	No
Has the organisation had any environmental / health & safety / information security regulatory visits that have occurred in the previous 12 month period?	No
Has the organisation got any environmental / health & safety / information security investigations or prosecutions that are pending or outstanding?	No

Summary of any accidents / investigations / regulatory visits in the previous 12 months and/or prosecutions that are pending or outstanding

No areas of concern discussed or evidenced during the five days of assessment.

Multi-site Certification - Central Office Requirements

In accordance with implemented systems the Central Office continues to effectively communicate and distribute management system, legal and other requirements, procedures and related controls to all sites included in the scope of certification?	Yes
The Central Office has provided ongoing training to all sites included in the scope of certification to ensure that the site personnel are competent with regards to the applicable management system, legal and other requirements?	Yes
All sites included in the scope of certification have been audited by the central office in accordance with the requirements of the applicable management system standard?	Yes
If this audit is a ISO 9001 / ISO 14001 Transition / ISO 45001 Migration audit, is evidence available to demonstrate that the Central Office has implemented new / revised requirements across all sites included in the scope of certification?	Yes

Multi-site Central Office Requirements - Audit trails, findings, comments and conclusions and evidence seen to demonstrate that the relevant management system requirements has/continues to be communicated and implemented across all sites included in the scope of certification

Multi-site locations have full access to the organisations Documented Management System via their intra-net portal. All updated documentation is stored within this and therefore directly communicated to all users. Training is co-ordinated through the central office, with several personnel training records viewed and found to be competent. All locations detailed on the certification have been assessed over the audit cycle, with sampling of records evidencing that the transitional requirements are operational throughout these locations.

Outsourcing

List of all outsourced activities / services

Previously Facility Management was contracted out to a Facility Management organisation, which is now under controlled migration to VCC/WBS/VHQ who have an in-house Facility Management Team and will facilitate all maintenance and refurbishment activities.
Waste Management - All streams, Air Conditioning, Gas Boiler Servicing and mechanical aspects of work and HV Maintenance - many of these are sourced through the NHS Procurement framework whilst others are tendered, mainly smaller contracts.

The organisation has determined **and** implemented the type and extent of controls to be applied to subcontractors in order to ensure that the externally provided functions or processes do not adversely affect the effectiveness of the management system(s), legal and other requirements? (e.g. the organisation's ability to consistently deliver conforming products and services to its customers or to control its environmental aspects / OH&S risks and commitments to compliance with legal requirements)	Yes

Outsourced Activities - Audit trails, findings, comments and conclusions

All external suppliers and contractors were shown to be controlled through higher level Management, where performance

management was assessed at regular intervals.

Context of the Organisation	
The organisation continues to determine the external and internal issues that are relevant to its purpose and that affect its ability to achieve the intended result(s) of its relevant management system(s)?	Yes
The organisation continues to determine the interested parties relevant to the relevant management system(s) and the requirements of these interested parties including those that are compliance obligations?	Yes
The organisations scope continues to be established and documented and is based upon the boundaries and applicability of the relevant management system(s)?	Yes

Context - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates, Industrial Placement Student.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
NHS Trust Policy Statement - Signed by General Manager.
WBS Environmental Policy Statement - Signed by Interim Director of Welsh Blood.
VHQ Environmental Policy Statement - Signed by CEO.

The Asst Director of Estates discussed his recent appointment into the position as Asst Director of Estates and the influence his role has in assurance of regulatory compliance (Future Generations Act), setting strategy for a Green Agenda and working with functional levels of management in reaching set goals within the NHS Trust.
The Asst Director of Estates and the team further discussed recently acquired Governmental Grants and the ongoing design and construction of the new Velindre Cancer Centre (nVVC), the environmental management systems for VCC & WBS with oversight from VHQ with roles and responsibilities elaborated by members of the team. The Trust Agile Working Policy was discussed with benefits within this process enabling further emissions impact reduction with staff working from home and energy reduction from offices. Further discussing travel plans for WBS nursing staff for blood collection and liaison with local transport links for the nVCC for future access and greater emission reduction, the Management Team gave an in-depth account of ongoing Steering Groups and progress made.
The Velindre Corporate Estates Manager further discussed future travel plans, hubs and the strategy of a future working environment for the nVCC with current enabling works such as ground testing and bush and shrubs removal, with scheduled doors of the hospital opening for 2025. Ongoing community liaison was further discussed by the Environmental Development Officer.

Objectives and targets of the Trust were linked with current risks, legal obligations and improvement programmes for existing locations with a conscious focus on refurbishment of the existing VCC without overspending on a future redundant asset. Ongoing improvements included upgrades to BMS, LED Lighting and Motion Sensors at several locations embracing investment in technology enabling greater efficiency and greater impact reduction measures.

Electric Vehicles (EV's) were discussed by several members of the team with infrastructure being the main restriction, additionally, range of vehicles, battery charging and facilities with a scoping report for fleet management and what this will look like in the next five years.

Communication of key documents and changes to the EMS, Objectives & Targets, Policy, Aspects are regularly emailed to all Trust Staff with documents retained within software and the Trust Intranet for all staff to peruse.

Interested Parties Identification with their needs and expectations and associated compliance obligations were identified within the Environmental Manual which included: Independent Members, Chief Executive (Top Management), Senior Managers (Top Management), Trust / Divisional Employees, Contractors, Patients / Donors / Visitors, Welsh Government, UK Government, Government Agencies (e.g., Medicines and Healthcare products Regulatory Agency - MHRA, Natural Resource Wales - Radiation Regulations), External Auditing Bodies, Welsh Audit Office and Future Generations Commissioner. Needs and expectations of several of these parties were discussed with the team which included the Future Generations Commissioner, Chief Executive, Senior Managers, Trust Employees, Contractors, Patients / Donors / Visitors, Welsh Government, with examples of information communicated and outcomes relayed.

The three Policy Statements were discussed and reviewed, recording the organisations commitment to compliance obligations, pollution prevention & controls with objectives evidenced discussed and presented throughout the assessment substantiating commitment statements. The documents are displayed on local noticeboards and communicated during regular meetings and inductions for all NHS Trust Staff.

The Management Team discussed current and future projects for VCC - New Cancer Hospital and WBS - Upgrade of Talbot Greens and satellite offices, additionally how the organisation intend to meet regulatory obligations such as Future Generation Act (Wales) and whilst employing various initiatives within their Sustainability Strategy, which included; Achieving Carbon Net Zero, Minimise use of Resources, Connecting with Nature, Creating Value within the Community and Maximising Potential of Workforce.

Scope of certification remains unchanged and reviewed for adequacy during the assessment: The provision of non-surgical treatment of cancer including non-surgical clinical, laboratory and office based support. Provision of Welsh Blood Transfusion Services.

The structure of the EMS remains unchanged other than updates to processes and registers, with an overarching manual setting out how the organisation have established, implemented and maintained their Management System. The Manual describes the Environmental Management System has been established to manage the performance and control risks associated with the organisations activities, as well as demonstrating their ability to consistently provide services that meet regulatory requirements. The framework provided by the EMS will also help to achieve continual improvement with the Manual and the various Operational Procedures detailing the interactions of the organisations Management System that covers areas; Planning, Management Commitment, Operations, Support and Evaluation. Objectives and Targets directed the Company improvement processes while ongoing monitoring and measurement of performance identified weaknesses in the systems while their KPI's set the targets for the company performance.

Leadership

Top management continue to take accountability for the effectiveness of the management system and demonstrate ongoing, effective leadership in the continual improvement of the system by (but not limited to): - Communicating responsibilities and authorities for relevant roles within the organisation for ensuring that the management system confirms to the requirements of the applicable standard(s) and reporting on the performance of the management system to top management, - Communicating and periodically reviewing the organisations policy for its suitability, adequacy and effectiveness?	Yes
As required by the standard(s), customer requirements, applicable statutory and regulatory requirements continue to be determined and communicated throughout the organisation?	Yes
The policy continues to include a commitment to fulfil its compliance obligations and includes a commitment to the protection of the environment, including the prevention of pollution? (ISO 14001)	Yes

Leadership - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Asst Director of Estates.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
NHS Trust Policy Statement - Signed by General Manager.
WBS Environmental Policy Statement - Signed by Interim Director of Welsh Blood.
VHQ Environmental Policy Statement - Signed by CEO.
Environmental and Sustainability Steering Group Meeting Minutes and Powerpoint.
Steering Group Meeting Minutes, dated 30 Sept 2021 - Cynefin.

Several key personnel gave an overview of their roles, including areas which go beyond the requirements of their position. Discussing leadership activities, how Management oversight of the EMS included monthly Steering Group meetings and performance evaluation meetings, internal audits and inspections ensuring maintenance of KPI's, ongoing CPD & awareness of staff employees and pop-up activity meetings on environmental initiatives.

The Environmental Policy Statements for all main sites were discussed and reviewed with the Management Team detailing each of the Commitment Statements and initiatives and controls implemented. The Statements recorded commitments to pollution prevention, compliance with legislation, engagement with interested parties, achieving net carbon zero and competency, awareness and leadership in maintaining ISO14001:2015. The documents continue to be displayed on noticeboards, intranet and detailed within the induction process and environmental awareness programmes, and written in both Welsh and English. The Management Team further discussed ongoing reviews and updates of these documents to ensure suitability, adequacy and effectiveness. Several Steering Groups drive the organisations compliance and improvement programmes with functional levels of the management team in attendance.

Risks and Opportunities, Legal & Other Requirements	
The organisation has determined and assessed the risks and opportunities that are relevant to the intended outcomes of the management system(s) associated to any changes in the organisation, its processes or the management system. In the case of any planned changes this assessment has been undertaken before the change was implemented?	Yes
The organisation identifies, has access to up to date and periodically reviews all the specific applicable compliance obligations (legal and other requirements) and determines how requirements apply to the organisation?	Yes
The organisation continues to plan actions to address risks and opportunities and if applicable how to address legal and other requirements and to prepare for and respond to emergency situations as applicable)	Yes
Documented information is available relating to: - Risks and opportunities, - The processes and actions needed to determine and address risks and opportunities, - Compliance obligations (legal and other requirements) including the results and actions taken (including ensuring it is updated to reflect any changes)?	Yes

Planning - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates, Industrial Placement Student.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.

VCC Master Compliance Register.
TRUSTENV 01 Identification of Environmental Aspects Register.
TRUSTWENV 01 Evaluating Environmental Aspects.
TRUSTENV 02 Managing Legal Compliance.
Trust Environmental Aspects Register, Version 8, dated 20/08/2021.
Trust Environmental Legal Register, Version 8, dated 29/08/2021.
PPM Schedule.
Minutes of Steering Group Meetings.
Objectives & Targets 2021 - 2022 & Strategic Improvements.

Sufficient planning documentation was discussed and evidenced with the document recording applicable regulatory obligations and the implementation of control measures. The documents recorded regular reviews and updates with a full understanding discussed by the team.
Areas of environmental risk were identified within the aspects register and risk rated for significance and control and further detailed within this report. Additional areas of environmental opportunity and improvement were evidenced which included the organisations objectives, targets and improvement programmes. Steering group meeting attended by functional levels of management discussed and planned how to maximise, implement and exploit these areas of improvement through the use of modern technology of biodiversity within VCC, WBS and NHS Trust properties. Examples of these areas are included within the Objectives and Targets:
Energy
Annual Target: Reduce energy emissions per m2 by at least 4%
Long-Term: Reduce energy emissions per m2 by at least 100% by 2030, with interim targets set at 50% by 2025 and 60% by 2027 (against baseline year 2017-18).
Implementation of LED Lighting, lighting senors as part of ongoing refurbishment through the Trust Premises, additionally energy systems installed within the nVCC Hospital projected for completion late 2025.

Environmental Aspects and Impacts - ISO 14001

Considering a life cycle perspective, and within the scope of the EMS, the organisation continues to determine the environmental aspects of their activities, products and services that they can control and influence, and their associated environmental impacts?	Yes
The organisation maintains documented information on its environmental aspects and impacts, the criteria used to determine its significant aspects and its significant aspects?	Yes

Environmental Aspects - Audit trails, findings, comments and conclusions

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates, Industrial Placement Student.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
TRUSTENV 01 Identification of Environmental Aspects Register.
TRUSTWENV 01 Evaluating Environmental Aspects.
TRUSTENV 02 Managing Legal Compliance.
Trust Environmental Aspects Register, Version 8, dated 20/08/2021.
Trust Environmental Legal Register, Version 8, dated 29/08/2021.
PPM Schedule.
Maintenance Certificates, Waste Transit/Consignment Notes.
Training Certificates.

The organisation have continued to review their existing environmental risks, with consideration for influencing and controlling recorded within the Register. The document was discussed with the Management Teams who further elaborated the scoring criteria for the identification of significant aspects with controls for risk reduction forming part of the objectives and targets with compliance measures recorded within the Legal Register also detailed within the Register.

Supporting documentation such as PPM Schedules, maintenance records and training certification were additionally reviewed which evidenced controls being maintained.

Significant Aspects were discussed for all locations with the smaller outlying WBS sites maintaining a higher emissions to air category due to transportation to centralised areas for blood collection and re-supply to sites. Additionally, an increase in personal transport affected by C19 controls in maintaining safe distances with staff now minimising shared transport. A minor increase in energy usage for the Wrexham site due to additional refrigeration units for the storage or blood and vaccines. The rationalising of increasing risk rating scores within the Aspects Register were discussed evidencing a solid understanding of ongoing analysis of situational circumstance.

Several Significant Aspects recorded included - Use of Electricity, Use of Gas, use of Water, Transportation, Oils Leaks/Gas explosion, Fire, Flood and Spillage of Harmful Substance all showing a risk rating of = or >60.

Aspect No A36 - Use of boilers - Release of flue gas emissions from boilers - Resource depletion, air emissions, contribution to climate change. PPM Schedule evidenced the FM Estates Team completing ongoing servicing of boilers with documentation reviewed.
The process of identifying, influencing and controlling operational aspects continues to be maintained and remains effective.

Objectives

The organisation continues to establish measurable objectives at relevant functions, levels and processes as required by the applicable management system standard(s), which are consistent with the policy, monitored and communicated? ?	Yes
Objectives are being / have been achieved and results evaluated, according to the documented action plans (i.e.what will be done, resources required, responsibilities, time scales and evaluation of results)?	Yes

Objectives - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates, Industrial Placement Student.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
Objectives & Targets - 2021.
Velindre University NHS Trust Sustainability Performance Results.
Velindre University NHS Trust Sustainability Report.
Trust Sustainability Key Performance Indicators.
NHS Trust Policy Statement - Signed by General Manager.
WBS Environmental Policy Statement - Signed by Interim Director of Welsh Blood.
VHQ Environmental Policy Statement - Signed by CEO.

The Senior Management Team discussed the current organisation environmental objectives elaborating on the functional level targets and performance measurement criteria. Several of the objectives continue to be linked with regional legislative and NHS Trust targets for environmental performance and improvements.
The Environmental Policy Commitment Statements were aligned with objectives for mitigation of identifed significant aspects / impacts & risks and exploitation of improvements programmes.
Key areas for objectives and environmental performance included; Achieving Net Carbon Neutral, Minimising use of Resources, Connecting with Nature, Creating Value with Communities and Maximising potential of Workforce.

Travel & Transport
Annual: Reduce the number of single occupancy car journeys made by staff by 5%
Long-Term: Reduce the number of single occupancy car journeys made by staff by 20% over the next 5 years (against baseline determined by the Trust Travel Survey).

Waste
Annual: Recycling waste per m2 by at least 70%
Long-Term: Recycling waste per m2 by at least 80% by 2025, with `Zero waste' being achieved (eliminating residual waste and reusing or recycling all waste) by 2030 (against baseline year 2017-18).

Energy
Annual Target: Reduce energy emissions per m2 by at least 4%
Long-Term: Reduce energy emissions per m2 by at least 100% by 2030, with interim targets set at 50% by 2025 and 60% by 2027 (against baseline year 2017-18).

Water Consumption
Annual Target: Reduce water consumption per m2 by at least 2%
Long Term: Reduce water consumption per m2 by at least 30% by 2025 (against baseline year 2017-18).

Certification
Annual: Target: Attain and maintain Trust certification to ISO14001: 2015 Standard.

Training
Annual: 90% compliance with Environmental Awareness Training needs analysis (against baseline year 2018-19) by 2022.

Biodiversity
Annual: Achieve the recommendations from the external biodiversity assessment.

The Management Team discussed the implementation of the objectives and targets, reiterating departmental ownership, set time frames for completion and KPI's for establishing success of initiatives. Where statistical analysis could not be measured, outcomes of refurbishment and completion of the objectives were the measurability of success, such as, the maintenance of the ISO14001 certification and implementation of biodiversity initiatives at all facilities.

Improvement Programmes - Several organisational pledges were discussed by the Environmental Development Officer, which included Pedaling to work, Plastic Free, Litter Free and enhancing Biodiversity.
Bio-diversity - Maintenance Programme within VCC - reduction in mowing, reseeding of wildflower meadows for the attraction of local flora, insects and pollinators, although restricted in circumstances to avoid contact with immunosuppressed patients.

Competence, Awareness and Training

The organisation continues to determine and provide the knowledge, resources, infrastructure and environment needed for the establishment, implementation, maintenance and continual improvement of the relevant management system(s)	Yes
The organisation continues to determine the necessary competence (knowledge and skills) of person(s) doing work under its control that affects the performance and effectiveness of the management system and ensures that the persons doing work under its control are competent on the basis of appropriate education, training or experience?	Yes
Persons doing work under the organisations control (workers) are aware of the policy and their contribution to the effectiveness of the management system(s), including the benefits of improved performance and the implications of not conforming with the relevant management system requirements?	Yes

Competence, Awareness and Training - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates and Industrial Placement Student.
Documents Reviewed:

Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
TRUSTENV 04 Training and Awareness.
Environmental Awareness Training PowerPoints.
Training Records & Attendance Registers.
Spill Kit Training - VCC & WBS Drivers
ESR Training Records - Various Personnel.
Noticeboards, Internal Posters & Intra-net Environmental Awareness Campaigns.

Maintenance of mandatory training requirements was evidenced with KPI's for completion set annually for all employees linked with performance reviews.
Training completion continues to be reviewed and discussed within the Management Review Meetings, the Minutes of which recorded a below expectation due to personnel being re-deployed to essential services and isolation of staff with no access to training platforms external to the NHS Trust network.
Induction training continues to introduce the organisational commitments to Environmental Management as recorded within the Policy Statements, with ongoing annual awareness training also being completed. Sampled ECR Training Profiles, records and attendance registers were reviewed.

Induction training for several new Porters were evidence, the induction process included environmental awareness:
- dated April 2021.

Letter of Appointment - Radiation Protection Officer -, Principal Physicist - dated 29/07/20219. Certificates of core competencies dated Nov 21 for appointed Radiation Protection Advisors.

Communication and Documented Information

The organisations communication needs and methods continue to be identified, implemented and maintained effectively in accordance with the relevant management system requirements?	Yes
The organisation continues to communicate significant environmental aspects / health and safety hazards and related control measures among the various levels and functions of the organisation? (ISO14001/ OHSAS18001/ISO 45001)	Yes
The organisation continues to maintain sufficiently controlled documentation as required by the relevant standard(s) requirements as determined necessary by the organisation?	Yes
Documented information (including documents of external origin) is available, adequately protected, distributed, stored, retained and under change control as required by the management system standard(s) and the organisation?	Yes

Communications and Documented Information - Audit findings and supporting evidence seen

Interview: Environmental Development Officer. Documents
Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
TRUSTENV 03 Communications.
Minutes of Meetings.
ISO14001:2015 - Green Team Date - 05.07.21 Trust HQ - CEO Office
Powerpoint Presentations.
TRUSTENV 05 Document Control.
Policies - VCC & WBS.
Software Systems - Intranet.
IT Server.

Communications within the organisation was evidenced to be of a high standard with several Steering Groups directing

initiatives for the betterment of the EMS and operational requirements. Sampled Steering Group Meeting were reviewed which included Environmental and Sustainability Steering Group Meeting Minutes and PowerPoint and Steering Group Meeting Minutes, dated 30 Sept 2021 - Cynefin. The Minutes of the meeting included action points and plans from previous meetings - Action Plan as at 24th June 2021 which included Action 46 - Management of contractors, Action Point 74 - Fire Warden Training, Action Point 84 - Water Safety Training, Action Point 91 - PPM for Contractors for next 12 months, Action Point 92 - Fridge/Freezer Maintenance and Action Point 93 - Flushing Usage and Evaluation.
The Trust continue to utilise emails, posters, flyers on noticeboards which continue to display relevant and informative information through infographics which are designed to inform and encourage all employees in the participation of ongoing NHS Trust's Environmental Initiatives.

The organisation continues to store its Documented Management System on the organisations server with access controls established for the control of documentation. Additionally, information can also be accessed by all personnel to be reviewed via the Intranet although documentation updates remain controlled. The EMS remains tiered level with the overarching Manual, Policies, Procedures, and Work Instructions, RA's, and Registers with evidence backed up within files and records. The Manual and Procedures reflected the organisations operations regarding Environmental Management, although connected with Quality and H&S in areas of operation where similar risks and controls managed. Documents were shown to be version controlled by issue number, date, and authorisation. Amendment history was detailed within the Documents Manual and Procedures.
The detailed list of operating procedures to cover all aspects of operations was reviewed within the Manual with examples of documentation recorded throughout this report. Policies and posters continue to be developed in Welsh and English with all employees within the Trust having a good standard of understanding of the written and spoken English language.

Emergency Preparedness and Response - ISO 14001 / (BS) OHSAS 18001 / ISO 45001

Process(es) needed to prepare for and respond to potential emergency situations (including the provision of first aid - ISO 45001) continue to be implemented by the organisation?	Yes
Emergency plans and response actions have been periodically tested, reviewed and revised if necessary, in particular after the occurrence of emergency situations and after tests?	Yes
Interested parties (e.g. contractors, visitors, emergency services, government authorities, local community as appropriate) are made aware of relevant arrangements (and where necessary trained if they are required to participate in the emergency response)?	Yes
Workers are informed of their duties and responsibilities in emergency situations?	Yes
Documented information is maintained and retained on the emergency response process and plans for responding to potential emergency situations?	Yes

Note: Discrepancy found during the audit of the emergency plans or any incident which occurred during an emergency or drill has to be considered as a nonconformity in the system, and appropriate corrective actions have to be taken in order to prevent recurrence.

Emergency preparedness and response - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates, Industrial Placement Student and Trust Fire Safety Advisor.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
SOP 041/FAC Temporary Emergency Evacuation Plan - Talbot Green (Only).
TRUSTENV 07 Spillages.
Training Certificates.
Fire Risk Assessments.

Fire Training Presentation - Delivered by Trust Fire
Safety Advisor. Servicing Records - Extinguishers.
Spill Response Training
PPM's - Generator Testing

Emergency Response Plans for several sites were discussed and evidenced - displayed on noticeboards through all locations.

Trust Fire Safety Advisor discussed ongoing training for Fire Prevention Processes and Fire Risk Assessments for all sites. A recent assessment identified requirements for upgrade to Fire Doors for the VCC Hospital which will progress in early 2022. Alarm Testing is completed on a weekly basis tracked through PPM's and linked with objectives - OT 3 & 4.

Emergency generator testing is schedule through PPM's were several exports from the software programme showing completed testing:
Welsh Blood Service - Talbot Green
Monthly Generator load Testing - PPMs evidenced 28/10/2021, 27/09/2021 - Job No's A76109 and A75443.
Blood Collection Drivers - Spillage Training 01/12/21.

It was assessed the Trust emergency response plans were effective.

Evaluation of Compliance

The organisation has evaluated compliance with legal and other requirements at determined frequencies, has taken action(s) as required and maintains knowledge and understanding of its compliance status? The evaluation(s) have been conducted according to the implemented process(es)?	Yes
The organisation retains documented information as evidence of the compliance evaluation results?	Yes

Note: auditors are not expected to conduct legal compliance audits. It is expected that auditors evaluate that the organisations processes are effective in ensuring such compliance by the organisation with legal and other requirements. It should be noted that legal compliance audits are not required by ISO 45001 or ISO 14001. For further guidance please refer to **EA-7/04 M:2017**

Evaluation of Compliance - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates and Industrial Placement Student.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
TRUSTENV 02 Managing Legal Compliance.
TRUSTENV 01 Identification and Evaluation of Environmental Aspects.
TRUST Legal Register, Rev 7, dated 01/08/2019.
PPM Schedules.
Vehicle Serving records.
Training Records / Driving License.
Waste Transport/Consignment Notes.

The document recorded such relevant obligations for energy usage, water use, waste and resources usage, transports, emissions and purchasing within the comprehensive register. The Development Officer discussed regular reviews for applicability and updates when required.
Determination of regulatory compliance is assessed through ongoing audits and inspections with evidence discussed and reviewed in the form of PPM inspections and supporting records and files.

Sampled Regulations included, The Traffic Management Act 2004 and Active Travel (Wales) Act 2013, with vehicle servicing records, operators licenses, driving licenses and vehicle records reviewed.

Additional supporting documentation was discussed and evidenced for all sites reviewed during this audit, applicable environmental aspects and regulatory controls in place.

Velindre Cancer Centre, Whitchurch, Cardiff, CF14 2TL - Waste Transit Notes - WEEE, Collection Notes & Invoices - WEEE Waste Transit Notes were evidenced.
Waste Carrier License - Redwood Environmental Services & Alba Pumps who completed maintenance work at VCC 29/06/2021 evidenced
License No CBDU4296, Registered on: 04/12/2015 and expiry date: 04/12/2021.

Performance Evaluation

Internal audit programme(s) are available which indicate the frequency, methods, responsibilities, planning requirements and reporting of internal audits?	Yes
The organisation has completed internal audits as required by the programme and documented information is available as evidence of implementation of the audit programme and the audit results?	Yes
Top management has reviewed the organisations management system(s) at planned intervals to ensure its continuing suitability, adequacy and effectiveness? Management review includes consideration of all the items (inputs and outputs) required by the applicable management system standard?	Yes
The organisations internal audit and management review(s) includes evaluations of compliance of legal and other requirements and related results to ensure that top management are aware of the risks of potential or actual non-compliance and have taken appropriate steps to meet the organisations commitment to fulfil compliance obligations with legal and other requirements (14001/ 45001)?	Yes
The organisation has determine opportunities for improvement and implement any necessary actions to achieve the intended outcomes of its management system (and enhance customer satisfaction)	Yes

Performance Evaluation - Audit findings and supporting evidence seen

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates and Industrial Placement Student.
Documents Reviewed:
Velindre University Trust Environmental Manual, Version 4, dated Oct 2021.
TRUSTENV 03 Communication.
TRUSTENV 10 Energy Monitoring.
TRUSTENV 09 Internal Audit.
TRUSTENV 08 Identifying Non-conformance and Corrective Action.
TRUSTENV 08-01 Corrective Action Report Form.
TRUSTENV 08-02 Corrective Action Register and Tracker.
TRUSTENV 09-01 Internal Audit Template.
VVHST EMS Audit Summary Report.
Trust Management Review Schedule (Jan to Dec).
Velindre University NHS Trust Management Review Meeting Minutes and Powerpoint.

The internal audit process remains effective with sampled process audits reviewed against a set schedule. Assessments were conducted with departmental managers with reports recording areas reviewed and applicable findings or observations.
Additional site operational inspections were also discussed and evidenced which included Duty of Care Inspection with the Clinical Waste Management organisation - Stericycle.
Internal Audit Report Reference: THQ -10-2021-001. dated 19 Oct 2021 - Completed by Rhiannon Freshney.
Internal Audit Report Reference:VCC - 09-2021-001 dated 1 Sept 2021 - Completed by Rhiannon Freshney.

No finding recorded with additional auditor comments detailing; COVID-19 has had a huge impact on the Trust HQ with limited staff on site.
There are areas of best practice, including the introduction of "Smart Hubs" which promote effective homeworking.
As staff begin to return to the office (in line with Agile Working Policy) ensure all infographics and promotional activities are to date and engaging.
Following a successful bid to Welsh Government Decarbonisation fund, the LED lighting has been upgraded in THQ. There is now motion sensors & all of the lights are sectioned by room (previously all each floor was on the same circuit).

Duty of Care Audit dated 27 Auguste 2021 with auditors recorded as Operational Services Compliance Manager Velindre Cancer Centre, Health & Safety Environmental Officer Welsh Blood Service and Waste And Compliance Manager Cardiff and the Vale University Health Board - No findings raised.
The internal process audits and operation internal external compliance inspections continue to be maintained and remain effective.

The Management Review Meeting and the content of the Minutes and supporting PowerPoint was discussed in detail by the Management Team. The Minutes evidenced a comprehensive review of operations with analytical evidence providing assurance of targets set were both compliant and effective.
The Minutes were dated 19/11/2021 with attendees to the meeting recorded as;Trust Environmental Development Officer, Industrial Placement Student, Assistant Director of Estates, Operational Manager, Health, Safety and Environmental Officer, Business Manager, with apologies noted from;Service Improvement Manager and Estates Manager.
The Minutes record all relevant business required and progress of set KPI's:
Training compliance in some departments continues to be below Trust benchmark (90%) and Trust wide is currently 73%, this KPI has not been achieve due to a number of reasons. A key element is in-person training has been paused since March 2020 and has not resumed. Although staff can complete the training on compliance figures on ESR; however, ESR unable to record number of staff currently home-working / unable to access relevant training material.

Overviews of key 2021 events - Successful events over the year 2021; Plastic Free July, Sustainability Challenge, Sustainability Day for Action, NHS Pride and Eat Seasonal Campaign.
Upcoming events such as; Sustainability Strategy - engagement & launch, Sustainable Travel Plan -development &implantation, Building Management System Upgrades, Decarbonisation Plan, Biodiversity Enhancements and and other Events - In Person!

The Minutes were supported by documentation which recorded in depth analysis of environmental performance which included results of audits and inspection, updates to legislative requirements, and changes to aspects and impacts and environmental improvements made throughout the NHS Trust.

Regular surveys are completed by staff and patients reviewing the environmental reduction measures for effectiveness were discussed by the team and further recorded within minutes of meetings.

Operation - ISO 14001

Consistent with a life cycle perspective the organisation continues to ensure that its environmental requirements are addressed in the design and development process for product / service and environmental requirements for the procurement of products / services are determined in accordance with established controls?	Yes
In order to manage environmental impacts the organisation continues to implement the necessary controls and operating criteria for those operations / activities that are associated with the identified environmental aspects / compliance obligations?	Yes

Operational / Process Audit Trails and Audit Findings

Process / activity audited	Operations and Emergency Controls - All Locations.

Audit trails, findings and supporting evidence seen related to the process / activity audited

Interview: Environmental Development Officer, Welsh Blood Service Quality Assurance Officer, Velindre Corporate Estates Manager, Asst Director of Estates and Industrial Placement Student.

It was assessed the NHS Trust operations were consistent with documented controls detailed within Compliance Register and Aspects & Impacts Register. Operational processes both internal and external to the Trust have considered impact reduction measure.

Improvement Programmes were discussed - WBS Infrastructure Programme Brief - highlighting improvement programme, more specifically Objective 4 - To provide a facility that supports the delivery of Welsh Government target of carbon neutral for all public sector buildings by 2050 through maximising efficiency and utilising innovative technologies such as solar photovoltaics, water turbine, bio mass boilers, ground source heat pump, has mechanical infrastructure that provides heat, cooling and hot water services in an efficient manner https://gov.wales/wales-commits-net-zero-2050-sets-out-ambitions-get-there-sooner.
In their Sustainability Strategy, Velindre University NHS Trust has outlined their commitment to achieve net zero carbon emissions by 2030. https://gov.wales/net-zero-carbon-status-2030-public-sector-route-map.
Additionally the Team gave an overview of improvements detailed within Welsh Blood Service, Sustainable Infrastructure Sustainability Feasibility Report dated Nov 2021.

The Management Team discussed the control and use of Contractors, linked with Objective OT3, selection and approval for external contractors is controlled by Shared Services with Contractor selection criteria set. The team further elaborated on the use of battery operated gardening tools apposed to petrol driven machinery which aligned to the organisations Environmental Policy for pollution prevention and noise reduction measures.
Velindre Operational Services discussed the Velindre Hospital Bio-diversity Enhancement Plan and the planned use of Crown Garden Services for a programme of works. The included planned Wild Flower Meadows, reseeding and the encouragement of local species of plants and insects as part of the VCC natural healing initiatives aligned with the concept of the Maggie Centre and the services which they provide.

TRUSTENV 06 Waste Management.
Sustainability Presentation - Intro to Requirements of ISO14001:2015
FACTS Software - Exportation of Statistics - Monthly trending of Planned Preventative Maintenance (PPM's) - WBS Monthly Generator Load Testings completed 28/10/2021 - Job Code A76109.
Trust Gas & Electricity Usage 2018 - 2021 Comparison of Usage - Discussed and evidenced.

Welsh Blood Service - Bangor and Wrexham Sites
WBS - Training & Competency Records reviewed:
Exports from ESR showing completed Environmental Awareness Training
NW team Bangor - additionally NE team Wrexham -.
WBS Drivers Competency Records - Drivers No 25834352 export from ESR Software showing compliance for Spillage Training, Environmental Awareness Training and Fire Safety.
WBS Location Bangor - Legionella Controls - Weekly Flushing records requested through set PPM's - reviewed previous three months - 26/11, 19/11, 15/11 and 08/11 - Requested by .
Aspects for the two WBS locations in North Wales were discussed with Health & Safety Environmental
Officer. Both locations are limited occupancy with electrical usage being minimal although the Wrexham site has several refrigeration units for the storage of blood and vaccines. More significant aspects include transportation - Blood and personnel to local collection site with initiatives to reduce the number of sessions although increase the time frames spent at each location.
Review of procurement of electrical vehicles ongoing - range and charging continue to be the restriction.

Welsh Blood Service - Talbot Green
Monthly Generator load Testing - PPMs evidenced 28/10/2021, 27/09/2021 - Job No's A76109 and A75443
Blood Collection Drivers - - Spillage Training 01/12/21

The organisation continue their scheduled audits for completion recorded within FACTS Software with PPM Compliance for VCC, WBS & THQ linked with regulatory obligations.
Completed assessment for Mechanical Servicing, Electrical Inspections & Servicing, Fire, Ventilation and Legionella were discussed and evidenced.
The Velindre Corporate Estates Manager discussed the migration from FACTS Software to Symbiotic Software for greater integration for all sites within the NHS Trust.

Appointed persons for key areas were discussed with competency records also evidenced - Appointed Person, ILM accredited training for Responsible Person - Water Quality Legionella and Pseudomonas aeruginosa Management & Control Risk Management.

Operational Services Compliance Manager - VCC discussed the Waste Management controls for VCC & WBS with an increase in the amount of Clinical Waste generated due to the pandemic as detailed in the previous assessment of 2020. Similar issues arising with the waste contractor who continues to service the NHS Trust requirements, however the pandemic is putting a strain on this requirement with additional measures implemented to ensure waste buildup is controlled.

Use of certification marks and/or any other reference to certification

The client is correctly using and controlling the BM TRADA certification marks and/or references to certification?	Yes

Use of certification marks and/or any other reference to certification - Samples reviewed, findings and conclusions

Certification displayed on main office notice boards.

Opening and Closing Meeting Attendees

Name	Job Title	Opening meeting	Closing meeting
	Environmental Development Officer.	✔	✔
	Industrial Placement Student.	✔	✔
	Welsh Blood Services Quality Assurance Officer.		✔
	Velindre Corporate Estates Manager.	✔	✔
	Operational Services Compliance Manager - VCC.		✔
	Trust Assistant Director of Estates, Environmental & Capital Development.	✔	✔

Confirmation of Certificate Details

You have indicated that the client requires a (revised) certificate. It is crucial that the certificate that is issued to the client contains the correct information. Therefore please ensure that you clearly indicate the certificate information below and review this with the client and get their agreement that the information is correct. The information below will be displayed on the clients certificate.

Type of Certificate Required

Certificate format required:	Electronic certificate	✔	Hard copy certificate	✔			
Type of certificate required:	Single site certificate		Multisite certificate	✔	Certificate per location (Multisite only)		
Reason for issue of certificate:	Initial certification		Recertification	✔	Reissue due to client changes		
	Reissue due to transition / migration audit						

Certificate details

Client name:	Velindre University NHS Trust.
Client address: (If multi-site this is the central office address)	Velindre NHS Trust Headquarters, Nantgarw, CF15 7QZ.
Scope of certification:	The provision of non-surgical treatment of cancer including non-surgical clinical, laboratory and office based support. Provision of Welsh Blood Transfusion Services.
If multi-site certification, please provide details of all site addresses to be specified on the clients certificate:	Velindre NHS Trust Headquarters, Nantgarw, CF15 7QZ . Velindre Cancer Centre, Whitchurch, Cardiff, CF14 2TL. Welsh Blood Service Headquarters, Talbot Green, CF72 9WB. Welsh Blood Service, Pembroke House, Wrexham, LL137YT. Welsh Blood Service, Unit 30, Llandegai Industrial Estate. Bangor, LL574YH. Welsh Blood Service, Unit 4 Llanelli Gate, Llanelli. SA14 8LQ.

Note: If the client has more than five sites to be included on the certificate and the site address details are available on alternative documentation please submit.

Additional information / instructions regarding the clients certificate:	Nil.
Name of client representative who confirmed certificate details as above as correct:	Rhiannon Freshey - Environmental Development Officer.

Audit Objectives and Guidance on BM TRADA Nonconformities

Recertification Audit Objectives

The purpose of the recertification audit is to confirm the continued conformity and effectiveness of the management system as a whole, and its continued relevance and applicability for the scope of certification. Recertification audits are conducted on-site.

The objectives of the recertification audit are as follows:

a) To review the performance of the clients management system over the most recent certification cycle
b) To review and ensure that the audit programme for the most recent certification cycle has been achieved, and any required adjustments to the audit programme for the new certification cycle are made
c) To determine the ability of the clients management system to ensure the client continues to meet applicable statutory, regulatory and contractual requirements. **Note**: A management system audit is not a legal compliance audit
d) To determine the effectiveness of the management system to ensure the client has and can continue to reasonably expect to achieve its specified objectives
e) To identify areas for potential improvement of the management system
f) To review and document significant changes to the client organisation and their management system
g) To review the effectiveness of actions taken to address any nonconformities issued at the previous audit
h) To review progress of planned activities aimed at continual improvement

Guidance on BM TRADA nonconformities and time scales for action

A nonconformity is issued when objective evidence during the audit demonstrates non-fulfilment of a standard requirement.

All nonconformities are issued on separate nonconformity reports, one report per nonconformity. Each nonconformity must be recorded against a specific standard requirement and must contain a clear statement of the nonconformity identifying in detail the objective evidence on which the nonconformity is based. All nonconformities must have been discussed with you, the client during the audit to ensure that the evidence is accurate and that the nonconformities issued are all understood. The auditor must not suggest the cause of the nonconformity or its solution.

BM TRADA issue two categories of non-conformities, Major nonconformity and Minor nonconformity.

Major Nonconformity

A major nonconformity is a nonconformity that affects the capability of the management system to achieve the intended results. A major nonconformity could be issued for example if there is a significant doubt that effective process control is in place, or that products or services will not meet specified requirements or is a number of minor nonconformities associated with the same requirements or issue could demonstrate a significant failure and thus constitute a major nonconformity.

Time scale for closure of Major nonconformities issued at the stage two audit

Major nonconformities issued at the recertification audit must be actioned by the client and closed by the auditor prior to the expiry of the existing certificate. Failure to close any major nonconformities prior to the expiration of certification will result in the certification becoming invalid, which can not be extended. Following expiration of certification BM TRADA can restore certification within 6 months providing the major nonconformities are closed. After 6 months a new stage one and stage two audit will be required.

Minor Nonconformity

A minor nonconformity is a nonconformity that does not affect the capability of the management system to achieve the intended results.

Time scale for closure of Minor nonconformities issued at the recertification audit

Minor nonconformities issued at the recertification audit must either be actioned and closed or have (planned) correction and corrective actions accepted by the auditor prior to the expiry of the existing certificate. Failure to action and respond any minor nonconformities prior to the expiration of certification will result in the certification becoming invalid, which can not be extended. Following expiration of certification BM TRADA can restore certification within 6 months providing the major nonconformities are closed. After 6 months a new stage one and stage two audit will be required.

Any minor nonconformities that are responded to with planned action, must be verified and closed within 12 months from the issue date. Failure to close the minor nonconformities within the 12 month month deadline will result in the minor nonconformity being escalated to a major nonconformity.

Process for responding to BM TRADA Nonconformities

For each nonconformity issued bmtrada require the client organisation to analyse the cause and describe the specific correction and corrective action(s) taken (or planned to be taken - Minor nonconformities only) to eliminate the detected nonconformance within the above time frames.

Root cause analysis must be completed to detail the causes of the detected nonconformity. identifying the root cause is the first step in preventing the cause(es) of the detected nonconformity from recurring. There are many root cause analysis techniques including the five-whys and fish bone. Whichever technique is applied it is important that the analysis goes far enough to ensure that no "why" questions remain and all factors are considered. All causes should be verified.

Corrective action must describe the solution, action(s) required to address the identified root causes, so that the detected nonconformity does not recur. Corrective action must be supported by evidence to support the action taken and its effectiveness.

Once correction, root cause analysis and corrective action has been taken and documented the nonconformity response must be submitted to the local bmtrada Office with a copy sent to the auditor. Upon receipt the auditor will review the corrections, identified causes and corrective actions and evidence submitted to determine if they are acceptable. The auditor will then either:

- Close the nonconformity, if acceptable
- Accept the planned actions to be taken, the nonconformity will be open for verification and closure at the next audit (minor nonconformities only)
- Require additional information / supporting evidence / special visit to verify the effectiveness of action taken
- Reject the response and request additional information / supporting evidence as required

The client organisation will be informed of the result of the auditor review. During the next audit the auditor will follow-up all previous nonconformities to verify the effectiveness of the actions taken.

Additional Information

A copy of this report shall be distributed to the client and to bmtrada.

The ownership of this audit report is maintained by bmtrada, who shall keep confidential all information relating to this audit and your organisation and shall not disclose such information to any third party except as required by law or by Accreditation Bodies. bmtrada assumes no responsibility (legal or otherwise) or accepts no liability to any person(s) for any loss, damage or expense caused by reliance on information provided in this audit report.

The audit is conducted to include evidence gathering techniques including document review interview and observation of activities. The audit is based upon a representative sampling process of the available information with the objective to evaluate to evaluate the fulfilment of the audited requirements of the relevant management system standard and other normative documentation to confirm the conformity and effectiveness of the management system and its continued relevance and applicability for the scope of certification.

As this audit was based upon a representative sample of the available information if no findings are raised it does not necessarily mean that no nonconformities exist within the management system and if findings are raised it does not necessarily mean that these are the only nonconformities within the system.

The bmtrada standard terms of business, certification services annex clause 3.1.1.8 require that bmtrada be informed of all relevant regulatory noncompliance or serious incidents that require notification to any regulatory authority. Acceptance of this report by the client signifies that all such issues have been disclosed as part of the audit process and agreement that any such noncomploance or incidents occurring after this audit will be notified to bmtrada as soon as practical after the event.

AUDIT COMMITTEE

DEBTS WRITTEN OFF 2021/2022

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Claire Bowden, 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 The Audit Committee regularly receive verbal updates in relation to debts written off during a financial year. At the meeting following the end of the financial year, a written paper is provided to the Committee with further detail including the total amount written off in the year.

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	265	4,984	5,249
Private Patients	92,889	0	92,889
Trade & Commercial	69	1,360	1,429
Overseas	360	247	607
Other	228	0	228
	93,811	6,591	**100,402**

2.2 The majority of these debts were included in the 2020/2021 provision for expected credit losses and therefore will not result in an additional charge to the Trust's Income & Expenditure statement for 2021/2022.

2.3 The age range of the debts written off are primarily between the years 2013 – 2019, with less than 10 debts written off being aged post 2019.

2.4 A significant number of the debts had previously been chased on many occasions some years previously but had not been written off as priority had been given to collecting other live debts rather than processing these write off forms.

2.5 A review of the collectability of aged irrecoverable Private Patient debts has also been undertaken and many have now been written off. The £93k Private Patients debts written-off this year have been analysed by the year the invoices were raised and compared to the income for that year to provide a calculation of the % of each year's income written off. Over the past 8 financial years there has been an average of 0.64% of income written-off:

FY	2020/2021	2019/2020	2018/2019	2017/2018	2016/2017	2015/2016	2014/2015	2013/2014	Total
	£	£	£	£	£	£	£	£	£
Total PP income reported in the accounts	1,952,000	1,375,000	2,089,000	2,073,000	1,839,000	1,862,000	1,683,000	1,565,000	14,438,000
Write offs during 2021/2022	1,009	8,102	12,607	2,723	16,954	17,363	27,699	6,444	92,901
% of PP income w/o	**0.05%**	**0.59%**	**0.60%**	**0.13%**	**0.92%**	**0.93%**	**1.65%**	**0.41%**	**0.64%**

Over the past year there has been significant action taken by the Private Patients team to improve the process around income recovery for private patients. The actions with the Private Patient improvement plan developed from the independent review of the services will further strengthen the processes.

Benchmarking private patient bad debt in both NHS services and US private sector provides context to the Trust reported position above:

The Centre for Health and the Public Interest (CHPI) produced a report 'NHS treatment of private patients: the impact on NHS'. This report identified that for the ten hospitals reviewed on average 3% of the income received from private patients resulted in bad debts.

The Healthcare Financial Management Association report 'Bad debt expense benchmarks: U.S. acute care hospitals show improvements since 2015' identifies that Bad debt expenses as a % of revenue for U.S. Acute care hospitals was 1.73% (2018), ranging from 1.45% to 3.23%.

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 a total of £100,402 was written off during the 2020/2021 financial year.

4. RECOMMENDATION

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

AUDIT COMMITTEE

Private Patient Service Review

DATE OF MEETING	3rd May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ann Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Services
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer Matthew Bunce, Director of Finance
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCC SLT	18/02/2022	ENDORSED FOR APPROVAL
		With the caveat to look at the timescales as dependent on the appointment of external support
EMB RUN	07/03/2022	APPROVED

ACRONYMS

COO	Chief Operating Officer
EMB	Executive Management Board
SLT	Senior Leadership Team
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 A high level overview of the Private Patient Service was delivered on the 2nd March 2021 as part of a 'Deep Dive' Session. As a direct output, a decision was made to commission an external review to be conducted as an urgent priority.

1.2 Internal Audit had identified the Private Patient Service as part of their Audit Plan which they agreed to defer to future years given the Trust decision to commission an external review. However, Internal Audit and the Audit Committee agreed this subject to the external report, its recommendations, management responses and actions being presented to Audit Committee.

1.3 A Proposal was agreed, TPW Consulting and Training Ltd were appointed and the review commenced 21st April 2021

1.4 The agreed areas for review were:-

(i) Undertake a strategic and operational management, commercial and regulatory compliance audit of the Private Patient Service at Velindre Cancer Centre, including the delivery systems, processes, staff support and infrastructure.

(ii) Review current private patient prices in the context of the service delivered and the market including an evaluation of current private medical insurer arrangements. The review will quantify any potential gains available to the Trust from a revision of prices and their application to current and potential private patient volumes.

(iii) Review the efficacy of current private patient billing arrangements and identify the level, if any, of private patient income under recovery and the potential windfall and recurrent benefits to be derived from a forensic billing exercise.

1.5 A change in management of the Private Patient Service was implemented in April 2021 as part of an Organisational Change Process.

1.6 A Final Report has been received from TPW (**Appendix 1 – circulated out of committee as commercially sensitive**).

1.7 Management responses have been drafted in response to the Report recommendations and an Action Plan established. The management responses are incorporated into the

draft Report (**Appendix 1– circulated out of committee as commercially sensitive**) and as a spreadsheet action plan (**Appendix 2**).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Trust received an initial draft report in July 2021, which following review by the Chief Operating Officer, Medical Director and Director of Finance several inaccuracies and unsubstantiated statements were identified. The view also was that the report needed to be re-structured to identify:

(i) Process, governance and operational aspects to present to the VCC SLT and Audit Committee.
(ii) Strategic, marketing and commercial aspects for the VCC SLT and EMB to consider initially and agree the strategic intent for the service before making a recommendation to the Board.
(iii) Comments were fed back to TPW at the end of September 2021. A revised report was received at the beginning of December 2021 which the Trust has added management responses and actions. This Final document has been signed-off by TPW.

2.2 Recommendations in the report to improve operational aspects of Governance and Management need to be implemented whatever Strategic direction is agreed.

2.3 The review took in to consideration:-

(i) Business strategy
(ii) Analysis of current and potential market
(iii) Statutory and regulatory compliance, and;
(iv) Strategic and operational management and processes, including commercial aspects such as the efficacy of private patient charging and billing income under recovery and potential pricing assessment.

2.4 Based on the consultants interviewed by TPW as part of the service review and from previous discussions around the private patient services at the VCC consultants meeting, it is recognised that there is a clear Consultant desire to undertake Private Patient practice at the Cancer Centre as the view is it generates charitable funding and aids recruitment and retention of high quality clinicians.

2.6 The report clearly documents the outcome of the review and includes identified strengths, weakness and potential opportunities and threats which should be carefully assessed with consideration being given in relation to the next steps.

2.7 Based on the report finings, a total of 28 recommendations were identified and categorised into three key areas:-

(i) Strategic Business Management and Governance
(ii) Commercial
(iii) Operational

Each Recommendation includes a Priority Rating (High, Medium and Low) to support and focus target dates for completion.

2.8 An Action Plan has been developed to implement each recommendation and monitor progress.

2.9 Initial work has commenced to procure external expert private patient input to support the Trust private patient team implement the identified actions, provide additional management capacity and provide education & development.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Private patients part of NHS clinical governance, quality and safety systems. Actions from review to identify any improvements required in relation to private patient service but currently not identified.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below: Governance Leadership and Accountability, Staff and Resources, staying healthy, safe care, individual care, timely care.
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Equality Impact Assessment not completed at the time of the Report submission. Initial assessment is no implications.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	Ensure regulatory and legal compliance
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Stabilise / Increase income and contribution to NHS, Management of aged debt and billing to reduce bad debts and write-offs

4 RECOMMENDATION

The Committee is asked to **NOTE**

4.1 the Final Report from TPW (**Appendix 1 – circulated out of committee as commercially sensitive**)

4.2 the Action Plan (**Appendix 2**)

4.3 the procurement of external expert management, training and development expertise to support the VCC Private Patient Team

Action Plan - Private Patient Service

Date Updated: 14.02.22

Ref No.	Status	Date	Action	Action Progress	Action Owner	Target Date	Priority
STRATEGIC BUSINESS MANAGEMENT AND MEDICAL GOVERNANCE							
PP1	OPEN	28.01.22	Executive Directors will consult with appropriate stake holders and develop a private patient strategy, also taking in to consider initial scoping work completed in 2018, detailed in the submission paper to the Trust Board on 13 September 2018. Strategy to be developed following outcome of consultation.	Paper submitted to the Executive Management Board and the Trust Board on 13 September 2018 the Board agreed to support the ongoing Private Patient Service at Velindre Cancer Centre and agreed that a strategy should be developed to incorporate marketing and additional income opportunities. The allocation of contribution to services to be shared with Senior Leads at Velindre Cancer Centre highlighting the benefits the function has to the service as a whole.	COB AMS	30/06/2022 30/06/2022	Medium
PP2	OPEN	28.01.22	The existing Private Patient Policy will be reviewed and updated in the context of the agreed private patient strategy and publicised. Implement a dedicated private patient rolling business planning cycle.	(GC04)	AMS	30/07/2022	Medium
PP3	OPEN	28.01.22	A patient management and information system will be developed or procured and implemented.		AMS	30/03/2023	Medium
PP4	IN PROGRESS	28.01.22	Task and Finish Group be set up to progress the establishment of a formal Medical Advisory Committee (MAC) to help govern private patient services within the Trust. Evaluate and review all Consultants undertaking private practice, formalise private practice and explore the need for the introduction of Practicing Privilege Rights documentation (template drafted). Produce job planning guidance to define NHS and private patient work within consultant job plans	Practice and Priviliege Document/Template drafted. The Private Practice Team maintain a register, which includes confirmation that each clinician has obtained Indemnity Insurance, (Certificate provided and stored locally), and reminder notification is in place when this is due for renewal.	JA EGE EGE	30/04/2022	High
PP5	IN PROGRESS	28.01.22	A level of scrutiny is in place for private patients, combined with NHS patients. As a responsibility, the Medical Advisory Committee will monitor specific outcome measures, to be determined following initial meeting.	This level of scrutiny is in place combined with NHS patients. The Medical Advisory Committee would like to monitor specific outcome measures, to be determined following initial meeting. Discussions have commenced with the Therapies Lead and Clinical Nurse Specialist Lead to progress service provision. An Agenda item will be included on the MAC to agree principles around the recording of discussions at MDT.	JA AMS JA	30/04/2022	High
PP6	OPEN	28.01.22	Explore and implement a private patient practice contract to be signed by all consultants who undertake private work at the Trust.		EGE	30/07/2022	Medium
PP7	OPEN	28.01.22	Private patient management arrangements will be revised by creating a Senior Private Patient Manager role reporting to the Chief Operating Office. Initially this role will be procured through an NHS Framework contract to manage the transition and provide quick access to experienced support to enable several of the other actions to be progressed at pace.		COB MB	30/04/2022	High

PP8	OPEN	28.01.22	A key action for the externally procured Senior Private Patient Manager role will be to renegotiate the contracts with the large insurers.		Senior PP Manager	30/04/2022	High
COMMERCIAL							
PP9	OPEN	28.01.22	Develop a new private patient tariff for both self-pay and insured private patients		Senior PP Manager	30/05/2022	High
PP10	OPEN	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.		Senior PP Manager	30/05/2022	High
PP11	CLOSED	28.01.22	Update the Undertaking to Pay form to include all the necessary legal and GDPR rules	Form reviewed and up-dated and signed off by the Information Governance Manager	AMS	30/09/2022	Low
PP12	OPEN	28.01.22	Develop a Terms of Business statement for sharing with patients before any care is provided.		Senior PP Manager	30/09/2022	Low
PP13	OPEN	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.		Senior PP Manager	30/09/2022	High
PP14	OPEN	28.01.22	Develop a new private patient pack, brochure, and stationery.		Senior PP Manager	30/05/2022	Low
PP15	OPEN	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital.		Senior PP Manager	30/09/2022	Low
PP16	OPEN	28.01.22	Increase private income through exploiting opportunities to expand the clinical scope of the private patient service.		Senior PP Manager	30/09/2022	Low
PP17	OPEN	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.		Senior PP Manager	30/07/2022	Medium
PP18	IN PROGRESS	28.01.22	Review all billing practices and revise where necessary to ensure there is reduced risk of the insurers 6-months treatment date billing cut-off being breached.	Review of billing practices has commenced and improvements have been made reducing the billing timeline down from six months to three months. The action will be monitored to reduce this down to one month.	AMS	30/05/2022	High
OPERATIONAL MATTERS							
PP19	OPEN	28.01.22	Invest in staff training to increase knowledge of the private patient business and its position within an NHS setting – this will initially be undertaken by the external support procured. Embrace a more open culture as regards the delivery of private patient services with managers and staff encouraged to interact with other NHS private providers.		Senior PP Manager	30/07/2022 and on-going	Medium
PP20	IN PROGRESS	28.01.22	Establish a monthly Private Patient Business Meeting to review the results for the period including financial results, patient volumes, operational problems, marketing, etc.	Monthly meetings in place with the Private Patient Team, this is to be expanded to review the results for the period including financial results, patient volumes, operational problems, marketing, etc.	AMS	Start 01/09/2022	Low
PP21	IN PROGRESS	28.01.22	Review, correct and update existing operating procedures and ensure they reflect best practice. Train all staff involved in private patient services in the operating procedures.	Register of Standard Operating Procedures has been created. Review, correct and update existing operating procedures has commenced to ensure they reflect best practice. Train has commenced for SOPs that have been reviewed and approved.	AMS	Start 01/09/2022 and on-going	Low
PP22	IN PROGRESS	28.01.22	Implement new procedures which clearly differentiate overseas and private patients within the patient health record and other systems.	The Welsh Patient Administration System (WPAS) enables 'Private Patient and 'Overseas Patient' to be recorded/categorised separately. This will be implemented in line with the Digital Health and Care Record implementation go live timeline.	AMS	30/05/2022	High

PP23	IN PROGRESS	28.01.22	Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report has been progressed.	CANISC (Patient Administration System) is the primarily system for recording activity, coupled with Radis, Aria/Mosaiq and ChemoCare. Clinical systems feed in to the local data warehouse. Three standard reports have been established:- Report 1 - General overview of private patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Patient KPI report (outpatient activity) drafted (to be reviewed and signed off by the Medical Advisory Committee). Requirements to provide a single report that captures all activity at a patient level (which can be filtered, inlcuding attendance month, year, department, activity type etc) have been provided. This is dependent upon BI resources and prioritisation. Dedicated finance resource required to produce monthly report for Senior Leadership Team.	Senior PP Manager	30/07/2022	Medium
PP24	CLOSED	28.01.22	Establish a formal regular 1:1 meeting with the Private Patient Manager and their line manage	Weekly 1-1 meetings with the Private Patient Manager and their line manager in place	AMS	30/05/2021	High
PP25	IN PROGRESS	28.01.22	Review and improve current preauthorisation management procedure for enfranchised (insured) patients. Review and where required update arrangements for communicating charges to self-pay patients.	Standard Operating Procedure for 'Top-Up' Patients (including pre-payment) in place.	Senior PP Manager	30/07/2022	Medium
PP26	OPEN	28.01.22	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.		Senior PP Manager	30/05/2022	High
PP27	OPEN	28.01.22	Review private patient debt management arrangements and develop agreed principles and new processes to mitigate bad debt risks.	Review of Private Patient debt completed back to 2016. Unapplied and Unallocated lists reviewed, private patient monies identified and process in place to link this to the correct budget, reducing debt position. Pre-payment in place for 'top-up' patients. Direct links established with Insurance Companies to correct shortfalls and prevent shortfalls reoccurring, and follow-up after invoice has been issued.	AMS	30/05/2022	High
PP28	OPEN	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.		Senior PP Manager	30/07/2022	Medium

AUDIT COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	03.05.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	7/3/22	NOTED
Quality, Safety & Performance Committee	24/3/22	NOTED
Trust Board	31/03/22	NOTED

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams
EMB	Executive Management Board

1. SITUATION AND BACKGROUND

The purpose of this report is to:

- Share the February extract of risk registers to allow Audit Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.
- To confirm, this paper was also received at Trust Board two weeks ago, however it is important there is a formal view at Audit Committee also given the Committee's role in overseeing the overall risk and assurance framework in terms of design and effectiveness.
- Summarise the feedback, and progress against that to date, on the process from the previous cycle of Committees and Trust Board.
- Summarise the final phase in implementing the Risk Framework.
- Provide the Audit Committee with assurance on the steps agreed by the Executive Management Board during this reporting period.
- Outline approach to risk appetite review for May-June.

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Key points for the Committee:

Risk Register:

- The action plans for Velindre Cancer Centre and Corporate risks need clearer articulation. This will be prioritised for the risks scoring 20 and 16 for the next reporting cycle. Welsh Blood Service and Transforming Cancer Services risks already clearly articulate actions in their reporting. When this report was received by the Quality, Safety and Performance Committee on March 24th, the Committee placed further emphasis on the importance of this further development.

- Executive Management Board have asked that the Digital Health and Care Record project team review again the calibration of the level of granularity and the scoring of the project risk profile. This will be actioned and reflected in the next reporting cycle.

- The geo-political risks relating to the war in Ukraine are being assessed by the business continuity team, will be reviewed in Executive Management Board and shared with the Board. It may be appropriate that this is reported out of cycle to

provide the Committees and Board with this analysis before the next meeting.

Implementation of Risk Framework:

- The final stages of implementation of the Risk Framework are dependent on the Policy and the Training being finalised. Once these are complete, the final milestones, particularly from a Welsh Blood Service migration into version 14, can be agreed upon.

2.1 THE TRUST RISK REGISTER

2.1.1 Total Risks

As discussed in the January reporting cycle, there has been a thorough review of the risks, scoring and associated records of management of those risks completed for all risks scoring 15 and above across the Trust.

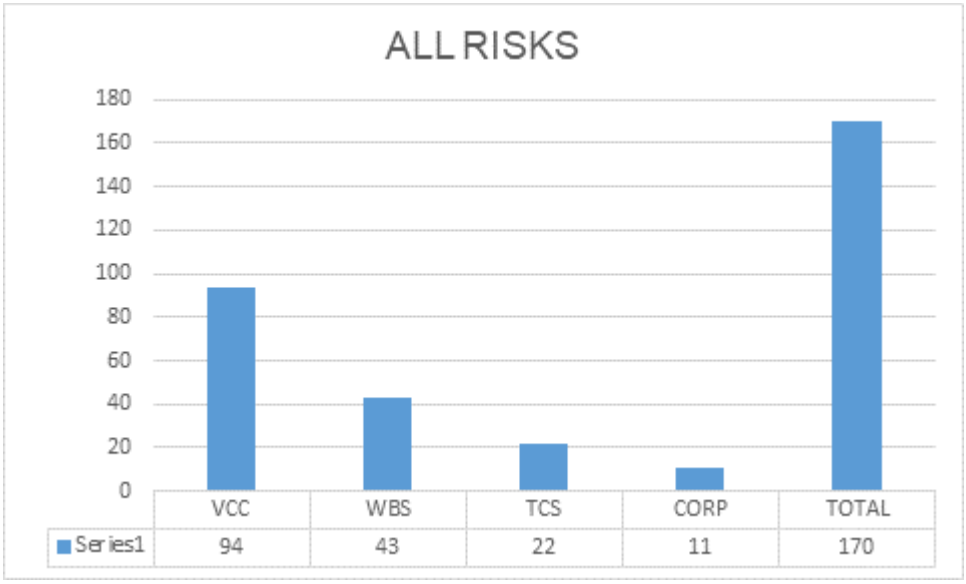
The same in-depth review will now take place for those scored 12 and above, phased over the next couple of reporting cycles.

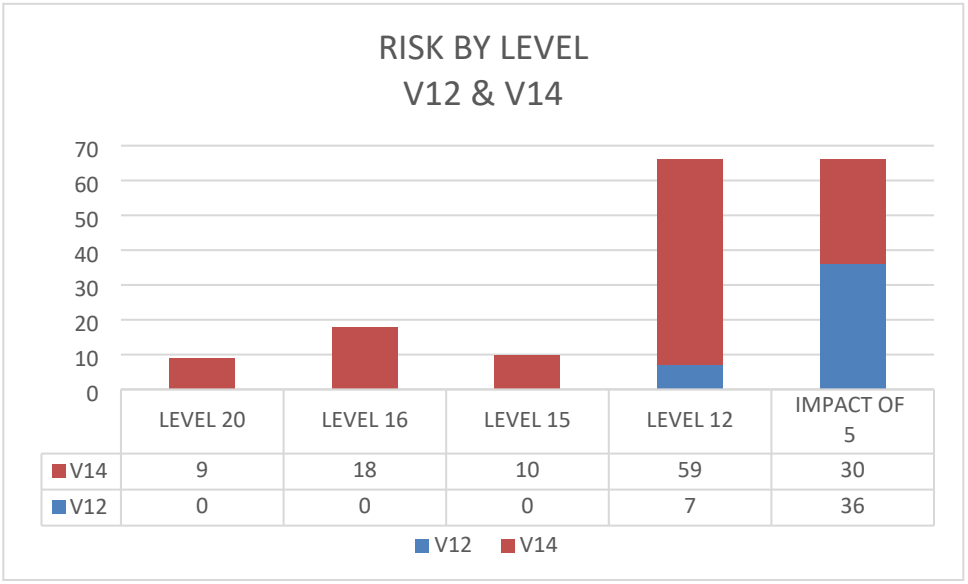
As a result of reviewing the reporting in the weekly risk Trust meetings, the key aspect that has come to light following this review has been that the “actions” field is not being used consistently across departments and divisions. This is going to be a focus for the next reporting cycle. Therefore in this report, the controls column is displayed, to provide some insight into the approach to mitigating the risk. Clearly this needs to be augmented with the specific, measurable, owned and time bound actions that will achieve the target risk score. The completion of this information in this way will be prioritised initially for the 20s and 16 for the next reporting cycle. For the Welsh Blood Service reporting in version 12, this information is clearly displayed in the Senior Leadership Team reporting.

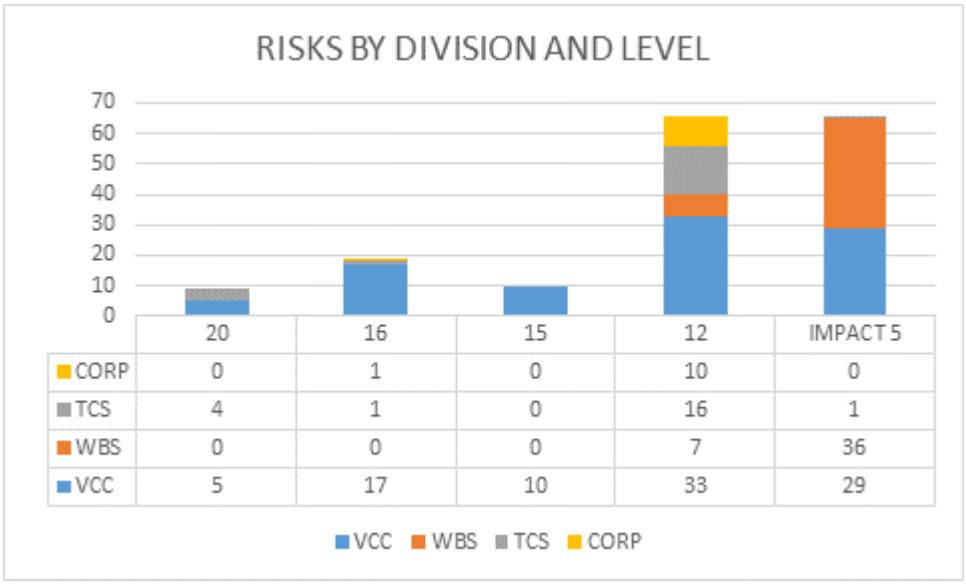
There are a total of 170 risks recorded in Datix Trust Risk Registers, 44 in version 12 and 126 in version 14. This is the same amount of total risks recorded in the February 2022 reporting cycle. The graph below provides a breakdown of the total number of risks by Division.

2.1.2 Risks by level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and Division is also included.







2.1.3 Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

Risks level 25

There are no level 25 risks to report in the March cycle. This is as per the January reporting cycle.

Risks level 20

The table below provides a breakdown of risks level 20. There are currently 9 risks with a current risk rating of 20 recorded, 5 for Velindre Cancer Centre and 4 for Transforming Cancer Services. This compares to 9 in the January 2022 reporting cycle, although there has been some movement within this:

- The risk regarding implications from Brexit has been closed by the Business Continuity Group and agreed by Executive Management Board.
- The Digital Health & Care Record team have reviewed their risk profile and some of the resulting changes are evident in this report:
    - 2206 – Digital Health & Care Record Project – Information Management and Technology Department - Covid-19 Pandemic – has increased from a 12 in January reporting cycle to 20 in March.
    - 2499 – Digital Health & Care Record Project - There is a risk that not all interfaces will be delivered timely for sufficient testing – is a new risk at score 20.
    - Previously risk 2437 was regrading delays in Radiographer graduates starting which has now been closed.
- As referenced in the developments section on page 13 of this report, as agreed in the January committee cycle of Quality, Safety & Performance and Audit Committees, the closure rationale is now a set automatic field to be completed on Datix when a risk is closed. This data is now being collated and will be reported from the system in the next reporting cycle.
- As referenced in the key points summary, in reviewing the risk profile in March Executive Management Board, there was an action agreed to request that the Digital Health & Care Record Project team reconsider the calibration of their scoring and the granularity of their project risk profile.
- Risk 2513 is a new risk with a score of 20; the risk is a Performance and Service Sustainability Risk relating to the number of practitioner's licenses held by staff for prostate brachytherapy.
- Risk 2360 is a new Transforming Cancer Services Programme level risk regarding the interdependencies between projects which was agreed to in the March Programme Delivery Board meeting.

ID	Risk Type	Division	Title	Rating (current)	Rating (Target)	RR - Current Controls
2206	Performance and Service Sustainability	Velindre Cancer Centre	Digital Health & Care Record DHCR003(R) - IM&T Departement - Covid-19 Pandemic	**20**	**9**	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.
2499	Performance and Service Sustainability	Velindre Cancer Centre	Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testing	**20**	**8**	Pressure on DHCW to provide interface on schedule. Testing window is fixed and protected not used as development contingency

2191	Performance and Service Sustainability	Velindre Cancer Centre	Inability to meet COSC / SCP targets	**20**	**4**	Plans are prioritised by start date to minimise delays. Physics staff are redirected to physics planning during periods of high demand. Weekly RT service capacity and demand meetings monitor position. Increased checkers rostered for a Friday to mitigate Monday starts. Plan to increase capacity is in progress. 4 additional surge posts have been created in treatment planning with recruitment ongoing (2 surge posts filled internally with backfill recruitment active, 2 filled externally but 1 staff member moved Trust).
2200	Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy Capacity	**20**	**6**	Ongoing monitoring of capacity, demand breaches and waiting times targets. Development of breach escalation process to ensure, where needed patients are prioritised effectively. - Extended working hours are in place on the treatment machines and in many other areas of service. - Agency Radiographers are in place to support additional hours. Assessment of potential Agency staff experience at point of hire to ensure that Agency staff are able to rotate around more than one work area / linac type / OMS type within department. - Outsourcing to The Rutherford centre for prostate and breast patients is underway. - Changes made to RT Booking processes, and staff flexibility used to maximise use of resources. - Understand and prioritise activities that promote wellbeing in the team. Diverse training sessions held to enhance mindfulness, wellbeing, and resilience. - Review of dose & fractionation, plan complexity and recruitment at clinical trials is being reviewed by SST's and Clinical Director.
2513	Performance and Service Sustainability	Velindre Cancer Centre	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	**20**	**10**	Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence
2400	Workforce and OD	Transforming Cancer Services	Risk that there is lack of project support for Project 5, outreach model development, which could result in impact on the overall clinical model assumptions in the programme.	**20**	**6**	Executive agreement on priority of agreeing final plan and implementation of that. SRO escalation and awareness. To see further detail in new risk 360 below.
2501	Financial Sustainability	Transforming Cancer Services	Risk of inflation leading to increased costs	**20**	**12**	Specific actions reported in private paper, due to commercial nature.
2360	Performance and Service Sustainability	Transforming Cancer Services	There is a risk that as a number of Projects remain 'On Hold' and/or incur delays impacts on interdependencies with projects which are progressing resulting in Programme Master Plan objectives / outcomes being delayed / not being met	**20**	**12**	1) Stocktake of all Projects and Programme to be undertaken 2) Refreshed Project Self-Evaluation toolkit 3) Refresh of Master Programme Plan 4) Review Programme and Project resources /gaps and make appropriate investments where required. 5) Fully implement new ways of working – Velindre Futures & Strategic Infrastructure Board

Risks level 16

The table below provides information of level 16 risks as per the Risk Register. There are currently a total of 18 risks with a current risk rating of 16, 1 for TCS, 16 for VCC, 0 for WBS and 1 for Corporate. This compares to 15 in the February 2022 reporting cycle. The three new risks included are:

- A new risk, 2514; relating to out of date Standard Operating Procedures within the Brachytherapy area.
- A new risk, 2454, workforce risk relating to Digital Services Capacity / Skill Mix
- Following the review of Covid-19 related risks, as reported in the extraordinary meeting of the Quality, Safety & Performance Committee in February, there was a new risk, 2505 that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Service.
- The Quality, Safety and Performance Committee questioned that risks 2329 and 2328 have a target risk score the same as current. This is being addressed in the Digital Health & Care Record Project review of their risk profile.

Risks reported from V14:

ID	Risk Type	Division	Review date	Title	Rating (current)	Rating (Target)	RR - Current Controls
2190	Performance and Service Sustainability	Velindre Cancer Centre	31/03/2022	BI Support for reporting of Breaches	**16**	**10**	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes
2211	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	**16**	**12**	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working
2203	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	**16**	**8**	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.
2221	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	**16**	**12**	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected
2324	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	**16**	**8**	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.

2326	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	**16**	**9**	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2329	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	**16**	**16**	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.
2328	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes of booking/admitting patients	**16**	**16**	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2440	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	**16**	**6**	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.
2454	Workforce and OD	Corporate Services	01/05/2022	Digital Services Capacity / Skill Mix	**16**	**8**	Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.
2193	Performance and Service Sustainability	Velindre Cancer Centre	30/04/2022	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	**16**	**2**	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).

2196	Performance and Service Sustainability	Velindre Cancer Centre	01/04/2022	Radiotherapy Department -COVID Isolation Impact	**16**	**4**	Ability to work from home with relevant IT equipment on completion of DSE risk assessmentIsolations rules to be reviewed regularly.7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.7/2/2022 - risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.
2345	Performance and Service Sustainability	Velindre Cancer Centre	06/12/2021	Radiotherapy Dept - Change to service due continued response to Covid19	**16**	**1**	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infectionDevelopment of outsourcing contract to private provider to deliver external beam for prostate and breast5/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.Mitigation1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken.2.Undertaking escalation work to minimise breaches.3.SST's being asked to review current dose/# offered to patients.4.Review of trials.5. All vacancies out to advert.6. Outsourcing to Rutherford Cancer Centre.
2505	Performance and Service Sustainability	Velindre Cancer Centre	31/01/2022	Risk that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Service	**16**	**6**	-SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full; increased virtual appointments-Radiotherapy - major limitations on capacity due to reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need; Changes made to Prostate pathway based on agreed framework; maximising third party provision.
2428	Compliance	Velindre Cancer Centre	31/03/2022	There is a risk of increased infection transmission due to poor ventilation.	**16**	**9**	UPDATE 14.02.22 from Mark David - A temporary air con solution will need to be installed for this summer (as per last year setup) with the hope of the ventilation BC being signed off later this Summer.Next steps will be for service to sign off decant plan so it can be included in the BC, this can then be signed off by SMT, EMB and then forwarded on to WG.UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan.* Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc.* Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc.* Full root cause analysis undertaken to ascertain cause(s) of any infections.* Business Case currently under development to seek funding for compliant ventilation system.
2514	Quality	Velindre Cancer Centre	29/04/2022	There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date	**16**	**4**	Following the retirement of the former Head of Brachytherapy Physics, ownership of RT physics documents has transferred to another member of staff who is reviewing SOPs. Similarly a review of documentation is taking place within Radiotherapy

2198	Financial Sustainability	Velindre Cancer Centre	13/12/2021	VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts	**16**	**6**	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism
2402	Performance and Service Sustainability	Transforming Cancer Services	31/01/2022	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	**16**	**9**	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment

3. Development of Risk Framework

Update on the progress during latest reporting cycle, in particular highlighting the action against feedback received by the Quality, Safety & Performance Committee, Audit Committee and Trust Board in the January reporting cycles:

- **Closure rationale**
  - Datix now has hard coding making rationale for risk closure a compulsory field.

- **Committee mapping of oversight:**
  - Currently Audit Committee, Quality Safety & Performance Committee and Trust Board receive full register.
  - Going forwards, Research and Development category of risks to Research, Development & Innovation Committee. Research and Development risks are reported and Datix currently, therefore specific reports can be developed for the committee.
  - There have been preliminary discussions with the Charity Director regarding the migration of the Charity risk register onto Datix. There is agreement in principle around this action, however a further meeting is planned in March to confirm the process, anticipating completion by end April for incorporation in risk reporting overall.
  - Transforming Cancer Services Programme risks will be continued to be reported to the Transforming Cancer Services Programme Sub-Committee.

- **Private risks** – review underlay and will complete in next cycle – see Private paper.

- **Link to Trust Assurance Framework** – the linkages between the risk and assurance frameworks is scheduled further development over coming months, in line with the further development of the Trust Assurance Framework, for completion and reporting Q3-4 2022/23.

- **Reporting of actions** – as articulated in the key points for the Committee, the action plans for Velindre Cancer Centre and Corporate risks need clearer articulation. This will be prioritised for the risks scoring 20 and 16 for the next reporting cycle. Welsh Blood Service and Transforming Cancer Services risks already clearly articulate actions in their reporting.

- **Colours for reporting** of score – formatting changes completed.

- **Articulation of risks** in Datix and way in which summary of title pulls through to this cover paper.
    - All 20 and above risks have been reviewed for WBS, VCC, TCS and Corporate and where appropriate updated on Datix and therefore will be reflected in this report.
    - Level 16 risks have been reviewed and amended on Datix for WBS, TCS and Corporate. The review is still ongoing at VCC and will be completed by the next reporting cycle.

- **Initial view on approach to risk appetite** review for May-June discussed in Executive Management Board.
    - Important to link to strategy discussions and will therefore bring back to next Executive Management Board Shape meeting in April.
    - May want to change a number of the thresholds for risk categories to be more calibrated at 16/15 rather than 12 for reporting residual level of risk to Board level.
    - Executive leads for risk categories will engage with Independent Member leads prior to bringing to Board for sign off and approval.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Completed for individual risks as appropriate
	Yes (Include further detail below)

LEGAL IMPLICATIONS / IMPACT	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If risks aren't managed / mitigated it could have financial implications.

4 RECOMMENDATION

The **Audit Committee** is asked to:

NOTE the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this cover paper.

NOTE the on-going developments of the trust's risk framework.

ID	Is this a Private & Confidential Risk?	Risk Type	Division	Area	Handler	Manager	Approval status	Service	Opened	Review date	Closed date	Title	Risk (in brief)	Rating (initial)	Rating (current)	Rating (Target)	RR - Current Controls
2187		Performance and Service Sustainability	Velindre Cancer Centre	Medical Physics	Windle, Rebecca	Millin, Tony	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	31/03/2022		Radiotherapy Physics Staffing	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. IMPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. IMPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	25	15	5	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk assessment due to the anticipated shortage of appropriate candidates.
2419		Safety	Velindre Cancer Centre	External Departments/Areas	Jones, Helen	Buswell, Stuart	Accepted	Operational Services	01/09/2021	31/01/2022		Risk Assessment of Marquee erected outside Out Patients Department	To manage the number of people in the Outpatients Department and to comply with Covid19 2m social distancing requirements additional waiting area space is required. In October 2020 a marquee was erected by County Marquees to provide additional waiting space. The marquee is provided with an electrical supply by the Trust Estates Department. There is a wooded floor covered by carpet. Patients are triaged on entering the marquee and then are able to wait there sitting on socially distanced chairs until it is their turn to enter the department. August 2021 the wooden floor was noted to have become uneven after a patient fell in the area. This is a temporary structure which is likely to remain on the VCC hospital site for some time and will require maintenance and inspection. Hazards identified: Deterioration in the structural condition of the Marquee over time A fault occurring with the structure of the marquee An electrical fault occurring within the marquee The marquee being damaged by inclement weather, antisocial behaviour or other damage	12	12	3	Bollards have be put in place to protect the marquee and people walking near it from being struck by vehicles. A hedge has been removed and replaced by concrete to increase the turning circle in the road adjacent to the entrance to the Out Patients Department. The edge of the flooring in the marque is demarcated with batons and high visibility tape. The marquee is fitted with fire detection and is situated 2m from the main building. Additional control measure are required to maintain and monitor the condition of the marquee.
2475	N	Performance and Service Sustainability	Velindre Cancer Centre	No Further Coding Required	Seary, Sarah	Cooper, Mrs Vivienne	Accepted	Whole Service	19/11/2021	31/03/2022		A risk that increase in COVID and the Winter pressures period potentially impacts Int. Care project delivery	COVID-19 and Winter Pressures - A risk that increase in COVID-19 pressures and the Winter pressures period potentially impacts project delivery Cause: Increase in demand that requires project resource to focus solely on clinical work Increase in staff sickness leading to gaps in capacity/back fills requirements/prioritisation of clinical requirements	16	12	8	Update 14.02.22 - Most projects have continued with minimal impact from staff absence. Progress of projects is closely monitored by the PMO office and weekly meetings take place with the Project Manager and IC service staff Update 10.12.21 - Regular meetings continue to take place with PMO to review status of projects and work plan. Activity monitored via the ICOG and sickness levels monitored by HODs. Mitigating actions: 1. Monitor staff sickness through the IC Operational Group 2. Monitor increase in demands via IC Operational Group 3. Update PM with resourcing issues for further escalation and re-prioritisation. Logged as a Project risk also for Integrated Care as may impact on project work streams
2523	N	Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Baker, MRS Kate	Baker, MRS Kate	New risk	Therapies	24/02/2022	18/03/2022		A risk to the delivery of the Physiotherapy Gynae-Oncology service	With monies successfully secured from Velindre Charitable Funds, and more specifically the Rhian Griffiths Forget Me Not Fund, a 0.8 FTE 3-year trainee Advanced Practice Gynae-oncology Physiotherapist role was recruited into in April 2020 with the primary aim of helping women to manage side effects from their cancer treatment. The staff member in post in unfortunately off work sick for at least the next month (4 weeks). The role is a single point of failure as we do not have any other physiotherapists who are trained in gynae-oncology to be able to review the patient caseload. Therefore the service will be put on hold for this period of time. The interventions provided for these patients can't be seen in general physiotherapy outpatient clinic due to the specialist nature of interventions delivered.	12	12	6	The VCC Gynae team are made aware of the service being put on hold for the time period of 4 weeks with the potential this may increase. Any new referrals to the physiotherapy clinic will be received and a waiting list letter sent to the individual patients
2503	N	Compliance	Velindre Cancer Centre	No Further Coding Required	Johnston, Sam	Gallop-Evans, Eve	Accepted	Medics	14/01/2022	01/02/2022		ALS Training Compliance	CTUHB have made the decision to cancel their Feb and March 2022 ALS training courses for external attendees. A number of SHO's, Registrars and Consultants who were booked on the course or have training expiring in the near future will be effected. This carries the risk of immediately impacting service such as the On Call rota for existing VCC staff. This will carry further impact when Junior Doctors join VCC as part of the next rotation. Junior Doctors are required to be ALS trained to enable them to work on the wards and assessment unit. Backlogs in training expired medical staff could result in further medical staff being out of compliance in the near future.	12	12	3	Business team has contacted the Resuscitation Council to query extension periods during COVID times. Made contact with Malcolm Jones, First Response Medical Training Ltd. with whom Nursing have an SLA contract to organise an additional training session for medical staff. Potential to undertake a RA to extend current compliance in the absence of future training courses, needs to be agreed and signed off by SLT.
2253	N	Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	27/10/2020	01/05/2022		Availability of CANISC System	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	15	15	5	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient demographic information - Welsh Results Reporting Service (WRRS) for all VCC radiology reports - Paper Radiotherapy Workflow (IRMER) - Manual Registration - new patients on Chemocare - Manual Registration - new patients on Aria and Mosaiq - Availability of Clinical correspondence created at VCC in Document Management System (DMS) from April 2019 that feeds into Welsh Clinical Record Service (WCRS) - Access to paper record that holds inpatient documentation, charts etc
2190		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Payne, Mrs Helen	Powell, Emma	Accepted	Radiotherapy Services	14/09/2020	31/03/2022		BI Support for reporting of Breaches	BI Support for reporting There is a risk that lack of high quality data informing in real time key activity (demand/ capacity) Key data inputs (RTDS) are done manually Different staff groups only understand their own systems. Resulting in a lack of ability to accurately forecast and model future demand for services which may impact on accurate capacity planning for the scheduling of patient pathways	16	16	10	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes
2511	N	Workforce and OD	Velindre Cancer Centre	No Further Coding Required	Johnston, Sam	Gallop-Evans, Eve	Accepted	Medics	28/01/2022	28/02/2022		Calculation of Medic A/L allowances	There is a risk that part time consultant A/L entitlements have been calculated incorrectly as a result of business processes which may lead to numerous risks including financial, reputational and compliance. A part time consultant queried that their A/L entitlement was incorrect due to the incorrect B/H A/L entitlement being issued. This was investigated by the medical business team and identified that the B/H A/L entitlement hadn't been included within the consultants A/L entitlement. Further investigation identified this wasn't an isolated case and that numerous part time consultants B/H entitlements were not included in the overall A/L. Other peripheral issues have been identified around medic A/L allocation and processes such as full time medics not being allocated or booking B/H A/L via the Intrepid system resulting in no audit trail or governance. Certain medics having various contractual arrangements without formal documentation (SLA/secondment documentation) in place detailing whose responsibility it is for A/L to be calculated and allocated by. This may lead to issues with up and coming guidance in relation to carryover/sell back of A/L.	12	12	2	Business team have added the risk to the directorates risk register. Business team have contacted and sought advice and support from WF colleagues. Business team have communicated has escalated the issue identified to the CD, MD and Director of Cancer Services Business team are currently exporting and requesting data to identify all part time medics who may be affected. Working group have met to discuss and identify all scenarios which could be present and affect medic A/L entitlement i.e. B/H allocation, contractual changes (years of service, role). WF currently reviewing contractual obligations and case law which is relevant. Working group have met to discuss current process, information sources and initial plan to resolve. Working group to develop SBAR detailing the above information for SLT. Raised for discussion at JLMC for discussion. --
2205		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Johns, Dewi	Wilkins, Paul	Accepted	Digital Services	14/09/2020	31/01/2022		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. No longer applicable - can be removed	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads
2202		Workforce and OD	Velindre Cancer Centre	Velindre Hospital	Sully, Nicola	Gallop-Evans, Eve	Accepted	Medics	23/02/2021	01/02/2022		Consultant cover for long term absences	Two consultants will be taking Maternity Leave in 2021 in Urology and Breast tumour sites. One Consultant is planning a career break in Spring 2022. One Consultant on Long Term Sick Covid related from Mar 2020.	20	12	4	The Directorate has employed a Consultant for a 1 year post to cover the Urology gap for Mat Leave in 2021 but may require extending the contract to Mid 2022 depending on how long the Consultant will be off on Mat Leave and also to cover the sabbatical in 2022. An additional temporary consultant will be required to cover the breast sessions for the 2nd Mat Leave.

2189		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Tranter, Bethan	Tranter, Bethan	Accepted	SACT	15/04/2020	01/05/2022		Covid - SCT - VCC Futures: Clinical plan for SACT Services through the COVID 19 pandemic	VCC Futures: Clinical plan for SACT Services through the COVID 19 pandemic As a stand-alone cancer centre, VCC has a vital role to play in ensuring continuation of essential cancer services throughout the pandemic and effective and rapid recovery of services afterwards. This will be essential to prevent worsening cancer outcomes from occurring as 'collateral damage' from the pandemic. VCC will be a 'cancer treatment hub' for the population of South-East Wales during the COVID-19 pandemic. Systemic Anti-Cancer therapy (SACT) is a highly effective cancer treatment, which can be given to cure cancer as primary treatment (with or without radiotherapy), to reduce the risk of relapse (after surgery) and to palliate symptoms and reduce complications. It is imperative that this service continues as comprehensively as possible throughout the pandemic and beyond. Clinical/Medical oncologists, pharmacists and nurses with SACT competencies are highly specialist NHS staff who will continue to utilise their skills throughout the pandemic to treat cancer patients. As the Covid-19 pandemic changes through the three identified phases (Acute phase (early & late pandemic), Recovery Phase (early & late recovery) and Reactivation Phase), there is a risk that VCC will be unable to match capacity with demand for SACT Services. This would result in patients being unable to receive the cancer care they require in a timely manner	20	12	9	Document providing strategic oversight of core documents produced by the Velindre Cancer Centre (VCC) SACT Strategic Group (SSG) and national bodies during Covid-19 and beginning to explore future adaptation to these as the risk from the pandemic changes, as well as a perspective on the recovery phase as the pandemic wanes - submitted to Silver Command 24.04.20 (Velindre Futures plan for SACT through COVID-19_Final Version 1.1 April 27 2020.docx) It is assumed that this evolution will happen over approximately six to nine months (March to December 2020), although the timings may vary. It is also accepted that there will be peaks and troughs in demand over this period so we need a system that will be agile. The aim is for VCC to be able to deliver a centralised, high quality, specialised SACT service, adapting quickly to the needs of cancer patients / services in SE Wales whilst minimising patient harm. VCC Futures: SACT Operational Plan currently in the final stage of production. This plan details options for how VCC will be able to operationally manage demand through the Recovery phase of the pandemic. Recovery of the SACT service is dependent on multi-professional capacity across the whole of Velindre Cancer Centre. In early Recovery, VCC will endeavour to adequately manage the predicted surge in demand for SACT Services and: A - Re-start SACT treatments that have been deferred in whom therapy is still appropriate (will need clinical review) B - Continue to deliver SACT in place of surgery for patients who cannot have surgery, as listed in the early phase plan C - Continue use of all adapted SACT regimens implemented during phase 1 and 2 of the response, to manage demand on the SACT service, until a phased adaptation is possible without impact upon new or existing patients D - Re-initiate outreach daycase services potentially following a different model, key areas to be considered. E - Embed changes to models of pre-SACT assessment clinics made during the peak of the COVID-19 crisis and to build on these through progress of the Virtual Assessment Pathways (VAP) project and continued SST leadership. 01.08.20 - Strategic and Operational papers have been approved. Pace of recovery has been unable to match demand with resultant impact on service. This is likely to be an ongoing issue and is included on the SACT SG general register Update - 29.10.20 - As we enter the second wave of COVID-19, demand is exceeding capacity and the number of target breaches has increased. PCH Outreach Unit now re-opened for 3 days a week and the MAH Parenteral Service on the Mobile Unit is being expanded as of November to help ease capacity issues - likelihood score raised from 2 to 3 Update - 12.01.21 - Mobile Unit with 3rd party provider service expanded to 2 days per week from mid-December. Proactive systems of SACT escalations introduce to manage urgent new referrals and on treatment demand. Current performance including and demand and capacity closely review in light of increased community incidents and effect impact on staffing service Update - 23.06.21 - Funding for SACT Surge approved and staff recruitment in progress. Timescales for recruitment will determine date for opening Outreach Unit at NHH - currently estimated as Sept / Oct 21 in coordination of obtainment of trained SACT staff - key pieces of work currently progressing to enable this
2504	N	Safety	Corporate Services	Infection Control	Wright, Lenisha	Fear, Lauren	New risk	Whole Service	18/01/2022	31/01/2022		Covid-19: Changing profile of Covid-19 infection risk, impacting our patients, donors and staff	Response to COVID-19 and the controls that need to be put in place. The Action plan: -Finalise operational review of Clinical Principles, including trigger points --governed through Gold 13.12.2022 via: -Strategic clinical advisory group -WBS risks based social distancing paper to be completed and approved	20	12	6	-Re-establishing command structure -Clinical governance strengthened, with establishment of Strategic Clinical Advisory Group at Gold level and Clinical Development Group at Silver level -Covid Cell established -Decision making framework refreshed, approved by Trust Board and reinstated -Changes to Board and Executive Meeting Structure, including increase frequency of Quality, Safety & Performance Committee
2480	N	Workforce and OD	Velindre Cancer Centre	No Further Coding Required	Sully, Nicola	Button, Mick	Accepted	Medics	23/11/2021	01/02/2022		Current and predicted shortfall of oncologists by 2025	A recent census (RCR 2021) has predicted a shortfall across Wales in clinical oncologists by 2025. Medical oncologist were not included in the census but should also fall under this risk due to overlapping clinical roles. There is a current shortfall with predictions that this will worsen over the next 5 years (NB this is likely to be a gradual worsening over a period of time; the census predictions only go up to 2025 so no data suggests sudden improvement after that time). Due to the nature of clinical work, these gaps may fall unevenly, for example one team/tumour site could be seriously affected while others are not. Drivers behind this are: increasing clinical care/complexity (increase in patient numbers, increase in treatment options/complexity for each patient), new demands (eg regional AOS delivery), increasing trend to LTFT working and predicted retirements. On top of this there are potential impacts from Covid (ill health), pension tax impact. This is likely to lead to: difficulties seeing new patients on time, managing all aspects of care (OP review, SACT, RT), delivering a regional model of care, supporting new areas such as AOS, impact on clinician health, wellbeing and teamworking. It may also impact on non clinical roles, ability to recruit/retain staff. Recruitment is challenging as this shortfall will be felt across the UK. Due to the nature of clinical work, finding backfill through re-allocations of individual sessions is challenging.	15	15	4	Training places have increased however will not feed through by 2025. Actively seeking to recruit Developing new multi-professional ways of working (but there are also workforce limitations in other professional groups and the time taken to train new colleagues is a challenge)
2395		Safety	Corporate Services	Estates Management	Fear, Jonathan	Fear, Jonathan	Accepted	Quality and Safety	26/05/2020	01/10/2022		Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	15	12	9	1.As noted above, site has holistic fire strategy where compartmentation plays a key role 2.Site has high level of fire detection to WHTM 05 (Firecode) 3.Provision of fire safety training to support implementation of fire safety strategy 4.Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5.Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6.In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7.Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8.Consideration of fire risk assessment findings (including compartmentation issues) as part of Capital Refurbishment schemes.
2223		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Bell, Mrs Tracy	Miller, Lisa	Accepted	Operational Services	21/07/2020	12/01/2022		Delay in re-starting outreach activity	The delay in re-starting outreach activity which is as a result of the COVID-19 pandemic, is impacting on outpatients resources and the availability of clinic rooms in VCC. This is because all outreach services have been repatriated to the cancer centre for the duration of the COVID-19 pandemic.	12	12	12	UPDATE June 21 - Discussions to repatriate outpatients clinics continue with health boards. Previously agreement from ABUHB to re-start outreach clinics in Nevill Hall but subsequently notified that space is not available, although not Royal Gwent. VCC group established to manage repatriation of clinics and SACT to NHH. Continue with ongoing discussions with other HBs as this remains a priority for VCC. SSTs have been asked to review all their clinics and highlight priority clinics for repatriation. Undertake surge planning and discuss impact with health boards
2185		Safety	Velindre Cancer Centre	Radiotherapy	Windle, Rebecca	Johnston, Sam	Accepted	Medics	14/09/2020	31/03/2022		Delination Risk treatment delay (16284)	There is a risk of Radiotherapy physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets. There is a lower risk that errors are missed at physics check and make their way to treatment. These errors are generally not picked up at medic peer review or during the physics planning process but by more experienced Clinical Scientists at final physics check, often the day before treatment. There have been a number of Datix incidents attributed to this - with Radiotherapy Physics previously trying to communicate the issues. Action is required to ensure these errors do not propagate to treatment.	12	12	6	Discussions, initiated by physics, have been held at the RMG quality focused meeting to ensure the medical workforce are aware of the issues and to enable discussions and learning within SSTs. Medic peer review processes (for some treatment sites). A physics quality improvement project categorised the errors - this information is available for learning. Further controls required – ensure volume peer review is in line with RCR recommendations and a Datix medic representative is available to ensure learning within medical teams. Also consider transferring PTV volume growth to the physics team.
2224		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Bell, Mrs Tracy	Miller, Lisa	Accepted	Operational Services	07/11/2019	12/01/2022		Demand for services outstripping capacity	Demand for services outstripping current capacity resulting in patients not being seen in a timely manner and waiting time breaches. Also results in overbooked clinics which are extremely busy. In addition, many of the outreach clinics continue to be run from VCC which is adding to the pressure on clinic rooms.	16	12	16	UPDATE June 21 - Risk rating increased to reflect current situation. Increasing referrals are leading to an increase in outpatient attendances resulting in very busy clinics. Continue with planning for any surge in activity due to cancer backlog and latent demand from health boards is being undertaken by VCC. Continue with weekly monitoring of outpatient referrals and activity. Progress with the work of the Demand Modelling group being led by the BI team. Continue to have discussions with health boards re. outreach clinics and likely demand for services.
2206		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	09/10/2020	03/03/2022		Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR003(R) - Could impact on key project team members capacity due to service requirements being prioritised, childcare needs, the need to self-isolate etc. The ongoing impact of the Covid 19 outbreak continues to have a significant impact of staff in terms of their well-being, their availability and their ability to absorb new ways of working and new systems within an already stretched environment. Also, additional clinical pressures/ demand on; clinics, inpatient activity, treatments and the presentation of potentially sicker patients, resulting from the impact of COVID19.	20	20	9	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.
2211		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	09/10/2020	03/03/2022		Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	16	12	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working
2296		Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	11/01/2021	03/03/2022		Digital Health & Care Record DHCR010(R) - Data Migration Resource	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR010(R) - The Head of Information who manages the Business Intelligence (BI) Service within VCC is actively involved with the Data Migration work. This includes assisting the Data Migration Specialist with the development and testing of data migration extracts from Canisc to WPAS. In addition, the Head of Information provides subject matter advice and guidance to the whole project team. There are currently competing priorities on the Head of Information time due and the need to delivery Capacity and Demand planning, ad hoc information requests etc. during the COVID pandemic, whilst supporting a new team. The impact of these competing demands and a number of new team members is the reduced availability of focused time for the Head of Information to undertake the complex data migration work. This has impacted directly on the capacity of the Head of Information to assist in the development and testing of the data migration extract and provided support/guidance in a timely manner.	15	15	6	Clear prioritisation of the BI Service work and Head of Information's workload is required. Notification to service users of unavoidability of BI Head for 3 weeks period in April 2021. A deep dive is planned to support this prioritisation. 09/06/2021 - LM & JH reviewed risk - situation still stands. LM to discuss with WJ.
2203		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	12/01/2021	03/03/2022		Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR013(R) - Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed from 18 months to 6 months. Data Migration Phase 1 (Patient Demographics and casenotes) and Phase 2 (Referrals, activity, Clinics, pathways and waiting lists) both need to be completed by prior to UAT testing which is due to commence in July 2021. There is a risk that any delay to these data migration activities could have a direct impact on the quality of the patient data migrated from Canisc into WPAS as there will be no time to review and cleanse the data prior. There is also a risk that any delay to the data migration activities will have a direct impact on the WPAS implementation date which may lead to the Service having to rely on an unstable and unsupported Canisc instance for a longer period of time.	16	16	8	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.

2221		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Norman, Sarah	Accepted	Health Records	24/02/2021	03/03/2022		Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'. This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding. This functionality is not available within WPAS; therefore it is requested that the functionality be developed. There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eRMER development. This could affect the implementation timescales. DHCW confirmed that they can replicate the copy coding functionality but that it could take up to 12 months. They have confirmed a temporary manual copy coding function that will be used in the interim. This will require 2 staff (or equivalent overtime) for up to 12 months. Without the ability to copy the RT Regular Day Admissions (in same sequence of admissions) will have a resource and financial impact. Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards. At present, 2 coders code 60,000 episodes of RT Regular Day Admissions. Without the function to copy the coding team would need additional resource to maintain deadlines. A full time coders would generally code approx. 6,000 episodes per year. Therefore an additional 8 full time coders would be required to maintain current levels of productivity. Financials can be calculated if necessary. Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards.	16	16	12	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected
2512		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Evans, Fran	Lloyd, Gareth	Accepted	Whole Service	02/02/2022	03/03/2022		Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR022 - A potential business continuity risk following implementation. Currently the WCP is used to access case note summaries for patients in order to provide business continuity when Canisc is unavailable. The impact in this risk would be felt after go-live but could impact on service delivery. This is potentially a service risk but will be considered and summarised for the project risk register and discussed further at the next Project Board Meeting	15	15	12	DHCW to develop a solution as this would have an effect on every HB when they have an Electronic Patient Record
2324		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR024(R) - DH&CR project support: There is a risk regarding the availability of SACT support for the DH&CR project, due to increased demand on the SACT service if & when SACT surge demand occurs or SACT capacity reduces The SACT DH&CR operational lead also provides clinical leadership for SACT booking services. Impact on clinical patient escalation & prioritisation process for SACT scheduling with potential impact on clinical outcomes if SACT DH&CR operational lead is unable to provide sufficient time to this element of service should SACT demand increase or capacity reduce. Conversely, there is the potential impact on the DH&CR SACT project progressing if resource is focussed on clinical prioritisation	16	16	8	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.
2325		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. There is a Risk of Canisc being shut down on 17/09/21 before SACT & MM have completed required activity in Canisc. Clinical teams will be unable to access patient records during Canisc switch off, leading to delays in decision making and potential error, along with poor patient experience There could also be an impact on data migration if all SACT switch off activities are not completed in time	20	12	8	All clinical teams and SACT administration to complete all work before switch off deadline. During this time, SACT & MM have requested that switch off of Canisc be delayed until 19:00 on Friday 17/09/2021. This aligns with RT & OP clinics
2326		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Evans, Fran	Stockdale, Ann Marie	Accepted	Operational Services	24/05/2021	03/03/2022		Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live. A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	16	9	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2329		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Administration (inc Bookings)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required. Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care.	16	16	16	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.
2328		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes of booking/admitting patients	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR035(R) - The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care Potential risk to patient safety because clinical staff are distracted by the administrative task Documentation will not be accurate impacting on clinical decision making Protracted administrative process causing stress to clinical teams whose primary focus is clinical care	16	16	16	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2432	N	Workforce and OD	Velindre Cancer Centre	Information and Technology	Evans, Fran	Seary, Sarah	Accepted	Whole Service	05/10/2021	03/03/2022		Digital Health & Care Record DHCR036(R) - DHCR Project Support from Service	Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care DHCR036(R) - DHCR project support: Availability of Inpatient Staff, Psychology, Therapies, Infection Control, Clinical Coding, Assessment Unit and Supportive Care staff and CNSs, to support DHCR project due to continued increased demand across all these services. 1. Project timelines could be delayed as training, testing may be seen as secondary to providing clinical care. 2.Once ways of working have been identified, time required to employ, train any additional resource required could impact project implementation.	16	12	4	Update 14.02.22 - Monthly Project Group meetings taking place along with fortnightly Inpatient meetings. Process Maps now completed and signed off by service. Currently looking at resources that may be required to support the new ways of working. Update 10.12.21 - Regular meetings continue to take with project leads. Ways of working almost completed for IC. Some process maps completed and signed off by service. Update 03.11.21 -Regular update meetings scheduled with project team leads to review progress and outstanding work. Attendance at Project Team meetings. Update 27/10/2021 -Dedicated time made available for operational lead. Continuous review of service capacity across the inpatient workstream prioritisation process. Weekly reviews with the Department Leads to monitor progress in DHCR project, but also to sense check the demands of the services.
2440		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	18/08/2021	03/03/2022		Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR046(R) - SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	16	16	6	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints 23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.
2498		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Lloyd, Gareth	Accepted	Digital Services	11/01/2022	03/03/2022		Digital Health & Care Record DHCR050(R) - There is a risk that Chemotherapy treatment information is not sent to Canisc post go	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR050(R) - There is a risk that Chemotherapy treatment information is not sent to Canisc post go live. During cutover this interface will be redirected to WCDS and WCRS. However it has been questioned whether this feed would still be required in Canisc, post DHCR golive i.e. would Chemo treatment information still be required for RT and Palliative Care (viewable in Canisc). The assumption would be that as the information would be available as a PDF in WCP, like the other results feeds, if we can get them elsewhere, let's turn the feed off. Additional development/cost maybe CIS,the ChemoCare, provider do not support multiple feeds, InSe would need to do additional work do send messages to multiple systems.	15	15	1	Two decisions required. 1. Turn off the interface (on the proviso that the results are available via PDF in WCP). 2. When should the interface be turned off – a.Precut over with suggested date. b. during cutover c. defined date post cutover
2499		Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Evans, Fran	Lloyd, Gareth	Accepted	Digital Services	11/01/2022	03/03/2022		Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR051(R) - There is a risk that not interfaces will be delivered in a timely manner for sufficient testing. * Clinical information will not be available in WCP/WPAS. * VCC runs a clinical safety risk if data is not available for decision support. *Not enough time will be available to provide adequate assurance.	20	20	8	Pressure on DHCW to provide interface on schedule. Testing window is fixed and protected not used as development contingency
2438		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Evans, Fran	Ikin, Kathy	Accepted	Radiotherapy Services	21/06/2021	03/03/2022		Digital Health & Care Record Risk DHCR043(R) - Completion of process maps and ways of working	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR043(R) - Further maps now having to be drafted due to development of e-IRMER and migration issue. e-IRMER workflow maps required, increased workload for project team, with limited resource.	20	12	9	Project team structure undergoing revision & recruitment planned. Workshop to be arranged to finalise workflow process maps with clinical input
2454	N	Workforce and OD	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/05/2022		Digital Services Capacity / Skill Mix	There is a risk that the Digital Services team are unable to support agreed Divisional and/or Trust strategic and operational objectives as a result of limited capacity within the team, which may lead to a delay in the delivery of new / updated digital services.	20	16	8	Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.

2461	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/01/2022		Failure of Building Management System (BMS)	There is a risk of failure to the Building Management System (Trust wide). This is for multiple reasons including being run on legacy operating system (Windows 7), no patch management and faulty hardware - this has led to multiple issues previously.	12	12	4	No controls relevant to suppressing the risk. Machine either requires upgrading, replacing or migrated to a virtual machine.
2394		Performance and Service Sustainability	Corporate Services	Executive Management Team	Wright, Lenisha	Fear, Lauren	Accepted	Governance	21/04/2016	28/10/2021		Fundraising Income Targets	This risk applies to external charities as well as those based on site at Velindre Cancer Centre. However, the control measures and focus of the remainder of this risk assessment relates to onsite charities.	12	12	3	The Trust has a clear fundraising strategy in place. Velindre Cancer Centre's branding guidelines introduced in July 2015 states that: - The Velindre University NHS Trust, NHS Wales, Velindre Cancer Centre and Velindre Fundraising will be the prominent brands on Velindre Cancer Centre premises. - Only 'Velindre Fundraising' and 'Friends of Velindre', charities which raise funds exclusively for Velindre NHS Trust, will be allowed to display publications, materials or media alluding to any form of fundraising on Velindre Cancer Centre premises. - Non-fundraising materials from other charities and organisations will be promoted where there are clear benefits for patients and carers.
2191		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Maggs, Rhydian	Ikin, Kathy	Accepted	Radiotherapy Services	14/09/2020	31/01/2022		Inability to meet COSC / SCP targets	There is a risk of poor compliance against COSC time to treat targets, potentially affecting patient outcomes and Trust reputation, due to inefficiencies in the current pathway and staffing issues. Staffing risks are raised separately for RT Physics, Radiotherapy and Medical directorate.	20	20	4	Physics mitigation described below: Plans are prioritised by start date to minimise delays. Physics staff are redirected to physics planning during periods of high demand. Weekly RT service capacity and demand meetings monitor position. Increased checkers rota'd for a Friday to mitigate Monday starts. Plan to increase capacity is in progress. 4 additional surge posts have been created in treatment planning with recruitment ongoing (2 surge posts filled internally with backfill recruitment active, 2 filled externally but 1 staff member moved Trust).
2393		Safety	Corporate Services	Health and Safety	Evans, Annie	OBrien, Cath	Accepted	Quality and Safety	19/06/2020	28/10/2021		Infection control	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex.	12	12	9	To be inserted
2397		Safety	Corporate Services	Health and Safety	Evans, Annie	Evans, Annie	Accepted	Quality and Safety	18/05/2018	28/10/2021		Infection Prevention & Control Service including staff attendance	1.Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2.Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3.Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4.There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT / sepsis leading to reduced engagement. This will hinder required service improvement in clinical audit.	16	12	9	Control Measures in place: 1.Risk assessment in place for ICNet and duplication of data entry but it doesn't take into account additional demands of imminent National Enhanced surveillance. 2.Core Microbiology service provision continues but opportunities for learning and clinical review missed as reduction in weekly microbiology ward rounds to every 3/ 4 weeks
2452	N	Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Mason-Hawes, David	Daniels, Gareth	Accepted	Digital Services	29/10/2021	01/02/2022		Intermittent IP telephony failure	There is a risk of ongoing (intermittent) IP telephony failures as a result of a recent upgrade to the Wi-Fi central controller, which does not fully support the older Cisco 7925 Wi-Fi IP phones in use across VCC, which may lead to telephony disruption for around 150 users.	15	12	3	New Wifi phones are in stock to replace the critical areas that require upgrades immediately. New Batteries are required to install these which will be ordered ASAP. Plan to replace all 149 handsets ASAP Attempt to fix the issue with the 7925 in the interim.
2456	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/05/2022		Lack of agreed software development standards	There is a risk that internal / 3rd party software development activity will fail (or be difficult to support) as a result of a lack of agreed software development standards, which may lead to inconsistent approaches to delivery of new software applications Outdated policies and procedures to support software development practices and processes within WBS have resulted in audit failures and the development of software products outside of existing procedures.	16	12	4	Currently software development follows existing guidelines. A Temporary SOP has expired but this is also being followed. Where possible peer review establishes validity of developments and stringent User Acceptance Testing is always followed.
2457	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/05/2022		Lack of dedicated web / SharePoint development resource within Digital Services	There is a risk that priority strategic / operational web / SharePoint developments cannot be supported as a result of a lack of dedicated web / SharePoint development resource within the Digital Services team, which may lead to a degradation of existing VUNHST websites and/or an inability to develop new website / SharePoint content to meet service needs. Current web development being managed on an ad-hoc basis by WBS Digital Services staff and Corporate Communications team. No dedicated full time support available to be responsive to the demands of the service	12	12	3	Ad-hoc support by trained individuals.
2254		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Fear, Jonathan	Wilkins, Paul	Accepted	Estates	16/06/2020	01/07/2022		Lack of mechanical ventilation at the VCC site (including inpatient ward areas)	This risk has 3 elements – 1. Potential for increased risk of infection due to a lack of mechanical ventilation, 2. Staff and patient discomfort in hot weather due to sub-optimal ventilation, and 3. Breach of Health & Safety regulations and Health & Safety Executive regulation to provide ventilation systems that are sufficient to ensure that high risk patients are protected from exposure to potentially harmful airborne microbiological organisms	12	12	4	Taking each of the three key elements of the risk: 1.Increased potential for infection due to sub-optimal ventilation •Full infection prevention processes are in place, and any patient with suspected infection is cared for in a side room which usually has a window for natural ventilation (in the summer months). 2.Staff and patient discomfort in warm weather due to sub-optimal ventilation •Some mitigations are in place, but further work is required with pace to ensure the well-being of staff and patients during the rest of this summer. •An external specialist will be commissioned to provide recommendations to reduce the heat, and a Task & Finish group has been set up w/c 15/06/20 to develop a hot weather business continuity plan •Further mitigations are being assessed, including use of theatre scrub uniforms for nursing staff and washable cooling blankets and mattresses for patients. 3.Non-compliance with Health & Safety standards due to sub-optimal ventilation across the VCC site •In order to address the sub-optimal ventilation at VCC, an external specialist been commissioned to provide recommendations to feed into the business case.
2252		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Staffurth, Mr John	Miller, Lisa	Accepted	Whole Service	14/09/2020	01/04/2022		Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	20	15	10	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR
2222		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Arndel, Karen	Gent, Carolyn	Accepted	Nursing	07/11/2017	31/03/2022		Loss of CANISC - compromise patient care	There is a risk that as Canisc is an 'end of life' system, it could fail which could compromise patient care. It could mean that some patients cannot be seen in clinic or some would experience long delays. This can lead to increased patient anxiety, frustration and stress for staff, overcrowding in waiting areas and a possible delay in prescribing chemotherapy.	16	12	12	Update June 2021 – DH&CR project continues at pace which includes plans to replace CANISC with WPAS. Regular meetings taking place to review OPD processes and clinics. CANISC BCP remains in place. Implementation of the Document Management Solution – copy of correspondence available electronically on local infrastructure. Correspondence viewable in the Welsh Clinical Portal. Correspondence sent to the GP electronically (via WCCG). Welsh Clinical Portal to link to the Master Patient Index – in the event of Canisc being unavailable this version of the WCP would be invoked enabling access to documents, test results and the GP Summary. Authorised staff members have direct access to Synapse (local infrastructure) – VCC radiology images and reports available to view. Aria and Mosaiq not reliant on Canisc – Radiotherapy treatment can continue in the event of a Canisc outage. ChemoCare decoupled from Canisc and held of local infrastructure – SACT prescribing, dispensing and delivery can continue
2193		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Hooper, Sue	Ikin, Kathy	Accepted	Nuclear Medicine	05/02/2021	30/04/2022		Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	Medical Physics Experts (MPEs) for Nuclear Medicine. This risk combines 8438 (submitted by S Hooper – MPE cover for clinical trials) and 15684 (submitted by M Talboys – Ra223 service) on the current risk register and has been expanded to encompass new developments on the immediate horizon. There is a significant risk is that Velindre Cancer Centre will not be in a position to safely and sustainably offer the Molecular Radiotherapy (MRT) demand, likely to be required in the next 12-18 months. This arises because of a lack of experienced Medical Physics Experts (MPEs), the timescales over which the implementation of new MRTs may be required, the predicted increase in workload and the anticipated number of other significant developments which will lead to not being able to implement MRT MPE cover within Nuclear Medicine for MRT has been extremely stretched for a number of years. There has been a large reliance on a single point of failure, for several molecular radiotherapies within Nuclear Medicine. An additional MPE was appointed in November 2018 but the individual appointed had no previous experience in radionuclide therapy (MRT). A temporary solution was implemented to provide MPE support for Ra223 by two individuals not employed within Nuclear Medicine. That offer of support was withdrawn (Jan 2021). Some experience has now been gained by the individual appointed in 2018 but there is now a requirement to provide back-up to that MPE (for Ra223). This is not feasible for the experienced MPE, who is already working in breach of working time directive and trying to respond to a predicted increase in MRT in the next 1-2 years at VCC. (This increase includes repatriation of a therapy to Cardiff from London, a potential large increase in prostate MRT 2022/23 (if NICE approved), personalised dosimetry for MRT patients to comply with legislation and involvement in a clinical trial). Wales is already behind England in implementing some of these treatments into routine clinical care, due to a lack of resilience in MPE support in recent years. Current predictions for MRT is that there will be an 18% compound annual growth (Journal of Clinical Oncology -Feb 2021).	20	16	2	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).
2258		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Walters-Davies, Rhiannon	Tranter, Bethan	Accepted	SACT	17/05/2021	28/02/2022		Medicines at Home Service:	There is a risk that patient pathways and supporting professional procedures and practices (eg SOPs) will not be appropriately or adequately reviewed because of a lack of resource OR that pharmacist attempts to review in the absence of an alternative suitable clinician are clinically insufficient which may lead to patient safety incidents There is a risk to service continuation and sustainability because of limited alternative clinical leadership within pharmacy (or wider SACT and MM Directorate) for the MaH service which may lead to the service needing to be reduced or discontinued with resultant negative impact on SACT and MM capacity and cost savings opportunities. There is a risk to financial sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been avoided OR because of lack of strategic leadership to continue to grow the service. There is a risk to patient experience and patient outcome if the benefits of released SACT service capacity provided via the Medicines at Home Service (oral and parenteral) cannot be maintained and increased There is a risk to VCC reputation because of an inability to progress action plan from RPS audit There is a risk to patient safety because of limited capacity for engagement by medical or nursing to review incidents, learn lessons and instigate remedial actions to reduce the likelihood for future reoccurrence There is a risk to patient safety because of limited resource within current team to review to manage oversight of all complaints and incident	16	12	4	Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision
2396		Performance and Service Sustainability	Corporate Services	Executive Support Team	Morley, Sarah	Morley, Sarah	Accepted	Workforce and OD	20/04/2017	28/10/2021		PADRs	Not all employees are receiving meaningful PADRs -PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	9	12	6	-PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.
2255		Financial Sustainability	Velindre Cancer Centre	Private Patients	Stockdale, Ann Marie	Miller, Lisa	Accepted	Private Patients	24/02/2021	31/03/2022		Private Patients Debt	An internal audit under in 20/21 reviewed debt management as one of its objectives. A key area requiring attention was the management of aged debtors by the Private Patient Service. The conclusion was that the aged debtors are not monitored or acted upon and there was no action plan in place to improve the situation. Also that there is no liaison between the private patient service and the corporate finance team. Analysis has shown that debtors go back a number of years and include self paying individuals as well as insurance companies. As at the time of submitting this risk the outstanding amount is £328,791.	12	12	4	1. Full review of all debtors in 2017 and 2018 to assess current situation and recommendation for follow up to be provided to Director of Finance. 2. Action plan developed for Trust Audit Committee which will be monitored by weekly meetings. 3. All debtors to be written to by 5th March 2021 providing 14 day payment period requirement. 3. Meeting arranged to discuss automation of process options. 4. Private Patient Manager to benchmark systems with other organisations. 5. Private Patient Manager to review current Standard Operating Procedures (SOP's) to improve current process. 6. Head of Operations and Delivery to work with Deputy Director of Finance to review Trust SOP's and engagement process. 7. Regular meetings with Private Patient Manager and corporate Finance lead to be established.

2200		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Jenkins, Paul	OBrien, Cath	Accepted	Radiotherapy Services	01/05/2011	31/03/2022		Radiotherapy Capacity	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes. 2/7/19 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. 23/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet. Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service	20	20	6	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy booking processes, and staff flexibility used to maximise use of resources. Project to be commenced to address ongoing capacity led by COO. Implementation of the above measures will not mitigate this risk- further measures required from escalation to Trust board 22/4/20 - We have sufficient capacity at this moment in time due to covid. We have taken 2 linacs out of routine use. One due to it acting as the machine for treating covid + patients, the other is removed as we have halted treating prostate patients. We are working 7-7 shifts on one machine to compensate for the large amount of H+N patients being treated at present. 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2.Undertaking escalation work to minimise breaches. 3.SST's being asked to review current dose/# offered to patients. 4.Review of trials. 5. All vacancies out to advert. 6. Outsourcing to Rutherford Cancer Centre. 23/11/2021 Update - Ongoing monitoring of capacity, demand breaches and waiting times targets. Development of breach escalation process to ensure, where needed patients are prioritised effectively. - Extended working hours are in place on the treatment machines and in many other areas of service. - Agency Radiographers are in place to support additional hours. Assessment of potential Agency staff experience at point of hire to ensure that Agency staff are able to rotate around more than one work area / linac type / OMS type within
2196		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Payne, Mrs Helen	Payne, Mrs Helen	Accepted	Radiotherapy Services	14/09/2020	01/04/2022		Radiotherapy Department - COVID Isolation Impact	COVID Isolation Impact Staff isolation as a result of coming in to contact with a COVID positive person, exhibiting COVID symptoms or receiving a COVID positive test result will affect the capacity (Linac & Pre-Treatment hours) of the radiotherapy department as the majority of staff are patient facing and are unable to work from home. Resulting in the need to contract the radiotherapy service.	16	16	4	Ability to work from home with relevant IT equipment on completion of DSE risk assessment Isolations rules to be reviewed regularly. 7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 7/2/2022 - risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.
2345		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Payne, Mrs Helen	Payne, Mrs Helen	Accepted	Radiotherapy Services	14/09/2020	06/12/2021		Radiotherapy Dept - Change to service due continued response to Covid19	There is a risk that there will be a continued change to service as a result of Covid 19 measures which may lead to contraction of the service and the creation of a waiting list As the service moves in to the recovery phase there is a continued risk of the availability of staff being impacted through infection prevention and control measures, thus potentially impacting on the service ability to deliver the required capacity to meet demand 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. □	9	16	1	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary 'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infection Development of outsourcing contract to private provider to deliver external beam for prostate and breast 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2.Undertaking escalation work to minimise breaches. 3.SST's being asked to review current dose/# offered to patients. 4.Review of trials. 5. All vacancies out to advert. 6. Outsourcing to Rutherford Cancer Centre.
2361		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Jenkins, Paul	Jenkins, Paul	Accepted	Radiotherapy Services	12/06/2020	01/04/2022		Radiotherapy Dept - COVID Social distancing	COVID Social distancing – Radiotherapy In response to national guidance to reduce the risk of contraction of COVID-19 due to close contact with persons and objects, social distancing measures have been introduced into the radiotherapy department in line with COVID-19 guidance. This may result in reduced capacity and the contraction of the radiotherapy service.	16	12	2	21/5/2021 – Risk reviewed by PJ & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – Risk reviewed CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service. 7/2/2022 – Risk reviewed CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service.
2502	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Hinton, Tracy		Accepted	New Velindre Cancer Centre	14/01/2022	01/03/2022		Risk of delay to start on site	There is a risk that the start of construction is delayed beyond the date stipulated in the outline planning permission decision notice 17/01735/MJR (27th March 2023), leading to delays to the project and a possible loss of planning permission.	12	12	4	1. Submit section 73 application to extend the date by which start on site must occur, to reduce the impact of any delays to the start of construction. Started 2. Regular monitoring and management of other projects/workstreams which may affect start on site date including enabling works and nVCC procurement. Ongoing
2501	N	Financial Sustainability	Transforming Cancer Services	No Further Coding Required	Hinton, Tracy		Accepted	New Velindre Cancer Centre	14/01/2022	04/03/2022		Risk of Inflation leading to increased costs	There is a risk that increased rates of inflation lead to the capital costs of the project exceeding the affordability envelope.	20	12	12	1. Paper on affordability submitted to WG. Ongoing
2401	N	Workforce and OD	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Bryce, Gavin	Accepted	Integrated Radiotherapy Solution	26/02/2021	03/03/2022		Risk of insufficient resources being made available to the Project	There is a risk that insufficient resources (people) being made available to the project will have an adverse impact on the quality of the procurement process	16	12	8	1) Detailed project Plan to identify resource requirements 2) Approved Capital Budget for the Legal & Staffing Costs 3) Regularly monitor staff availability (annual leave & sickness)
2407	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Hague, Andrea	Accepted	Radiotherapy Satellite Centre	17/01/2020	20/05/2022		Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	16	12	4	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline
2249		Financial Sustainability	Velindre Cancer Centre	Finance	Wilkins, Paul		Accepted	Operational Services	27/02/2020	20/12/2021		Risk of service disruption due to number of posts funded by soft monies leading to financial instability,recruitment difficulties	A high proportion of VCC workforce are funded via 'soft monies' from the Trust Charity or Third Sector. This leads to risks around service continuity, recruitment and retention and staff wellbeing. It also poses a financial and reputational risk for the Trust should funding be ceased. For 20/21 there is approximately £2.8 million of charity/3rd sector funding which is supporting service delivery.	12	12	4	Funding ending in the next year to be included in cost pressures for 2020/21. Review posts funded externally to establish: Number of posts, length of funding, contribution to service, and contractual position of postholder. Establish Financial contingency. Through the scrutiny process ensure future risks are considered for all new and extended posts. Prioritise work in order of funding stream end date
2402	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	10/05/2021	31/01/2022		Risk of time-consuming infrastructure work	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	16	9	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment
2424	N	Safety	Velindre Cancer Centre	Therapies Areas	Baker, MRS Kate	Baker, MRS Kate	Accepted	Therapies	28/07/2021	25/02/2022		Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels	There is a risk that there could be breaches of waiting times, reduced patient experience and outcomes as a result of reduced staffing levels in the Dietetics department which may and stress on the remaining staff members. Due to x1 maternity leave (Clinical Lead DT) and x1 LTS (band 6 PSU cover) with the Dietetic department the workforce is currently reduced from 5wte qualified staff to 3.5wte. Scrutiny approved 1.0wte band 6 DT and an internal upgrade band 6-7. Unfortunately we did not recruit into either of these posts. Our locum also finished on 7th July 2021. Scrutiny have however approved an external band 7 Clinical Lead DT 1.0wte, which is currently out to advert and in the recruitment process. There is therefore a current risk on the workforce that will hopefully be mitigated by recruitment into the vacant post. For the next 2-3 months, there will not be the required capacity to deliver a high quality, timely DT service. This will lead to breaches of waiting times, reduced patient experience and outcomes and stress on the remaining staff members. We are currently trying to recruit a Locum to cover this period however at present we are unable to secure one.	12	12	6	Remaining DT staff are trained to appropriate levels and clear re what they can and cannot do Clear prioritisation criteria is in place Discussions with Senior managers and exec colleagues to make them aware of situation Locum agency searches. Temporary cessation of some services will be required. Recruitment for the 1x external Clinical Lead Dietitian vacancy is underway
2416	N	Quality	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that COVID may lead to delays on Project progress	There is a risk that potential further waves of COVID may lead to delays that effect the development & key activity of the outreach project	20	12	6	Agreement with HBs of ways of working during any possible covid resurgence to ensure that project is able to continue making progress

2505	N	Performance and Service Sustainability	Velindre Cancer Centre	Human Resources	Wright, Lenisha	Miller, Lisa	Accepted	Whole Service	18/01/2022	31/01/2022		Risk that Covid 19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Servic	Further focus on demand and capacity modelling, linked to current action plan – subject to Gold review 19th January	20	16	6	-SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full; increased virtual appointments -Radiotherapy - major limitations on capacity due to reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need; Changes made to Prostate pathway based on agreed framework; maximising third party provision.
2507	N	Safety	Velindre Cancer Centre	No Further Coding Required	Wright, Lenisha	Miller, Lisa	Accepted	Medics	18/01/2022	31/01/2022		Risk that current regulations in Wales regarding isolation has impacted on patients being able to commence treatment	current regulations in Wales regarding isolation has impacted on patients being able to commence treatment	16	16	9	-Research underway into practices nationally conducted via Silver Command for reporting into Gold -Finalise recommendation for Gold decision, as appropriate, on any changes
2403	N	Quality	Transforming Cancer Services	No Further Coding Required	Pinocci, Francesca		Accepted	Enabling Works	08/06/2020	04/03/2022		Risk that enabling works construction exceeds timescale	There is a risk that enabling works construction, including bridges, exceeds 15 months, leading to delays to nVCC construction and incurring financial loss claims from the MIM contractor.	12	12	9	1. Regular review of possible areas which may cause delay: Most recent review of the plan shows only minimal slack between the end of the enabling works construction and beginning of MIM construction Ongoing 2. Partial mitigation through normal contract condition re liquidated and ascertained damage – where events in the contractors control can result in compensation for costs incurred by the client resulting from time or cost overruns. Need to be within expected reasonable limits. Care required in setting that limit to steer away from punitive damages as few contractor would price the works, pushing up tender prices. Scaling delay damages clause added to tender documentation to ensure contractor is incentivised to complete work on time. Complete 3. Focus to be applied to detailed construction programme following return of EW D&B bids. Complete
2423	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Bryce, Gavin	Accepted	Integrated Radiotherapy Solution	08/09/2021	03/03/2022		Risk that IRS evaluation process is delayed due to resource pressures	There is a risk that as the nVCC Competitive Dialogue clashes with the IRS Final Tender evalutation, there is pressure on resource availability leading to delays in finalising the evaluation process	12	12	6	1) Works has started to understand which staff and resource are impacted to explore availability and potential impact of this to the Project
2408	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Bryce, Gavin	Accepted	Integrated Radiotherapy Solution	22/04/2021	03/03/2022		Risk that IRS Project FBC is delayed or not approved	There is a risk that the approval for the FBC for the IRS Project is delayed or not approved, due to changes in approval timescales which would lead to delays to project delay, project abandonment impacting on other TCS Projects (nVCC & RSC) deliverables	16	12	8	1) Engagement with Capital & Treasury teams - ongoing 2) Previous presentations to IIB - complete 3)OBC shared with WG Officers for comment - complete 4)WG notified of timescales for FBC so they can align resources - complete 5)Specialist advisors used to support delivery of Business Case - ongoing
2389	N	Safety	Velindre Cancer Centre	Therapies Areas	Seary, Sarah	Cooper, Mrs Vivienne	Accepted	Therapies	28/05/2021	25/02/2022		Risk that patients with altered airways may not receive appropriate care from the MDT clinical team	There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management. Definition of these patients fall into 3 groups; • Head and neck patients with tracheostomy or laryngectomy stoma. • Respiratory patients requiring suction • Palliative patients requiring suction	12	12	6	Update 10.12.21 - Recruitment underway for a Head & Neck Advanced Nurse Practitioner with interviews taking place w/c 13.12.21. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Update 03.11.21 - additional mitigating actions: We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team. •Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level • Advice available from PSU nursing team Mon-Fri in basic competency levels - needs scoping as there is potential for enhancing straining and assessment through this service. •Ward Nursing staff – some basic skills – training needs analysis needs to be completed •H&N CNS and consultant radiographer – skills need scoping but these work Mon-Fri, what are the opportunities for cover across the 7 days? •Training being sourced by nurse education lead •Group 2 & 3 patients •Recent survey of competencies of VCC physios (available on request) with an action plan for roll out to the other disciplines •Establish competencies and work out how best to complete/maintain them •Link with Pall Care to determine a clearer pathway for when suction is required •Benchmark as to what other areas do, i.e. Rookwood, Hospices, Cancer centres. •Explore research further to identify clear precautions/contraindications for certain respiratory techniques for oncology patients •Link with C&V physios and critical care team to access competency based training. •Staff competencies across the organisation to be scoped and potentially access the C&V training for all. •Re-instate the Altered Airways training for clinical staff asap
2405	N	Quality	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that projected growth assumptions for Outreach will be less than required	There is a risk that the projected growth assumptions for outreach delivery of SACT, ambulatory care and outpatients is less than will be required, leading to undersized locations.	16	12	6	1) Re-run projections around growth assumptions. 2) Activity model will be re-run with outputs presented to project Board. Any additional requirments will be presented to the Programme Delivery Board with recommendations. Individual meetings with Health Boards to ascertain their requirments will be undertaken.
2413	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Hague, Andrea	Accepted	Radiotherapy Satellite Centre	29/06/2020	30/06/2022		Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility	There is a risk that the Radiotherapy Satellite Centre will not have required skilled staff in place to run the facility once ready to be operational. This would impact on radiotherapy capacity and resilience for the Trust.	15	12	6	1) An integrated Radiotherapy and Physics workforce plan is required to consider the service as a whole taking account of a full operating model that includes current activity, projected activity, IRS and RSU. 2) Provisions from across the whole service will be reconfigured to meet the requirements of the satellite unit.
2418	N	Reputational	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Fear, Lauren	Accepted	Programme	05/10/2020	14/01/2022		Risk that TCS Programme does not have support from Stakeholders	Risk that the TCS Programme does not have support from Stakeholders (pts, HB, politicians, WG, clinicians) Causes - Lack of engagement with all relevant stakeholders/ Misinformation shared from external sources / Inconsistent engagement from specialist resource / Change of views over a period of time / Lack of alignment between TCS programme and other strategic priorities across the organisation and individuals / Political leadership change Consequences - WG and LHBs do not support key decisions / Reputational damage for Velindre Trust as an organisation / Petitions & opposition to plans for TCS Programme / Delays to programme and project progress / Failure to deliver some/all of programme benefits	16	12	4	1) Further engagement is being planned with specialist stakeholders – broader and more targeted who are not fully supportive. Programme Communications resource in place & recruitement of additional comms resource to support comms/engagement activities 2) Better use of technology being reviewed and rolled out to share key messages 3) Variety of stakeholder events held over a number of years - complete 4) Clinical workshops held throughout Programme lifetime - ongoing 5) Professional meeting forums held e.g. DoPs, MDs, CEO's etc - ongoing 6) Ongoing engagement with local elected members (MS, MP, Councillors) 7) Dialouge beteen exisiting cancer forums e.g. cancer leads in SE Wales HBs - ongoing through CCLG 8) Monthly meeting with WG Head of Capital and Director General - ongoing
2400	N	Workforce and OD	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2417	N	Reputational	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Fear, Lauren	Accepted	Programme	08/07/2020	14/01/2022		Risk that there is lack of TCS Programme Comms Plan	There is a risk that there is a lack of TCS Programme wide communications plan resulting in the objectives of projects and interdependant links are not communicated effectively and the wider networked clinical model not understood.	12	12	4	1) Revise TCS website - complete 2) Improve internal TCS teams Comms - complete 3) Improvements to intranet - started 4) Improvements to the link between Programme Governance and Comms - tbc
2410	N	Workforce and OD	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Morley, Sarah	Accepted	Programme	05/10/2020	18/03/2022		Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet the needs of the TCS Programme outputs. Causes - Workforce supply not available in required professionals groups or with required skills / Requirements for workforce capacity and capability no longer accurate. Consequences - Inadequate staffing of Velindre facilities across the SE Wales region / Impact on providing treatment and care to patients	12	12	2	1) Service planning is sufficiently developed to facilitate effective workforce planning techniqies to be applied 2)Ensuring each project has clear and well developed workforce plans which are predicated on clear service plans 3) Clarity of expectations for workforce team involvement 4) Clarity of Role & Responsibility for Workforce planning input team in relation to Project & Programme need 5) Workforce team to support service to ensure the right people are available and allocated to support
2229		Workforce and OD	Velindre Cancer Centre	Velindre Hospital	Miller, Lisa	Miller, Lisa	Accepted	Operational Services	12/03/2019	24/01/2022		Risk to timely communication /engagement activities as a result of dedicated resource leading to low morale, reputational damage	There is a risk that positive communications are not distributed in a timely manner as a result of lack of dedicated VCC resource therefore positive communication is not provided in a timely manner to staff or externally. VCC has no dedicated specialist communication resource to support the patient and staff experience. This limits the processes that can be developed and also poses a risk to media handling. There is no dedicated support to develop social media policy or channels which limits communication options.	12	12	4	Resource increased within corporate communications and TCS teams.

2256		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Tranter, Bethan	Tranter, Bethan	Accepted	SACT	26/03/2020	28/02/2022		SACT / Divisional	Reporting on treatment pathway changes As a result of the COVID-19 Pandemic, it is likely that some patients will not be initiated on a new Systemic Anti-cancer Treatment (SACT) treatment regimen, whilst others will have their current SACT regimens deferred or discontinued earlier than originally planned. It is expected that VCC will be requested to report on the number of patients whose treatment pathway has been affected by the COVID-19 Pandemic. Thus, the number of patients that require deferral or cancellation of their SACT or who are not offered / do not accept SACT must be captured. There is a risk that this data will not be captured correctly / adequately which will result in VCC being unable to report the information	16	12	12	A paper providing an overview of the possible methods which are available to capture this data along with the challenges of doing so was submitted to the VCC Clinical Group on 26.03.20 and accepted. Staff guidelines for clinical staff were sent out in the daily Coronavirus Staff Update via e-mail and also made available in the Coronavirus section of the VCC Intranet 1 - All Clinical Staff to be directed to (where appropriate): - utilise the drop down reason code "COVID-19" on ChemoCare, - include COVID-19 in all Canisc annotations and - include "COVID-19" as the "Description" title when utilising the "Other" tab in Canisc 2 - Clinical Audit Department to lead on the capture on this data and to ensure compliance with these recommendations 3 - Recognition that a solution to identify patients whom have not been referred for treatment to VCC due to COVID-10 has not been identified. 1st Aug 2020 Solutions as identified within the paper were not consistently utilised throughout service. SST Lead and SACT Clinical Lead leading on pieces of work to identify all patients whom have had treatment pathway altered due to COVID. Work of clinical leads continues to endeavour to undertake this work and Head of P and P with BI support providing additional support and insight. This is an important piece of work which will help to identify future SACT demand and thus capacity requirements 12.01.21 - work to identify impact of first wave COVID on patient pathway was subsequently led by planning and performance colleagues and future demands work in on-going. For 2nd wave, clinical colleagues have the message reinforced that use of term COVID-19 is to be used (see above). No further mitigation available to the SACT service.
2243			Velindre Cancer Centre	Velindre Hospital	Membury, Rebecca	Tranter, Bethan	Accepted	SACT	30/06/2021	01/05/2022		SACT staff turnover	There is a risk that SACT Daycase may not be able to deliver care at the current level as a result of staff turnover which may lead to SACT reducing capacity at the SACT Daycase Unit which will impact on patient care and patient experience.	16	12	3	Senior SACT management working in the numbers Clinical trainer working alongside junior staff closed mobile unit on MONDAY Senior staff working on helpline Deputy Director of Nursing undertaking a review on the turnover/retention and education pathways Daily meetings to ensures that staffing levels are appropriate and that if needed patients are clinically prioritised.
2244		Workforce and OD	Velindre Cancer Centre	Medical Physics	Windle, Rebecca	Wilkins, Paul	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	12/02/2021		Senior Management Capacity	Senior Med Physics Management Capacity is under pressure due to some staff being utilised on IRS Multiple major programmes pull senior staff away from service delivery. COVID exacerbates the situation Separation between service and major programme means there is a loss of continuity and ownership	12	12	4	Deputies for the programs to be identified without affecting service delivery
2245		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Jenkins, Paul	Jenkins, Paul	Accepted	Radiotherapy Services	12/04/2019	31/03/2022		Service impact of delay in equipment replacement	Service impact of delay in equipment replacement Current provisions for Radiotherapy Services at VCC are based on the assumption that a new Cancer Centre and associated Satellite Centre will be clinical by 2021/22. Delays on these projects will impact negatively on the Radiotherapy Department at VCC. Linear Accelerators have a recommended clinical life of 10 years. In 2019, there are currently 3 (out of 8 (38%)) linacs aged 10 years or above. In 2021 there are currently 5 (out of 8 (62%)) linacs aged 10 years or above. Identified hazards are to be found in the risk assessment attached as a document.	15	12	3	Timely / effective communication with Commissioners / Government re. Linac life, performance etc. Older linacs can receive deep services / upgrades with the intention of extending clinical life. Ability to add functions / services to older linacs / equipment such as RPM / DIBH make this viable. Uptime is maximised by good in-house engineering support. Engineers are very experienced at VCC. Service contracts allow access to Manufacturer's engineers when required. Complaints procedure in case of issues with quality of service. Gaps procedure assist with direction in times of breakdown. Experience and skill of staff allow effective dealing with delays and patient issues. RCR guidelines guide protocols for acceptable prolongation of treatment courses prior to compensation (NB. Latest update suggests that standard 3-week course of breast treatment should ideally not be prolonged for more than 2 days). Regular update of staff from management re. New centre / satellite sites. TCS website, events to publicise new centres. Prioritisation list of latest technologies / innovations, to ensure that patients receive most prudent treatment. 22.7.20. New VCC - IRS cycle 5 ongoing. No update at this point. New linacs for current department tied up with IRS. Satellite - OBC submitted. 20.10.20. New VCC - IRS cycle 5 ongoing. No update at this point. New linacs for current department tied up with IRS. Satellite - OBC submitted. PJ. 25.1.21. Awaiting formal updates on IRS. Currently appraising options for maximising capacity PJ 21/5/2021 – Risk reviewed by PJ & CRD. Risk remains Awaiting formal updates on IRS. New linacs for current department tied up with IRS. Satellite – working on full business case, to be submitted Autumn 2021 1/11/2021 - Risk updated by CRD. Risk remains. IRS evaluation still to be completed. Work started on Breast service contingency to ensure resilience in the event La6 is no longer available.
2455	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Daniels, Gareth	Accepted	Digital Services	29/10/2021	01/05/2022		TAO Windows Server 2003 Failure (VUNHST Finance)	There is a risk that key Finance activity may be disrupted as a result of a failure of a Windows Server 2003 which hots a key IT application used by Finance, which may lead to an ability to perform critical finance activity (payroll, invoicing etc.). There is currently no resilience / business continuity arrangement in place for this server.	16	12	4	RegKey changes applied to change/add ProviderFlags to 1. New VM has been built to the latest supported version - DO to liaise with Finance for an appropriate upgrade time.
2513	N	Performance and Service Sustainability	Velindre Cancer Centre	Theatres	Millin, Tony	Gallop-Evans, Eve	New risk	Whole Service	09/02/2022	01/08/2022		There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Currently only one staff member has a practitioners licence for Prostate Brachytherapy	20	20	10	Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence
2388		Safety	Velindre Cancer Centre	Outpatients	Stockdale, Ann Marie	Miller, Lisa	Accepted	Nursing	18/06/2021	31/03/2022		There is a risk of high temperatures, increased spread of infection a result of lack of ventilation	OPD Environment - Temperature of the Outpatients department There is a risk that during the summer months, due to a lack of ventilation and air conditioning in the outpatients department, the temperature exceeds that which is comfortable or safe for patients and staff. There is a risk that due to the extremes of heat, patients and staff could become unwell. Wall mounted fans should not be used due to covid restrictions.	12	12	8	Doors and windows left open where possible to increase ventilation. Staff providing cold drinks to patients in the department throughout the day. Increased seating outside the OPD entrance. Staff issued with lightweight scrubs. Staff to take regular breaks to ensure they remain hydrated.
2428	N	Compliance	Velindre Cancer Centre	First Floor	Miller, Lisa	Wilkins, Paul	Accepted	Nursing	02/08/2021	31/03/2022		There is a risk of increased infection transmission due to poor ventilation.	Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description	16	16	9	UPDATE 14.02.22 from Mark David - A temporary air con solution will need to be installed for this summer (as per last year setup) with the hope of the ventilation BC being signed off later this Summer. Next steps will be for service to sign off decant plan so it can be included in the BC, this can then be signed off by SMT, EMB and then forwarded on to WG. UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan. * Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc. * Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc. * Full root cause analysis undertaken to ascertain cause(s) of any infections. * Business Case currently under development to seek funding for compliant ventilation system.
2236	N	Quality	Velindre Cancer Centre	Outpatients	Miller, Lisa	Stockdale, Ann Marie	Accepted	Operational Services	08/04/2019	31/03/2022		There is a risk of poor patient experience as a result of insufficient space and poor environment	The design of the OPD department is not fit for purpose, there is a lack of available accommodation, insufficient space in waiting area, the reception desk is not ideally placed and the fabric of the area is in poor condition.	15	12	12	1. Nurse 'rounding' in place to monitor patients on regular basis 2. External 'canopy' waiting area 3. Information provided explaining visiting restrictions but process in place to call relatives into consultation if appropriate 4. High level of virtual consultations 40-50% 5. Clinic planning and preparation undertaken daily 6. Task and Finish Group to lead repatriation of OPD and phlebotomy to HB's 7. Service improvement programme to reduce waiting times, improve experience etc 8. Appointment system implemented for phlebotomy appointments
2248	N	Safety	Velindre Cancer Centre	Velindre Hospital	Seary, Sarah	Cooper, Mrs Vivienne	Accepted	Nursing	29/10/2020	31/03/2022		There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection	There is a risk a risk that that non-compliance with the Health Protection (Coronavirus Restriction Wales) Regulations 2020 could place patients and staff (FFW, CIU) at increased risk of infection and contracting COVID-19, resulting in illness. Regulation 7A of the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 dictates: - that all reasonable steps have been taken for staff to work from home; - when they are in work environment, all reasonable steps have been taken to maintain a 2m distance; - and where people cannot be 2m apart, everything practical done to manage transmission risk.	16	12	12	Update 14.02.22 - Social distancing still in place; enhanced cleaning and full IPC measures still mandated. IPC team continue to monitor compliance and undertake regular clinical practice and environmental audits in all departments. Update 10/12/21 - Regular updates and guidance given by IPC Team to all staff to remind them of IPC requirements. Enhanced cleaning still in place; social distancing measures remain in place; cleaning wipes and sanitiser freely available along with face masks. Mitigation -Cleaning regime reviewed as part of changes made, e.g. all ward staff including visiting staff wearing suitable PPE (e.g. cleaners, admin, pharmacy, RT etc.) -Hand Sanitiser stations installed -Hand washing posters at sinks -Sterilising materials, wipes, spray etc available for all staff -Enhanced hand washing regime -Staff who can work from home being assessed and if applicable currently doing so -Care taken to manage 2m space where applicable -Social distancing posters -If appropriate reduce amount of staff in working area where applicable. The FFW offices, are areas where social distancing is unable to be maintained for hand overs etc.PPE is provided for use on the FFW at all times. Process constantly reviewed against guidance. Analysis and then clear signage of occupancy levels in appropriate areas if applicable Enhance cleaning practices for all equipment as per standard and covid regulations. UV cleaning of rooms for high infections. Testing for staff with symptoms as per covid guidelines. Zoning during outbreak. COVID Patient pathway to minimise interaction with staff and other patients. Reduction of beds Restricted visiting in lines with All Wales Guidance. Patients are triaged on admission and rapid testing prior to admission to FFW

2188		Compliance	Velindre Cancer Centre	Velindre Hospital	Miller, Lisa	Miller, Lisa	Accepted	Operational Services	18/04/2018	24/01/2022		There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service de	Lack of physical space to accommodate the current service requirements, statutory building note requirements, health and safety standards and other legal requirements at Velindre Cancer Centre. This risk affects all areas within VCC. A number of internal and external audits have demonstrated a significant lack of physical space within all areas of VCC. COVID 19 pandemic has further reduced available site capacity by 40-50%. Increased provision of clinical services and workforce requiring additional space. Requirement for Digital Programme Team to return to VCC site in view of DHCR replacement programme, testing and training requirements etc.	12	12	6	1. Ongoing review of current accommodation to ensure best use and maximisation. 2. Review service models and the balance between on site and outreach services to make best use of all resources. 3. Implement changes in working practices where appropriate (e.g. working from home, extend the working day) 4. Office sharing principles reviewed in light of COVID19 which has led to reduction in available office accommodation due to 2m rule. 7. Open plan and flexible working. 8. Additional space within CRW to be utilised as a temporary measure for Digital Programme Team as part of DHCR Programme. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work. 12. Business case being produced for ventilation improvements in clinical areas. 13. Trust has entered into formal lease agreement with for additional accommodation (Bobath). This has provided space for some staff displaced due to social distancing and to allow wellbeing space for staff. 14. Reassessment underway of corporate and other staff on VCC site that can be relocated to other Trust premises. 15. SACT and ambulatory care services operating extended hours, bank holidays and some Saturday working.
2515		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Millin, Tony	Millin, Tony	New risk	Whole Service	09/02/2022	27/05/2022		There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	15	5	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place
2514	N	Quality	Velindre Cancer Centre	Radiotherapy	Millin, Tony	Millin, Tony	New risk	Whole Service	09/02/2022	29/04/2022		There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date	Key staff have not been available to review the SOPs due to work pressures and reviews are not routinely undertaken at an operational management level SOPs could be outdated which could potentially lead to the standard operating procedures at Velindre not aligning to National requirements, or requirements for patient safety. Staff could be operating in a sub-optimal way to treat patients.	16	16	4	Following the retirement of the former Head of Brachytherapy Physics, ownership of RT physics documents has transferred to another member of staff who is reviewing SOPs. Similarly a review of documentation is taking place within Radiotherapy
2517	N	Financial Sustainability	Transforming Cancer Services	No Further Coding Required	Hinton, Tracy		Accepted	New Velindre Cancer Centre	14/02/2022	01/03/2022		There is a risk that the competitive dialogue participants tenders excced the CAPEX limit leading to increase project costs and	CAPEX There is a risk that the competitive dialogue participants tenders excced the CAPEX limit leading to increase project costs and potential delays.	12	12	12	1. Discuss with Welsh government.
2431	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	James, Carl	Accepted	Programme	23/07/2021	31/12/2021		There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption	There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption resulting in potential misalignment of project activity and as such further impacts to Programme Plans and Deliverables	16	12	4	1) Project plans being reviewed with programme support to ensure they are up to date and where projects are now 'unpaused' to bring plans in line with more mature projects. Complete 2) Master Programme Plan updated to reflect update to projects and to show dependencies across projects and programme activity. Complete 3) Review and reporting on Master Plan to PDB and Scrutiny committee. Ongoing
2486	N	Quality	Transforming Cancer Services	No Further Coding Required	Pinocci, Francesca		Accepted	Enabling Works	07/12/2021	04/03/2022		There is a risk that the Section 278 application takes longer than expected to be approved,	S278 Application There is a risk that the Section 278 application takes longer than expected to be approved, meaning that works traffic accessing the 'straight' TCAR are delayed, leading to a delay to construction and longer overall construction timeline.	9	12	6	This application process has started.
2220		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Windle, Rebecca	Maggs, Rhydian	Accepted	Medical Physics (previously Radiotherapy Physics)	07/11/2018	28/02/2022		Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2198		Financial Sustainability	Velindre Cancer Centre	Velindre Hospital	Miller, Lisa	Miller, Lisa	Accepted	Operational Services	29/12/2017	13/12/2021		VCC mayface financial loss, legal action, inaequate service provision as a result of no coordinated system for SLAs, contracts	VCC has numerous contacts and SLA's for services delivered by NHS organisations and external companies. To manage such legal agreements it is crucial to have robust governance structures for the development, management, monitoring and renewal of such documents. There are a lack of processes, clarity regarding responsibility regarding responsibility, management etc and a varied level of monitoring.	16	16	6	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism
2213		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Daniels, Gareth	Accepted	Digital Services	09/07/2018	01/05/2022		VCC Phone System - External Phone Lines	There is a risk that external telephony services in VCC may be disrupted as a result of the ongoing use of the 'end of life' PBX gateway ISDN30 line, which may lead to the inability to make inbound and outbound external calls, resulting in significant disruption to clinical / patient and administrative services.	16	12	4	22 phone lines are strategically placed around VCC site to enable dialling to public telephones in the event that an ISDN30 line is lost. Discussion with supplier commenced. Capital funding to be secured for delivery of resilient SIP.
2251		Compliance	Velindre Cancer Centre	Radiotherapy Physics	Windle, Rebecca	Jarvis, Richard	Accepted	Medical Physics (previously Radiotherapy Physics)	18/03/2016	30/03/2022		XVI imaging termination faults resulting in repeat acquisitions	There is a risk that the patient will require an additional CBCT scan to confirm treatment position as a result of a known fault with XVI which may lead to additional patient imaging dose. Under new IRMER guidance if 3 scans are required to achieve 1 usable dataset this becomes reportable. This fault is known UK wide issue. When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy treatment targets the tumour and spares Organs at Risk and critical structures. This is a known issue nationally and Public Health England and HIW are aware.	15	12	6	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining imaging fractions. 4. All partial scans to be recorded on the imaging form. 5. Radiotherapyl Physics and the treatment superintendents must be informed if the units are regularly failing during a day, and these failures recorded in the unit log book. 6. Additional dose contributions are calculated for all patients affected and recorded in the Datix incident system. 7. Failure rates are reviewed weekly during the multidisciplinary linac status meeting and fault causes are actively investigated.

ID	Risk Type	Division	Approval Status	Review date	Title	Risk (In Brief)	Rating (Initial)	Current Rating	Rating (Target)	RR - Current Controls
2187	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	31/03/2022	Radiotherapy Physics Staffing	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental timeExample of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	25	15	5	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk assessment due to the anticipated shortage of appropriate candidates.
2253	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Availability of CANISC System	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	15	15	5	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is aviable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient demographic information - Welsh Results Reporting Service (WRRS) for all VCC radiology reports - Paper Radiotherapy Workflow (IRMER) - Manual Registration - new patients on Chemocare - Manual Registration - new patients on Aria and Mosaiq - Availability of Clinical correspondence created at VCC in Document Management System (DMS) from April 2019 that feeds into Welsh Clinical Record Service (WCRS) - Access to paper record that holds inpatient documentation, charts etc
2205	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	31/01/2022	CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no “fall-back” method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. No longer applicable - can be removed	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads
2260	Compliance	Velindre Cancer Centre	Accepted	01/01/2022	Control of Asbestos at VCC	Working on the infrastructure or fabric of the building and causing the release of asbestos which may endanger patients, staff, visitors and contractors.	15	10	5	Large areas of Asbestos have already been removed from Velindre Cancer Centre. Trust Asbestos Policy and Management Action Plan in place. Supervision on site has received “Management of Asbestos in Building Training” (P405). VCC has and maintains an asbestos register which Estates staff can access. The maintenance ducts have been identified as having asbestos material within them; maintenance staff have been informed not to enter these ducts. Safe systems of work are in place at VCC, all jobs competed by Estates staff are automated through the FACTS system which locates any asbestos in the working area and records them on the job sheet identifying the risk as Level 1, 2, or 3. Estates staff have completed Asbestos Awareness Training within the last 12 months. Estates staff complete Health and Safety training. Contractors are given tool box talks before being allowed to work on site which includes information on Asbestos and known locations. Prior to any destructive works on site Refurbishment and Demolition Surveys are completed. Socotec are the appointed consultants to support professional advice and assistance. Annual asbestos inspections are also undertaken. Annual staff Asbestos Awareness Training delivered.
2447	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Cleartext credentials stored in memory	There is a risk of a cyber security breach as a result of due to the storage of account credentials in 'cleartext' format, which can be leveraged and result in a loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2444	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - CVE-2019-0708 BlueKeep Vulnerability	There is a risk of a cyber security breach as a result of the presence of the CVE-2019-0708 BlueKeep vulnerability within the VCC network, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Affected Radiology services are protected behind IT security (firewalls - external to NHS Wales) with access to those systems limited to a small number of named access.

2442	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - End of Life Desktop/ Client Operating Systems on the VCC network	There is a risk of a cyber security breach as a result of the ongoing presence of devices within the VCC network running the legacy Windows Operating System (Windows 7, XP etc.), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National Firewalls. Anti-virus controls in place.
2458	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - End of Life Server Operating Systems on the VCC Network	There is a risk of a cyber security breach as a result of the ongoing presence of servers within the VCC network running the legacy Operating Systems (Server 2003, Server 2008 etc.), which may lead to the disruption or loss of IT services across VCC. There are numerous end of life server operating systems within Velindre Cancer Centre (including Windows 2003 & 2008), which increases the risk of a successful cyber-attack as these devices are not appropriately patched and vulnerable to exploit.	20	10	5	Current controls in place include Firewalls (DHCW), Antivirus software (Mcafee and Defender), access control lists and network segmentation.
2450	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Inactive Edge Firewalls on VCC Servers	There is a risk of a cyber security breach as a result of VCC server firewalls being in 'passive' mode (meaning communications are not filtered), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls used as protection for VUNHST.
2451	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - No Client Firewalls on VCC devices	There is a risk of a cyber security breach as a result of the lack of client firewalls on VCC devices, which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls in place. Anti-virus may mitigate malicious software, if attempted.
2448	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - NTLM hashed credentials stored in memory	There is a risk of a cyber security breach as a result of NTLM hashed credentials being stored in memory, which can be leveraged and result in the disruption or loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2445	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Risk of malicious payloads not being blocked by anti-virus (McAfee)	There is a risk of a cyber security breach as a result of malicious payloads not being blocked by VCC anti-virus (McAfee),, which may lead to the disruption or loss of IT services across the VCC.	20	10	2	VCC currently migrating to Defender Anti-Virus and will be moving towards Defender DLP. Mcafee still in use on various servers and DLP enabled.
2460	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Risk of privilege escalation on local user accounts	In the event of a successful cyber attack against Velindre Cancer Centre there is a risk that a local user account could be leveraged, to the spread the attack further due to excessive privileges.	20	5	5	Controls in place include national firewalls, Anti Virus & ACLs.
2446	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Weak Passwords in use on Admin / Privileged IT accounts	There is a risk of an external agent compromising VCC admin/privileged IT accounts as a result of the use of weak passwords in use within the VCC Digital Services team, which may lead to a cyber security breach and/or the loss of IT services across VCC, resulting in the disruption or loss of IT services across VCC.	20	10	5	Various Cyber Security tools in place including national firewalls, AV and ACLs which provides defence in depth. Work ongoing to remove weak passwords.
2512	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	03/03/2022	Digital Health & Care Record DHCR022 (R) - Business Continuity Risk following Implementation	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR022 - A potential business continuity risk following implementation. Currently the WCP is used to access case note summaries for patients in order to provide business continuity when Canisc is unavailable. The impact in this risk would be felt after go-live but could impact on service delivery. This is potentially a service risk but will be considered and summarised for the project risk register and discussed further at the next Project Board Meeting	15	15	12	DHCW to develop a solution as this would have an effect on every HB when they have an Electronic Patient Record

2261	Safety	Velindre Cancer Centre	Accepted	30/09/2022	Lack of electronic prescribing at Teenage Cancer Trust	There is a potential safety risk to Teenagers and Young Adults who are under the care of VCC and TCT and therefore can be admitted to either facility. Currently VCC and TCT have two different systems, VCC operate an e-prescribing system whilst TCT still use paper prescriptions.	16	10	4	Experienced medical and nursing staff - familiar with both processes. TCT staff have access to CANISC but any changes to dose etc. would be via chemocare. The actual dose prescribed will be transferred to Canisc in the next version of chemocare. Pharmacy staff clinically check script(only if access to medical records/prior treatment). Inpatients will receive visit from pharmacist/med recs/clerking but this is not always the case for outpatients so its probably a highter risk for outpatients. Business case is being developed for an all Wales National e-Prescribing solution (single solution). VCC to provide input and implement procured solution. Timescales to be confirmed. 31.08.20 - Working group has been established between VCC Pharmacy, UHW Pharmacy and wider UHW TCT reps since Feb 2020. An interim work around solution has been developed to enable TCT access to VCC ChemoCare and thus for the prescribing of regimens to occur electronically. Development of the SLA continues TCT to be included within VCC version 6 training and roll out programme subject to SLA agreement. With interim work around solution in place, risk= 5x2=10 11.05.21 – Workaround in place between UHW and VCC Pharmacy Dept continues to be supported with no safety issues or concerns noted. ChemoCare version 6 roll out will be paused in June 2021 due to overlap of implementation of DH and CR replacement and Wellsky and impact on staff training. Roll out (to include TCT) will re-commence post implementation and embedding of these 2 systems which is likely to be Autumn 2021 (date TBC). 27.05.21 – UHW informed that implementation is temporarily paused as above. VCC will continue to install and test latest patch (version j). Subject to successful UAT, VCC and UHW will liaise to determine if there is a) an immediate need for roll out to TCT ahead of the VCC programme, b) whether VCC can resource such a roll out and c) consequences to VCC of VCC clinicians utilising version 6 ahead of VCC site rollout.
2252	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/04/2022	Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	20	15	10	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR
2262	Safety	Velindre Cancer Centre	Accepted	01/07/2022	Releasing passenger lift release	In the event of a person being trapped in a lift, they will need to be released in a manner that will not endanger themselves or others.	10	10	5	The lift release key has been removed from Switchboard and has been placed in the Estates key safe to prevent unauthorised use. Staff will not release people or the lift be lowered by manually hand winding unless they have been trained on that lift in accordance with BS 7255 (training has been provided by OTIS). Furthermore there must be at least three members of staff available if the lift is to be lowered by manually hand winding. Persons trapped within a lift are only to be assisted out of a lift if they are within 200mm of a landing. A maintenance contract for lifts at VCC which includes the releasing of persons have been set up with OTIS Lift Company. Any derogation from the above in an emergency situation must be discussed with a senior member of the Estates Management team prior to any action. British Engineering insurance inspections are also undertaken on all lift throughout the Trust.
2336	Safety	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury or ill health to Estates staff whilst working in a lone working environment	Risk of injury or ill health to Estates staff whilst working in a lone working environment and a possible delay in receiving medical treatment in the event of an adverse event. Due to slips, trips and falls, contact with machinery, contact with electricity, serious illness, overcome by noxious fumes, falls from height or coming into contact with an aggressive violent person.	15	5	5	Safety shoes with non-slip soles provided. Hard hat areas identified or hazard tape used to identify bump hazards. Toughened gloves available. Two way radios are available should the Estates worker deem them necessary. Machinery has guards to prevent entrapment. Trained qualified staff to work within their capabilities. Staff carry Cisco WIFI phones and/or mobile phone. Some plant rooms have telephones Permit to work required for electrical work. Ongoing program to barrier roof areas. Violence and aggression training is provided. Health and Safety training is provided. All plant rooms have automatic smoke detection. Co2 detector is fitted in the main boiler house. All boiler rooms have ventilated doors. Regular boiler maintenance is carried out. Basic Life Support training level 1 with practical CPR for maintenance technicians is delivered. Outside stairs are illuminated. Medical staff available on site should a medical emergency occur. Maintenance staff will assess the need to use a safety person when required (out of hours Security may be used or a member of Estates staff may be requested to return to work to assist). All chemicals being used will have a COSHH risk assessment.
2338	Safety	Velindre Cancer Centre	Accepted	01/07/2022	Risk of injury or ill health to staff whilst working in subterranean ducts (confined space)	Maintenance staff working in confined spaces such as the subterranean service ducts to either run in new services or to maintain existing ones. The ducts are not full height and therefore staff will have to crawl along these spaces. In the event of a person collapsing, difficulties would arise with emergency evacuation. Issues noted when working in confined areas include, but are not exclusively, cramped conditions, heat, gas, fire/explosion, radon gas, exposure to asbestos and problems carrying out an emergency evacuation in the event of injury or illness.	15	5	5	Staff not trained in confined spaces are prohibited from entering confined spaces under any circumstances, therefore should an occasion arise when entry to a confined space is required out of hours and an untrained Estates worker is on call, he will have to contact one of the confined space trained tradesman to assist. Members of the Estates department have received confined space training and two have received confined space supervisory training. Lighting has been upgraded in the ducts. An asbestos removal has taken place in the ducts, however residual asbestos is still in the Horseshoe and main duct therefore Estates workers are not to enter either the Horseshoe or main duct. An asbestos survey was carried out in the Whitchurch duct and no asbestos was recorded (additional sampling is to take place). Staff have completed Health and Safety training. Hot works permit to works are in use on site. PPE is available for all members of Estates (this includes CAT B disposable suits and over boots, FP3 masks, safety shoes, and gloves). A personal gas monitor is used by the Estates team. Sub-contractors competency to access confined spaces is confirmed prior to any works being undertaken by sub-contractors within the confined space. Risk assessments and method statements are provided for all tasks undertaken by sub-contractors. Currently, access to the main service ducts has been prohibited to the Estates staff.

2339	Safety	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury to staff whilst using single and double extension ladders and steps	Risk of injury to staff whilst using single and double extension ladders and steps.	15	5	5	Operative using ladder will inspect before use and report any defects. Safety man should be utilised when required. Barriers are available should they be required. Steps and ladders are regularly inspected and results are documented. Ladder training provided to staff.
2340	Compliance	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury to staff, patients, visitors if equipment hasn't been PAT tested	There is a potential risk of injury to building users if equipment have not been PAT tested.	15	5	5	No equipment to be used on site unless it has a valid PAT sticker. Patients equipment is tested and PAT sticker is applied (staff are responsible for informing Estates via the FACTS system of patients' equipment which requires testing. Industry Guidelines consulted to decide frequency of testing for IT equipment (every three years). Medical equipment is tested by Bio engineering (outside of the Estates remit). All other equipment is tested annually. Asset register of appliances created during testing by contract labour. Department managers are informed prior to annual testing taking place within their department. Any incidents regarding portable electrical equipment are raised on DATIX and discussed at the Electrical Safety Group.
2341	Safety	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury to staff/contractors when working at height where there is a lack of edge protection	Injury to persons from falling from roof, and exposure to radiation whilst being on the roof.	5	5	5	Method statements and permits to access roofs from contractors. Working at heights has been a topic during team meetings to raise Estates staff awareness. Roof edge protection fitted to commonly accessed areas. Access to roof areas controlled through gate and locking system.
2342	Safety	Velindre Cancer Centre	Accepted	01/07/2022	Risk of patient using curtain track as ligature point	Risk of patient using curtain track as ligature point.	10	5	5	Approved contractors will install and validate anti ligature curtain rails where it has been identified via discussions with department managers as they are required.
2400	Workforce and OD	Transforming Cancer Services	Accepted	31/01/2022	Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2513	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/08/2022	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Currently only one staff member has a practitioners licence for Prostate Brachytherapy	20	20	10	Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence
2515	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	27/05/2022	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff	15	15	5	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place

2472	Safety	Velindre Cancer Centre	Accepted	31/03/2022	There is a risk that there is a traffic accident on site which may lead to someone being injured or damage to vehicles	All car parking areas on site. Vehicle movements on site including Staff, patients, deliveries and contractors. Pedestrian walkways on site. Specific risks include adverse interaction of vehicles and or pedestrians, slips trips/ falls, theft and vandalism.	15	10	5	Hazards identified: LPG storage cage close to road with no bollard protection (behind LA 2 and 3) Large vehicles encroach on coming traffic on narrow roads Pedestrians getting hit by cars Poor lighting resulting in slips, trips ,falls List control measures in place: Car park: 5mph speed restriction. Directional flow traffic system and road marking in place. Information signage directing visitors to the different departments on site. Designated ambulance parking areas and Ambulances fitted with audible reversing warning signals. Designated patient drop off/ pick up areas. Designated disabled parking spaces and pharmacy collections. Patient parking located near entrances allowing easier access for users. No parking zones are in place around the site and clearly visible. Dropped kerbs in place with tactile surface for pedestrians. Road and pavement surfaces in good condition. Drainage is good with no evidence of excess water holding during period of heavy rain. Junctions are clearly marked for right of way. Digital speed signs in place to show drivers their speed. Pedestrian crossings in place. No contractor parking on site unless essential to works and prior agreement must be made, with areas/ spaces agreed for use. Bollards are in place to protect the temporary waiting area (Marquee) from any traffic at the entrance to out-patients. Max height signage in place at main entrance to warn drivers because of canopy. Deliveries: Any planned deliveries using large vehicles are arranged to take place outside of patient hours, usually 6am with bollards/ barriers removed where needed and vehicles martialled into place. Any un-planned large vehicles/ deliveries are martialled through the site where possible, the junction to radiotherapy/ stores can be used to turn them around. Large vehicles might have difficulty accessing stores area for delivery so unloading may take place on road near the junction to the stores, and items moved by pallet truck to the stores. However, deliveries to the stores are mostly vans, they reverse un-aided to stores entrance. Waste: Waste contractor collections are mostly before 7am there are exceptions to this with SDCL
2220	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	28/02/2022	Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2343	Compliance	Velindre Cancer Centre	Accepted	27/07/2021	Water Systems - Legionella	Maintaining the water systems free of Legionella at the Velindre Cancer Centre using a range of monitoring and control systems for water treatment and flushing across the VCC site. Continual improvement to remove redundant pipework and upgrade water systems where possible.	20	5	5	Regular monitoring of water temperatures. Regular testing and sampling. HEPA filters on shower outlets in the patient areas. Risk assessment and audit of water system by external consultant. Water Safety Group in place with appropriate members which meet regularly. Water Safety plan and written scheme are in place. Pre-planned preventative maintenance are also on FACTS and are routinely undertaken by competent staff. Removal of redundant pipe work where possible. Legionella management policy in place. Responsible person trained. Water sampling regime has been constructed and reviewed by Water Safety Group members and is currently in place on all sites.

ID	Division	Approval status	RA Date	Title	Description	Controls in place	Current Risk Rating	Review date
16894	Welsh Blood Service	Final approval	28/10/2021	Transfusion associated acute lung injury risk reduction strategy	WBS supply of apheresis platelets from female or previously transfused donors, not screened for HNA antibodies	Donor screening identifies donors that may have experienced sensitising events (previous transfusion/pregnancy) but without HNA antibody screening is not able to mitigate the risk of these antibodies being present.	5	07/05/2022
16900	Welsh Blood Service	Final approval	18/10/2021	Apheresis Premises at Velindre cancer Centre	Velindre Cancer Centre Hospital building	Hospital facilities are inspected by an external contractor (Hurley & Davies). The VCC collection suite has been licenced by the HTA and will be regularly inspected by the WBS. H&S, Fire inspections regularly undertaken.	5	18/10/2022
16809	Welsh Blood Service	Final approval	06/09/2021	Malaria Risk – Delay in Implementation of the Process to Support Amended Malarial Testing for a Specific Donor Group	Non-compliance with donor assessment based on the JPAC Donor Selection Guidelines for donors with MALR, MALF and MALP risks. No malaria discretionary test is undertaken following re-exposure to a malarial risk for donors in this group.	This issue has been fully discussed at JPAC / SACTTI-(Parasites) group. The MHRA have laisied with the Chair of JPAC- the conclusion is that whilst WBS practice is safe, the recommendation is to align WBS practice with other UK Services. By definition all these donors will have tested negative for malaria at their first donation - this part of the process is robust. It is the subsequent testing post re-exposure that is missing.	5	06/09/2022
16762	Welsh Blood Service	Final approval	13/08/2021	Supply Chain disruption of Blood Collection tubes	All other tubes not on the shortage list (10ML, 6ML etc)Update-17/08/2021	"Internal stock take and regular monitoring and management of WBS stock position. Stock holding of 8 weeks supply at present. Stock projection received from BD for coming months and identification of WBS allocation."	10	18/03/2022
16780	Welsh Blood Service	Final approval	22/04/2021	Transport of Donor Records to and From WBMDR Collection Centre	Transport of paperwork that may contain donor personal identifiable information (PII)	Paperwork transported by WBMDR staff is kept to the minimum required (note: all WBMDR documentation only contains the minimum required PII to facilitate the collection). Staff are aware of the GDPR requirements, and have received training in Information Governance. Information and training provided by the WBMDR and stated in the standard operating procedure for the stem cell/PBL collection (SOP HUB-903). Staff advised to drive directly between the WBS and the collection centre unless absolutely necessary to stop or divert. Paperwork stored together securely (in a closed folder or bag) and out of sight in the vehicle.	5	22/04/2022
16788	Welsh Blood Service	Final approval	16/03/2021	Apheresis Premises at Nuffield The Vale Hospital	Nuffield the Vale Hospital building	Hospital is HIW inspected, HTA licenced and inspected by the WBS. H&S, Fire and HIW inspections regularly undertaken.	5	16/03/2023
16398	Welsh Blood Service	Final approval	11/12/2020	Review of modules used in Oracle Finance & Procurement System - GxP impact	Purchasing - used to manage the procurement of both stocked items (using the Inventory module), and non-stocked items (using the IPROC module).	Functionality verified in CQ test scripts for IPROC and Inventory (Note: issues would only be identified in the Live environment during CQ testing)	12	25/04/2022
16467	Welsh Blood Service	Final approval	27/11/2020	Receipt, Storage and Distribution of Covid 19 Vaccines	Recording time of vaccine removal from -80 freezer	Labels printed with time Print labels before removal of vaccine from freezer risk treatment - validate printed labels	5	22/10/2022
16295	Welsh Blood Service	Final approval	22/09/2020	Use of Female Plasma for Manufacturing Pooled Cryoprecipitate	WBS Cryoprecipitate made from female donors not tested for HLA/HNA antibodies	"Prevention 2) Low level of plasma from each donor, reducing any potential antibody concentration"	5	12/04/2022
16266	Welsh Blood Service	Final approval	15/09/2020	Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain	Inability to operate clinics at the same efficiency verses pre-Covid 19 due to social distancing and IPC measures/amount of donors able to attend venue due to social distancing measures.	Escalated to the Director of WBS And Chief Operating Officer for VUNHST, Head of Planning Logistics and Resource to submit SBAR outlining emerging situation and required support. Explored with MOD available venues. Ongoing dialog with PHW and WG about conflict between vaccination and WB venues. Update 28/01/2021 - A number of Health Boards have not yet responded to email , those that have showed that there will be some conflict with venues in certain regions. Working on proof of concept for use of trailers in a socially distanced environment, Also looking at options around a potential fixed site.	12	01/08/2022
15973	Welsh Blood Service	Final approval	19/05/2020	Exposure to Potential Pre-symptomatic, Asymptomatic Individuals at Verification Sample Procurement, Donor Information, Medical A	Donor Exposure to potential pre-symptomatic, asymptomatic individuals at VT sample collection - Performed by a Health Care at Home under contract to the WBMDR.	Assurances received from Health Care at Home that correct protocols are being implemented with regards to social distancing and use of appropriate PPE.	5	06/03/2022

16009	Welsh Blood Service	Final approval	18/05/2020	Social Distancing measures within the Laboratory environment (Lab Services and WTAIL)	See attached FMEA	See attached FMEA. Reviewed FMEA attached. Risk further reduced by staff vaccination program. All other measures remain in place. GS, 27/05/21	5	27/05/2022
15937	Welsh Blood Service	Final approval	04/05/2020	Covid-19 implications of handling biological samples within the WBS	Handling of untested or presumed COVID-19 negative samples for laboratory testing	Appropriate staff training, supervision and comptetence. Good laboratory practice. Use of standard laboratory PPE including nitrile gloves and labcoats. Risk treatment plan and recommended actions: All staff should be aware that there is the potential for any sample to be positive for COVID-19, as patients or donors may be asymptomatic. If appropriate, all primary samples should be centrifuged and left for at least 10 minutes before decapping to reduce aerosol risk. Centrifuge bucket lids must be used to reduce aerosol production risk in the event of tube breakage. Aerosol-generating or potential splashing procedures should be performed in a Class-2 microbiological safety cabinet if possible and appropriate. If these cannot be performed in a cabinet these procedures must be identified and additional proportionate controls put in place, such as capping of tubes, safety screens or PPE. Local Risk assessment within each laboratory should be performed to identify these procedures. Update 06/01/2021. Vaccination for all front line/lab staff has ben tolled out, Increased UK testing capability, increased use of PPE for all staff. No evidence of laboratory COVID-19 transmission has been seen, and no evidence (either locally or worldwide) that COVID-19 has been transmitted by aerosol from laboratory samples.	5	05/10/2022
15932	Welsh Blood Service	Final approval	23/04/2020	Impact of COVID-19 stabilisation phase to WBS	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	VUNHST planning team and WBS blood health team are liaising with hospitals to determine future demand. Existing MOU with the UK blood services to support in the event of a shortage in a blood component. WBS planning team have forecasted future collection models based on potential scenarios. Currently working on a proof of concept around trailer use in a socially distanced environment and also considering fixed site options.	12	12/08/2022
15533	Welsh Blood Service	Final approval	27/09/2019	Manual Double Entry of Test Results in Automated Testing - Contingency Process	Manual entry of test results which are normally interfaced directly from an analyser into BECS.	Components from a positive donation are physically removed from the supply chain by Automated Testing staff.	5	14/06/2022
15456	Welsh Blood Service	Final approval	11/07/2019	Clinical RA for not providing HbS negative red cells	HbS negative blood not supplied by WBS as recommended by JPAC guidance	"- low incidence of HbS in Welsh population (0.02% in 2013) '- Most HbAS units block leucodepletion filters and don't make it to a usable donation"	5	25/08/2022
15373	Welsh Blood Service	Final approval	27/06/2019	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	Increased complexity of networking / integration architecture in respect of the middleware used to interface devices that require interfacing to MAK-System products (e.g. ePROGESA). Additional costs incurred for establishment and maintenance of interfaces to MAK-System products (e.g. ePROGESA).	Ability to liaise with suppliers during procurement to advise on WBS preferences in respect of middleware arrangements for connected devices. MAK have recently confirmed "non partners" will still be permitted to interface devices to ePROGESA and other related MAK services. Subject to ongoing monitoring and discussion via International MAK-System User Group (IMUG).	12	31/08/2022

15398	Welsh Blood Service	Final approval	06/06/2019	Facilities Infrastructure	Electrical circuitry is not installed to current standards	Not installing any new equipment until power supply has been updated..	10	19/08/2022
15297	Welsh Blood Service	Final approval	29/04/2019	WBS Cyber Security Attack or Breach	WBS Systems and Services	Antivirus software deployed to detect threats. Device control deployed to limit access to removable devices. E-mail messages are scanned for threats and spoofing by NWIS. Web browsing is via a proxy server that scans for viruses and malicious content. Software updates are rolled out to address vulnerabilities in operating systems and key applications. Firewalls are enabled at device level as well as network levels to restrict access from unwanted systems. Newer operating system deployments are harden against security baselines recommended by suppliers and NCSC. Regular backups of critical and key data. Vulnerability scanning conducted against WBS devices. Phishing exercises targeted at WBS users	10	22/04/2022
15261	Welsh Blood Service	Final approval	01/04/2019	Microsoft Windows 7 and Server 2008 R2 End of Support	Windows Server 2008 R2 server operating system (ePROGESA)	Server operating systems are protected by local and network firewalls - this limits which devices can access the servers. Antivirus software provides detection and remediation against known threats. Internet usage and E-Mail is generally blocked from servers. System have been hardened against best practices. General users are only able to access limited parts of the ePROGESA environment, for example, Database Servers are not accessible	10	04/01/2023
15262	Welsh Blood Service	Final approval	01/04/2019	Oracle Java 8 End of Support	Oracle Java Runtime Environment	Java environment has been hardened to limit where applications can be launched from. Client operating systems are protected by local and network firewalls - this limits which devices can access the clients. Antivirus software provides detection and remediation against known threats. Removable media controls limit threats from USB/DVD drives. Internet usage is monitored to protect from web and downloadable threats. E-mail messages are scanned for threats. System have been partially hardened against best practices	5	22/04/2022
15189	Welsh Blood Service	Final approval	22/01/2019	Red Cell Antibody detection on the PK7300	Failure to detect high level anti-D on PK7300 - impact on Apheresis donations - not neonatal	None	5	13/01/2023
14764	Welsh Blood Service	Final approval	09/10/2018	Brexit - Implications of Exiting the EU - No Deal Situation	Increased expenditure	Public Contract Regulations Budgeting and financial controls	20	06/04/2022
14744	Welsh Blood Service	Final approval	03/09/2018	Abbott Microbiology Platform	Result Transfer to eProgesa	WBS Procedures Peer Review	5	13/01/2023
14508	Welsh Blood Service	Final approval	09/07/2018	Management of Work Place Related Stress	Could affect every activity within WBS including collections, processing and distribution etc. of blood products	Policy (Trust wide Mental Health , Wellbeing and Stress Management WF43) Toolkit to support Good Mental Health, Wellbeing and Reduce Stress. Employee assistance programme All Wales Wellbeing Tool Kit Stress risk assessment (completed by manager with staff member) Sickness absence policy Manager Training Mindfulness / complementary therapy Team Assistance Organisation Development facilitated discussion and mediation Organisation change RA Blood Supply 2020 relating to stress. Work life balance - flexible working. Health and wellbeing - Cycle to work scheme to promote healthy activities. Monitoring of sickness and absence reasons and levels. PADR process - clear roles and responsibilities. Manager support. Update Oct 2019 Continue to monitor sickness and absence levels WBS Sickness and Absence Deep Dive Stress Related Absence document produced Dec 2018 Ongoing wellbeing initiatives Initiatives introduced to look at finances - Home finances impact on stress Menopause Policy developed and initiatives to look at this introduced (Menopause Café) which impacts on work place stress	12	01/08/2022

14215	Welsh Blood Service	Final approval	06/03/2018	Risks associated with the implementation of Prometheus into WTAIL	Failure of WTAIL to meet its regulatory obligations (e.g HTA)	URS signed off and agreed. Regular meetings with supplier to ensure URS requirements are fulfilled. Regular communication with supplier in respect of changing/ new regulatory requirements. Development complete. Update 13/10/2020 UAT is complete.	10	01/04/2022
13311	Welsh Blood Service	Final approval	08/11/2017	Reprinting Group Labels for overweight imported red cells	Reprint group label for imported red cell which is overweight (outside maximum volume parameter)	"NHSBT & SNBTS have an automatic discard set for components that are overweight/ over-volume (i.e. all Blood Services comply to the Red Book Guidelines and have their processes controlled accordingly). Laboratory staff identify non-conforming donations.	5	12/04/2022
12342	Welsh Blood Service	Final approval	29/03/2017	Use of the External Plasma Freezer	Safety of staff whilst using the freezer	None (PPE)	5	01/11/2022
12104	Welsh Blood Service	Final approval	02/02/2017	Movement of WBS personnel within the service yard area	Staff movement in the service yard .	Designated speed limit of 10 mph within the service yard area. Entrance gate controlled from central point (reception). Entrance gate is kept closed and access to the service yard is via intercom. Adequate lighting located in service yard area. All transport department staff and CCA drivers who use the service yard are provided with a service yard awareness briefing. This is undertaken as part of their training and is detailed in the training booklet prepared by transport department. Donor Services personnel and facilities staff are issued with hi visibility jackets /vests to wear when working on service yard area and this is a compulsory requirement. Transport and Facilities staff provide hi visibility jackets/vests to visitors and these visitors are escorted whilst on the service yard. Additional controls include hi vis paint work, periodic service yard inspections, contractor leaflet read and understood before work commences. CCTV coverage of the service yard.	10	01/08/2022
11522	Welsh Blood Service	Final approval	17/10/2016	Antibody detection by Luminex based technology	Detection of HLA antibodies by Luminex based methods	sample collection requirements are stated in WTAIL user guide. samples are only taken by trained phlebotomists and nursing staff. Acceptance of results based on review of patient history as and when available and take into consideration patient own type. Platelet cases require increment data for review of increment levels to determine further support required. Multiple samples are tested for those patients requiring long term support.	10	29/10/2022
9515	Welsh Blood Service	Final approval	03/07/2015	WBMDR Sterile Tube Welder	Sterility	Documented system at Collection centre (by two individuals) to check docking undertaken correctly (recorded on form WBM-551). Use of standard concession system (SOP 566/HUB) in the event of a dock failure. Routine sterility testing of all HPC products (100% testing)	5	04/11/2022
8719	Welsh Blood Service	Final approval	17/12/2014	GMP-0273 (Premises)	Storage area	Restricted access to authorised staff only. Physical segregation of product from routine blood stocks. Clear identification as HPC product	5	20/11/2022
8706	Welsh Blood Service	Final approval	15/10/2014	GMP-0062 (PBSC Collection)	Collection of product	pre-assessment of veins by 2 different healthcare practitioners. BM collection available as possible back-up	5	09/02/2023
8712	Welsh Blood Service	Final approval	15/10/2014	GMP-0066 (Assess Donor Fitness)	Failure to receive completed report in time for 'Final Clearance'.	None	5	09/02/2023
8717	Welsh Blood Service	Final approval	15/10/2014	GMP-0071 (HPC Storage & Transport)	Storage of PBSC/PBL	Stored in GMP monitored area of WBS. Stored in secure area. Controlled product release.	5	05/11/2022
8713	Welsh Blood Service	Final approval	15/10/2014	GMP-0067 (G-CSF administration)	Incorrect dose.	Prescription calculated according to SOP by consultant with nurse. Dosage actually given is recorded on prescription at time of administration.	5	03/03/2023
8715	Welsh Blood Service	Final approval	15/10/2014	GMP-0069 (Final Release)	Product Inspection	Visual inspection of each bag in accordance with documented procedure. Documentation to allow audit trail. Formal concession system to account for any sterile docking failures. 02/11/2016 No change to control measures required.	5	09/02/2023
8707	Welsh Blood Service	Final approval	15/10/2014	GMP-0063 (PBL Collection)	Collection of product.	IDM Testing and Lifestyle questionnaire performed	5	09/02/2023
8708	Welsh Blood Service	Final approval	15/10/2014	GMP-0064 (Whole blood for immunotherapy)	Donor Fitness for purpose	IDM testing and lifestyle questionnaire	5	26/11/2022

7746	Welsh Blood Service	Final approval	02/04/2014	Liquid Nitrogen supply system for TT1-17.	DATIX 2725 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17 immediately: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; Overfill or fan failure will cause nitrogen supply to be stopped by emergency cut-off valves, PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by specialist external contractors; Warning signs; Overfill and low pressure alarms on individual units linked to EMS; On-call staff available to respond to alarms out of hours; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112. Annual insurance inspection, CCTV in yard and alarmed external doors near external tank.	5	15/04/2022
7736	Welsh Blood Service	Final approval	31/03/2014	Liquid nitrogen storage and retrieval of frozen cells - room TT1-17	DATIX 3482 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by external contractors; Warning signs; Written instructions on safe manual handling displayed on wall; Steps available to aid access to vessels for staff as required; Risk assessment on manual handling carried out by Hu-tech; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112.	5	04/02/2022
7137	Welsh Blood Service	Final approval	07/11/2013	Electrophoresis in WTAIL Molecular Genetics - analysis of PCR-SSP reactions by agarose electrophoresis	DATIX 3486 - transferred from paper assessment	SOP: MOL/022 Safety policies POL(S)-009, POL(S)-007 Training PAT testing Visual inspection during cleaning Intact lids prevent access to energised liquid or electrodes whilst in use. Annual H&S inspection Use of electrophoresis will significantly reduce due to implementation of new technologies - will only be used for HPA typing. Technique will probably be fully superseded in a few years.	5	15/04/2022

7026	Welsh Blood Service	Final approval	03/10/2013	WTAIL liquid nitrogen automated filling system (low pressure) TT1-17	DATIX 3467 - transferred from paper assessment	Cryostorage refrigerators are sited so their open lids cannot damage the piping; The system has a regular Insurance inspection (Zurich); Piping, valves and controllers have regular maintenance by specialist contractors; Room has mechanical ventilation (monitored and alarmed by the EMS system); Laboratory Safety procedure POL(S)-009; Oxygen depletion sensors are present in the room, with audible and visual alarms; Induction training; Liquid Nitrogen emergency cut-off switches present both inside and outside of room to stop flow in event of problem: SOP 112/TTY, Management of the liquid nitrogen system in the Welsh Transplantation and Immunogenetics Laboratory. CryoVent system bleeds Nitrogen gas from lines before filling to prevent splashing. Use of cryo-protective gloves, coats, enclosed shoes and goggles mandatory. Laboratory safety procedures (POL-S 009), includes 'buddy system' for out of hours access.	10	02/08/2022
6987	Welsh Blood Service	Final approval	23/09/2013	Operation of the BacT/ALERT	Operation of the System	Staff trained to SOPs Good Laboratory Practise Process Design Competency Assessment Appraisal Controls	5	06/01/2022
5394	Welsh Blood Service	Final approval	21/05/2012	Remove the class I HLA-A, HLA-B, PCR-SSP result from the UBM database for stem cell donor 15568709	Remove incorrect HLA type from UBM Database	IT working instructions Post implementation check performed	5	15/11/2022
2556	Welsh Blood Service	Final approval	23/04/2010	Missing Hazardous Items	9-4-10:The standard procedures for storage and transportation of all hazardous material created during a blood donation clinic should ensure that none of these items go missing. Hazardous material is defined for the purposes of this SOP as:- "Sharpsafes containing used items e.g. needles "Boxes containing contaminated waste "Vacutainers containing blood samples "Blood transportation boxes containing full blood donations/Non Conforming Donations	9-4-10: Standard operating procedure SOP: 014/BCT. WBS Transport record sheet (SOP: 022/BCT).Donor are health screened, before giving blood, which reduced the risk of contamination with blood borne pathogens. Training to SOP's. Agency Drivers have ID checks.	5	06/09/2022

AUDIT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable – Public

PREPARED BY	Emma Stephens, Head of Corporate Governance and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	21/03/2022	Noted
Strategic Development Committee	23/03/2022	Noted
Trust Board	31/03/2022	Noted

1. SITUATION

1.1 The purpose of this paper is to provide the Audit Committee with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework, which may affect the achievement of the Trust's Strategic Objectives, and the

assurances in place to evidence the effectiveness of the management of those risks.

- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework within the Trust.

To confirm, this paper was also received at Trust Board two weeks ago, however it is important there is a formal view at Audit Committee also given the Committee's role in overseeing the overall risk and assurance framework in terms of design and effectiveness.

1.2 The Audit Committee is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

b. **NOTE** the progress made in supporting the continued development and operationalisation of the Trust Assurance Framework since January 2022.

2. BACKGROUND

2.1 The Audit Committee must be able to assure itself that the Trust is operating effectively and meeting its Strategic Objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

2.2 The Trust Board received the first iteration of the populated Trust Assurance Framework at its September 2021 meeting, which outlined the high-level Principal Risks that may threaten the achievement of the organisation's Strategic Objectives and intent, a further update was reported to the Trust Board in January 2022.

2.3 As previously indicated there is not expected to be significant movement in the articulation of these risks in the short-term, instead these will be reviewed and evolved in line with the Trust's Integrated Medium Term Planning cycle or in response to significant external changes.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following provides a high level summary of the work undertaken since January 2022, to update the Trust Assurance Framework, support its continued development, articulation and operationalisation within the Trust.

3.1 Revised reporting mechanism

3.2 Discussion and engagement with risk colleagues in other Health Boards across Wales has been undertaken to identify and assess options available to support increased automation of the Trust Assurance Framework.

3.3 It has been identified that there is an opportunity to utilise Datix Version 14, to record the management of the Trust's ten high level Principal Risks detailed in the Trust Assurance Framework. Datix is currently already utilised to record the Trust's Operational Risks and is in the process of managing a phased data migration exercise from Version 12 to Version 14. As such, transfer of the management of the Trust Assurance Framework to Datix Version 14, would present a number of possible opportunities. In particular, utilisation of a single shared platform to record all risks i.e. Principal and Operational would enable a hierarchy of risks to be developed, that provided a holistic view of which risks feed up into the overarching Principal Risks to afford increased scrutiny and assurance. This has previously been discussed via the Trust Audit Committee as a key requirement to support the continued development and maturing of the Trust Assurance Framework.

3.4 Transfer of the management of the Trust Assurance Framework to Datix 14 would also enable further automation, providing more streamlined and effective reporting arrangements, monitoring of agreed action plans and enhanced data analysis. In particular, this would also lay the foundations for the medium to long term objective to move towards increased utilisation of Power Business Intelligence Reporting. Scoping work has already been initiated to assess the feasibility of moving to Datix 14 within existing resources, possible timelines and how this may be best supported and achieved within the context of the wider risk management arrangements/framework. A clearer view of the anticipated timelines for this transition will be reported to the May 2022 Trust Board, once further discussion with key leads has taken place.

3.5 What the Trust Assurance Framework is reporting this month

3.5.1 The updated Trust Assurance Framework Dashboard Report is included at ***Appendix 1.***

3.5.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since January 2022 in respect of the following Principal Risks:

			NO REVIEW TAKEN PLACE			
			REVIEWED NO CHANGES			
			REVIEWED AND UPDATE			
			MARCH	APRIL	MAY	JUNE
01	Demand and Capacity	COB				
02	Partnership Working / Stakeholder Engagement	CJ				
03	Workforce Planning	SFM				
04	Organisational Culture	SFM				
05	Organisational change / 'strategic execution risk'	CJ				
06	Quality & Safety	NW				
07	Digital transformation - failure to embrace new technology	CJ				
08	Trust Financial Investmnet Risk	MB				
09	Future Direction of Travel	CJ				
10	Governance	LF				

3.5.3 The following is a high level summary of the key changes that have been made to the Trust Assurance Framework since January 2022, a full overview of these changes is provided in the Trust Assurance Framework Dashboard at ***Appendix 1:***

- To note, 'Residual' Risk Score is the current score, with the current control environment, and it's effectiveness, taken into account. 'Inherent' is the risk score without the control environment operating.
- **TAF 01: Demand and Capacity**
    - ***Residual Risk Score -*** has remained the same at **12**.
    - ***Overall Level of Control Effectiveness -*** has been assessed as 'Partially Effective'. However, the recent review has identified an opportunity to reconsider the risk to broaden the controls and the assurance to include actions being undertaken to address capacity and demand planning that are wider than data sources and their use which are the elements currently included in this risk theme. This is being reconsidered by the senior leadership teams and will be reported through Executive Management Board Shape to then update on in the May 2022 reporting cycle.
    - ***Sources of Assurance –*** The original key controls are in place but again these will be reviewed and enhanced.
    - ***Action Plan for Gaps Identified –***These will be reconsidered as part of the review.

- **TAF 02: Partnership Working / Stakeholder Engagement**
    - ***Residual Risk Score*** - has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is being developed to specifically address the control deficiencies and will be reviewed through Executive Management Board Shape to then update on in the May 2022 reporting cycle.
    - ***Sources of Assurance*** - ratings have now been added and assessed for the majority of the key controls in place operating as the first line of defence.
    - ***Action Plan for Gaps Identified*** – Ways of working changes, including with partner organisations, has been agreed with Internal Audit as an advisory piece for the 2022/23 work programme.

- **TAF 05: Organisational Change / 'strategic execution risk'**
    - Risk been developed and reported for first time, residual risk score of **12**.

- **TAF 06: Quality & Safety**
    - ***Residual Risk Score*** - has remained the same at **15**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review, this is detailed further below.

- ***Sources of Assurance*** - ratings have now been added and assessed for the majority of the key controls in place operating as the first line of defence.
- ***Action Plan for Gaps Identified*** - has been updated with revised target dates to address gaps in controls and assurance. Key updates to highlight include the completion of the Trust wide consultation on the Quality & Safety Framework with final draft due in May 2022. Progress in the constitution of the Divisional Quality Hubs has been adversely affected since January 2022, due to the impact of the Omicron Variant.

- **TAF 07: Digital Transformation – Failure to embrace new technology**

  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review. However, progress has been limited since January 2022, due to the current vacancy held within the Trust for the Chief Digital Officer, recruitment for this post is underway with interviews scheduled for the end of March 2022.
  - ***Sources of Assurance:*** all key controls now have in place a first line of defence and the majority also now have a second line of defence assessed and in place.
  - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance, slippage as outlined above has been the result of the existing vacancy for the Chief Digital Officer.

- **TAF 08: Trust Financial Investment Risk**

  - ***Residual Risk Score*** – has remained the same at **12**, however the target risk score has been increased from 9 – 12 following review to reflect the current context.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review. Key changes are reflective of the current position with the ongoing discussions with commissioners, health board colleagues and WHSSC around funding arrangements for the next financial year and beyond.
  - ***Sources of Assurance:*** the existing key controls in place have been strengthened with additional lines of defence now provided for C3-7.
  - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance. A key update to highlight includes the review of the contracting model for impact of COVID-19 related measures.

- **TAF 9: Carl James – Future Direction of Travel**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.

- ***Sources of Assurance:*** the existing key controls in place have been reviewed and further articulated.
- ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance.

- **TAF 10: Lauren Fear – Governance**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
  - ***Sources of Assurance:*** the existing key controls in place have been strengthened with the addition of a further key control Quality to Assurance provided to the Board, which has been currently assessed as 'Partially Effective'.
  - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance. The detail of the action plan will be completed following the Board's receipt of the 2022/23 Governance Development Plan paper at its March 2022 meeting.

3.5.4 In addition to the above, the following provides a high level summary of the two remaining Principal Risks that were reviewed with no changes made to the overall risk status, key controls and sources of assurance in place:

- **TAF 03: Workforce Planning** - Key Control **C1** - People Strategy is due to be finalised in May 2022. This will provide the strategic framework for effective workforce planning arrangements going forward and an update reflective of this will be included in the May 2022 reporting cycle.

- **TAF 04: Organisational Culture** - it is anticipated that an overall change to the status of this risk will also be reflected in the May 2022 reporting cycle as this will reflect the planned completion of the Trust Enabling Strategies that underpin this risk that will ultimately effect the culture of the organisation and the way in which it works as a whole to effectively deliver services and achieve its ambitions

3.6 Next Steps in Development

3.6.1 Annual Review of Principal Risks

A Board Development Session will be planned and utilised to support the annual review/refresh of the existing Principal Risks following the completion and submission of

the Trust Integrated Medium Term Plan to Welsh Government. This is to be taken forward as part of the Board Development Programme for 2022/23.

3.7 Key Points from March Governance Cycle

3.7.1 Strategic Development Committee

There were three key themes which were discussed in the March Strategic Development Committee for the Committee to note:

3.7.2 The concept of "issues" was discussed, as events which are/have already occurred that may have an adverse consequence. These would be reflected in the Trust Assurance Framework through sources of assurance and also in the control effectiveness ratings of the current control environment.

3.2.2 In addition, as noted in the Risk Register paper in this meeting, the link between the risk register and the TAF is to be developed further to link relevant risks on the register to the strategic risks in the TAF with this year's work plan. Following the development of the performance and quality frameworks, key metrics relating to the strategic risks will also be linked. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards,

3.7.3 The third key theme discussed in Strategic Development Committee was to understand the impact of the overall profile and the impact of a collection of these risks being brought together. The concept of reverse stress testing was commented on, that is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability and will again be worked into the TAF development for this year' programme.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes Please refer to ***Appendix 1*** for relevant details.
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	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Audit Committee is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

b. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework.

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	**Goal 1**
EXECUTIVE LEAD	Lauren Fear	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	E		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee Trust Board	PA	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment	PA

TAF DASHBOARD

GOVERNANCE

												Audit Wales Review of Quality Governance Arrangements	

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA
C6	Quality of assurance provided to the Board	Lauren Fear	X			PE	Quality of Board papers and supporting	IA	Trust Board assessment via formal	IA	Internal Audit Reports.	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
None	Third line of defense in respect of C4 – Board Development Programme: no course of action is proposed

TAF DASHBOARD GOVERNANCE

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Apr-22
Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been reviewed and is to be agreed by Independent Member by mid December.	Complete
Actions as agreed in the Governance Development paper for 2022/23	Lauren Fear	Will be completed in detail following the Board's receipt of the 2022/23 Governance development plan paper in March 22 meeting.	Various - to be detailed following March 22 Board

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists

07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investmnet Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance
09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	Second Line of Defence functions that oversee or specialise in risk management	Third Line of Defence functions that provide independent assurance
Self-Assurance	**Internal oversight**/specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management Staff training and compliance with policy guidance Teams take responsibility for their own risk identification and mitigation	Quality & Safety IT Governance (corporate/Clinical)	External Audit Regulators & Commissioners Wales Audit Office reviews Stakeholder reviews Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures *Local management information / departmental management reporting*	*Board, Committee and Management Structures which receive evidence from* *Finance reports*	*Recent internal audit reviews and levels of assurance* *External Audit coverage*

Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting	*Compliance against Policies*	
Staff Training Programmes		

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Asessment of the assurance arrangements is pending.	Not Assessed

RISK SCORE

IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients

Quality/complaints/ audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
	Informal complaint/enquiry	Formal complaint (stage 1) Local resolution	Formal complain (stage 2) complaint	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
		Single failure to meet internal standards	Local resolution (with potential to go to independent	Low performance rating	Inquest/ombudsman inquiry
		Minor implications for patient safety if unresolved	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards
		Reduced performance rating if unresolved	Major patient safety implications if findings are not acted on		
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporilly reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
			Unsafe staffing level or competence (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
			Low staff morale	Loss of key staff Very low staff morale	Loss of several key staff
			Poor staff attendance for manadtory/key training	No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation	Single breach in statutory duty	Enforcement action	Multiple breeches in statutory duty
		Reduced performance rating if unresolved	Challenging external recommendations/ improvement notice	Multiple breaches in statutory duty	Prosecution
				Improvement notices	Complete systems change required
				Low performance rating	Zero performance rating
				Critical report	Severely critical report
Adverse publicity/ reputation	Rumours	Local media coverage	Local media coverage	National media	National media
	Potential for public concern	short-term reduction in public confidence	long-term reduction in public confidence	coverage with <3 days service well below reasonable public expectation	coverage with >3 days service well below reasonable public expectation.
		Elements of public expectation not being met			MP concerned (questions in the House)
					Total loss of public confidence

Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruptionenvironmental impactr	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on enrionment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

LIKELIHOOD MATRIX

LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Nopt exepcted to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occure at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD

RISK MATRIX	**LIKELIHOOD(*)**				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 -Neglible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

TAF DASHBOARD

DEMAND AND CAPACITY

RISK ID:	TAF 01	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	BI Strategy?											
C1a	Business intelligence Plan which is based on the Velindre Cancer Service	Lisa Miller	X			NE	Divisional Performance Review and the Quality & Perfomance Report. Velindre Futures Programme Board. Patient and Donor feedback		Assurance source			
C1b	Trust Business intelligence plan which is based on the Welsh Blood Service	Alan Prosser	X			PE						

TAF DASHBOARD

DEMAND AND CAPACITY

C2	Active work ongoing to establish data sets and pathways for the Cancer Service with health boards supported by the Delivery Support Unit.					PE						
C3	Active work ongoing to establish data sets and pathways for the Cancer Service with health boards supported by the Delivery Support Unit.	Cath O'Brien	X			PE						
C4	Active engagement with Health Boards in Service Planning including the established Service Level Agreement Arrangements in place to plan demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Alan Prosser	X			PE						
C5	Active operational engagement with health boards on demand		X			PE						

GAP IN CONTROLS	GAPS IN ASSURANCE

TAF DASHBOARD

DEMAND AND CAPACITY

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
1.1 Review our Business Intelligence Structures	Cath O'Brien	Agreed approach with both Divisions - need to work through a plan and agree	Plan to be agreed by May 2022

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	System structures – core cancer services commissioning arrangements;		X			PE	Commissioning contracting reporting	IA				
1.2	with effectively delivering ways of working/ work programmes;			X		PE	Supply and demand reporting	IA				
1.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
2.1	Blood - core blood services commissioning arrangements;			X		PE	Commissioning contracting reporting	IA			Regulatory scope re MHRA	
2.2	with effectively delivering ways of working/ work programmes;			X		PE	Supply and demand reporting	IA				

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

2.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
3.1	South Wales Collaborative Cancer Leadership Group system model;		X			PE	Agreed to model for next phase	IA				
3.2	with effectively delivering ways of working/ work programmes			X		PE	Collectively agreed to and documented work programme	IA				
3.3	and data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	IA				
4.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				
4.2	with effectively delivering ways of working/ work programmes			X		NE	Collectively agreed to and documented work programme	NA				
4.3	and data and measures to clearly track progress against objectives.				x	NE	With respective measures reported	NA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line of defence assurance are in place to a certain extent across most of the key controls. However, there is limited coverage from second and third line perspectives

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Progress has been made across all controls since the Janaury update. However, the pulling together of an overall plan will now be progressed and taken the the April EMB Shape meeting for then onward reporting to the Board and Committees in May.	May-22
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James	Action progressed with the ways of working changes being agreed with Internal Audit as an advisory piece for the 2022/23 work programme. Scope and timing to be agreed further.	May-22

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy		Internal Audit Reports		To be completed as per compliance/ reg tracker update	
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback		Trust Board reporting against Trust People Strategy		To be completed as per compliance/ reg tracker update	
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	Performance reports via divisional and committee					
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE						

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE						
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE						
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE						
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE						
C9	Agile Workforce Programme established to assess implications for planning a workforce followinf COVID and learning lessons will inlcude technology impact accessments.	Sarah Morley			X	PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Sarah Morley		May-22, previously Dec-21

TAF DASHBOARD

WORKFORCE PLANNING

1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		May-22, previously Dec-21

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL CULTURE:** The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	**Goal 1**
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	2	4

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	

TAF DASHBOARD

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group					
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group					
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group					
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group					
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group					
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings					

TAF DASHBOARD

ORGANISATIONAL CULTURE

C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Edcucation and Training Steering Group					
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined					

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defense assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Sarah Morley		May-22, previously Jan-22
1.2	Development of 3rd Line of defense assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		May-22, previously Jan-22

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	2	4

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	Trust strategy to provide clear set of goals, aims and prioritoies	Carl James	x			E	Executive Management Board review		Internal Audt Review		Audit Wales	
1.2	Intergrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x			E	Executive Management Board review		Internal Audt Review / CHC		Audit Wales	
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x	PE	Executive Management Board review/ patient and		Internal Audt Review / CHC		Audit Wales	
1.4	Risk managament framework / arranagments in place to identfiy/monitor/manage risks at corporate and service level	Lauren Fear		x		E	Executive Management Board review		Internal Audt Review		Audit Wales	
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x			PE	Executive Management Board review / staff feedback		Internal Audt Review		Audit Wales	

1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x			PE			Internal Audt Review		Audit Wales/HIW	

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented	
Not all supporting strategies approved by the Board	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in may 2022	May-22
Develop IMTP t provide priority for action and application of resource	Carl James	Final draft going to Board for approval march 2022	Mar-22
Information requiremsnts being scoped	Cath O'Brien	First phase to support new performance measures	Jul-22
Implement revised performance management framework	Carl James	New scorecards being finalied for implementation	Jul-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**		
NEXT REVIEW	May-22	Goal 1		
EXECUTIVE LEAD	Nicola Willams			

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE
C2	CIVICA pt/donor feedback system system being implemented	Nicola Williams			X	NE
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
EMB	IA			Professional bodies	Not Assessed
Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfct Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews					
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework not finalized due to pandemic	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality & Candor guidance still under development	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	May-22

TAF DASHBOARD

QUALITY AND SAFETY

1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. OCP Process has commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	May-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	Jun-22
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Will be established once OCP completed	Jun-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training arranged for March - delayed due to Omicron	Jun-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Planned for March 2022	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and establishe for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23	Jun-22
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	Jun-22

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	4	**12**	3	4	**12**	2	3	**6**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports	PA	To be completed as per compliance/ reg tracker update	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E	Trust digital governance reporting	PA	Internal Audit Reports	PA		
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	Trust Board reporting against Trust Digital Strategy	PA		
C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA		

TAF DASHBOARD

DIGITAL TRANSFORMATION

C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map –	PA	Trust digital governance reporting	PA		
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust	PA	Trust digital governance reporting	PA		
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA				
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	PA				
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	PA				
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital officer			X	PE	Review via Divisional SMT / SLT	PA	Review via EMB / Trust Board	PA		

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2
	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

DIGITAL TRANSFORMATION

1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to April / July meeting of SDC.	April/ July Strategic Development Committee
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to April / July meeting of SDC.	April/July Strategic Development Committee

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	**Goal 5**
EXECUTIVE LEAD	Matthew Bunce	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	3	4	**12**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance	PA	Monthly Performance Review with Executives and Senior	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

KEY CONTROLS **SOURCES OF ASSURANCE**

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review	PA	Quarterly Directorate financial reviews	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA
C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Divisions	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and “live” operation to follow.	Jul-22
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to	Jul-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Jul-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	**Goal 2**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			PE
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE
C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Executive Management Board review		Strategic Development Committee		Audit Wales Reviews	
Executive Management Board review		Strategic Development Committee		Audit Wales Reviews	
Executive Management Board review		Strategic Development Committee		Audit Wales Reviews	
Executive Management Board review		Strategic Development Committeen and performance		Audit Wales Reviews	
Executive Management Board review/ patient and donor feedback		Strategic Development Committee		Audit Wales/MHRA & HIW/ regulators	

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review		Strategic Development Committee		Audit Wales/MHRA & HIW/ regulators	
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review		R< D & I Sub-Committee and Performance Management		Audit Wales/External Research organisations & Welsh	
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review		R< D & I Sub-Committee and Performance		Audit Wales/External Research organisations &	
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review				Audit Wales/External Research	

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capaility to leverage the strategic oppo	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James		May-22
1.2	Board decision on strategic areas of focus/to pursue	Board		May-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board
1.5	development of clinical and scientifc strategy	Jacinta Abraham		tbc
1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions in may 22

TAF DASHBOARD GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	**Goal 1**
EXECUTIVE LEAD	Lauren Fear	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	E		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self-Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee Trust Board	PA	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment	PA

TAF DASHBOARD

GOVERNANCE

											Audit Wales Review of Quality Governance Arrangements	
KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA
C6	Quality of assurance provided to the Board	Lauren Fear	X			PE	Quality of Board papers and supporting	IA	Trust Board assessment via formal	IA	Internal Audit Reports.	PA

GAP IN CONTROLS	**GAPS IN ASSURANCE**
None	Third line of defense in respect of C4 – Board Development Programme: no course of action is proposed

TAF DASHBOARD GOVERNANCE

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Apr-22
Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been reviewed and is to be agreed by Independent Member by mid December.	Complete
Actions as agreed in the Governance Development paper for 2022/23	Lauren Fear	Will be completed in detail following the Board's receipt of the 2022/23 Governance development plan paper in March 22 meeting.	Various - to be detailed following March 22 Board

AUDIT COMMITTEE

AUDIT ACTION PLAN

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The report has been prepared in order to update the Audit Committee with respect to the audit recommendations that have been made, including those that are overdue **(Red)** and requesting an extension **(Green)** for the closed actions. The Audit Committee is requested to consider the contents of the report and the attached action plan.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Analysis:

2.1.1 The Audit Committee Action Log tracks the status of actions identified in internal and external audits carried out across the Trust.

2.1.2 The Audit Committee, at its meeting held on 14 October 2021, reviewed the full Audit Action Tracker which included **all** actions currently on the Audit Action log.

KEY TO STATUS OF ACTION	
RED	Indicates that implementation has passed and management action is not complete
GREEN	Completed or discharged

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	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	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Committee are requested to **NOTE** the contents of the report. The Trust will continue to present the Audit Action Log to the Audit Committee to provide them with appropriate assurance of activities undertaken to address audit recommendations.

4.2 Where actions closed in this period – this a recommendation for the committee to approve. For future actions, the responsible officer should provide a brief summary of the actions taken to the Audit Committee, along with a request to close the action.

Audit Action Plan

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 passed management action not complete

Priority
Low
Medium
High

Velindre UNHS Trust

INTERNAL AUDIT - Core Financial Systems					Date received at Audit Committee: 21 January 2021				
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee
5	The Financial Department should introduce a rolling programme of budgetary management information training in place for new budget holders	Low	The recommendation is accepted. The Finance Department will introduce training for new budget holders as suggested	David Osborne, Head of Finance Business Partnering	31/05/2021. **Update 08 July 2021: Extension agreed to 31/12/2021.** **Update October 2021: Extension agreed to 31 March 2022.**		Training materials and subsequent roll out plan remain in development. Budget Holders (new and existing) are met with on a regular basis and direct training issues addressed, bespoke awareness session provided to aspiring leaders/managers. **Extension required to March 2022**, in view of optimising potential face to face/Teams facilitation and a core comprehensive programme of core competencies (assesment and training) for budget holders.	No update provided, intention remained to have a developed budget holder training programme and initiate rollout.	Extension requested to Sept 2022, comprised of Q1 focus on development of training materials (part completed) and Q2 rollout (additionally, dedicated sessions for non budget holders planned May and Oct). Delays resultant from focus to support services at peaks of high pressure due to pandemic. Additionally, a rollout of training at peak times of elevated staff absences within services was not deemed appropriate.

Audit Action Plan

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Priority
Low
Medium
High

Velindre UNHS Trust

INTERNAL AUDIT - Effectiveness of Counter-Fraud Arrangements									
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee
11	Implement mandatory counter-fraud training for some or all staff groups	Low	As part of the Compliance and Competency section within the Heath Body's Electronic Staffing Record (ESR) Database, then any such training, which is deemed as being mandatory, has to be agreed and by the Health Body's Workforce Department in conjunction with Staff Side Representation before it can be implemented.	Matthew Bunce, Executive Director of Finance and Sarah Morley, Director of OD and Workforce	Ongoing with review date of 31 March 2021. **Update 08 July 2021: Extention to 31 October 2021.**	Completed	Ongoing as per July update.	This discussion needed for Counter Fraud with the Trust Education Steering Group on speific questions it has relating to this item has not taken place due to meeting being stood down for Covid Response reasons. This will now take place during 2022 qtr1.	On 24/03/22 The Education Steering Group endorsed the training as a mandatory requirement for the relevant staff groups. Nigel Price will work with the Workforce Development Manager, ESR will be updated and a training plan will be produced on delivery mode, access and roll out. Complete.

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Priority
Low
Medium
High

Velindre UNHS Trust

INTERNAL AUDIT - Governance Arrangements during COVID-19 Pandemic

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee
11	**Information Governance** * The need to maintain privacy in the household when using video conference/telephone call or other applicable work from other household members. * Ensuring that laptops are locked when not in use/away from the desk. This is even more important in a public environment if agile working is to be promoted, for example, coffee shops. Consideration could be given to reducing the screen lock functionality within Windows. * How physical copies of information are held and how they should be securely stored away from other household members/visitors. * The risk that staff using their own devices at home are potentially more susceptible to malware/phishing attacks, as they may have insufficient security on their phones/home computers etc. This is likely to be more relevant with people able to access the OneDrive/Office 365 with just an internet connection from any device.	Recommendations		Matthew Bunce, Executive Director of Finance	30/06/2021. **Update: 08 July 2021: Extention to 30/09/2021.** **Update October 2021 meeting: Extension agreed 31 December 2021 Estimated Completion 31 January 2022.** **Extention requested to May 2022.**		New Information Governance Manager start date is not yet confirmed, but will hopefully start in the next two months and take forward this action as they start.	The Head of IG came in to post on 29 Nov 21. A review of all IG policies is underway with the aim of bringing them up to date, aligning them with UK GDPR (Post-Brexit) and include remote working considerations. The estimated completion date is 31 Jan 22. The first Policy to be reviewed is the Data Protection Policy, the draft of which now incorporates significant changes in an expanded Section 6 (Training, Awareness and Practical Considerations). The revised Policy includes all of the recommended points from the Internal Audit report (Column B) as well as other additIonal practical remote working considerations which will be cross referred across all IG policies. Training will be delivered in the new year to "bolt on" to the existing ESR package to support Policy and to re-inforce remote working considerations on a risk-based approach basis (i.e. - areas within the Trust which present the highest risk/balanced against compliance data).	The policies are being worked on with the aim of getting them to EMB during May 22.

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Priority
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Medium
High

Velindre UNHS Trust

INTERNAL AUDIT - ESTATES MAINTENANCE - Dec 2015 AC

	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee
EM2015.1	An estates strategy will be developed; including relevant priorities for the period.	Medium	As highlighted within the audit, the Trust has developed a high level outline estates plan as part of the 3 year Integrated Medium Term Plan. The Trust will aim to develop an estate strategy in accordance with the long term strategy for the future development of the Velindre Cancer Centre and the future estate requirements of the Welsh Blood Service.	Stephen Lloyd Now undertaken by Jason Hoskins, Assistant Director	~~31st August 2016 AC agreed extension of date to April 2017~~ ~~31st May 2018~~ ~~September 18~~ ~~31st March 2019~~ ~~30 September 2019~~ ~~September 2020~~ ~~December 2020~~ ~~March 2021~~ **Extension requested to 31 May 2021. Update 08 Jul 2021: Extention to 30/11/2021.**		Ongoing. Significant process made in this area including completion of engagement process with the wider organisation on support strategies	Further engagement is planned for the new year in support of adopting this strategy. Strategy documentation due to be finalised and presented to EMB and Board during Q4 2021/22. Implementation expected Q1 2022/23	Consultation has taken place surrounding the strategies, and comments from earlier EMB have been included in the latest itterations.. The Estates strategy will formally be presented to EMB and Board for sign off in Q1

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Priority
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Medium
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Velindre UNHS Trust

INTERNAL AUDIT -RISK MANAGEMENT - May 2019 Reasonable rating

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee
RM2019.5	Management needs to ensure that formal Risk Management training is provided for relevant staff that have responsibility for identifying new risks, carrying out risk assessments and updating the DATIX system. Management should review the arrangements in place for the provision of Risk Management advice.	Medium	A Training Needs Assessment (TNA) will be completed to identify training requirements for relevant staff who have responsibility for identifying new risks, carrying out risk assessments and updating the DATIX system. A review of the arrangements in place for the provision of Risk Management advice will be undertaken as part of a wider Executive/Director portfolio review.	~~Lisa Heydon~~ This action now falls with Lauren Fear	Extention to 30 June 2022 requested.		• Datix form finalised • Training to be completed by end Nov 2021 • Approach to migration of risks from version 12 of Datix module to version 14 of the module to be agreed and implemented in full for VCC and Corporate - WBS in plan to follow by end November • Updated to risk Policy package, including user guides etc, to be refreshed through Trust Board November 2021	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.

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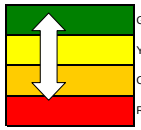
Velindre UNHS Trust

Final Internal Audit Report - WAO - Structured Assessment 2019 /20 - Reasonable Assurance

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee
2019-R3	Board Assurance and Risk Management The Trust should complete the development of its BAF with pace, ensuring that it is appropriately underpinned by up-to-date risk management arrangements. Specifically, the Trust should; a) review the principle risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; b) update the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; c) provide risk management training to staff and Board members on the resulting changes to the risk management framework.	Medium	A BAF which triangulates risk, performance and assurance is planned for implementation in 2020-21, and is a priority of the Interim Director of Corporate Governance who commenced with the Trust on the 2nd December 2019.	Lauren Fear, Director of Corporate Governance	Extention to 30 June 2022 requested.		a and b complete, regarding finalising framework and completing a first version of the BAF- and c, regarding training for Board, execs and staff.	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
2579A2021-22	**Recommendation 2** **Articulation of strategic priorities** Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.	Low		Lauren Fear, Director of Corporate Governance - Corrected to Carl James and Cath O'Brien	Mar-22			Action for Carl James and Cath O'Brien - Due to be actioned in line with refresh of strategy and IMTP by March 2022	Complete - included in 2022-25 IMTP
	Tracking Internal and External audit recommendations 2018 R4b Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close the action.			Matthew Bunce, Executive Director of Finance	No progress (overdue) No progress has been made on this recommendation.				As part of its 2021/22 follow-up on prior year recommendations review, Internal Audit is considering the appropriateness of action updates provided on the recommendation tracker and will provide recommendations on the Audit Tracker process, including sharing learning from other NHS Wales organisations. This work was nearing completion at the time of writing and will be reported to the July 2022 Audit Committee.

Audit Action Plan



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Priority
Low
Medium
High

Velindre UNHS Trust

Final Internal Audit 2019/2020 - Capital Systems: Financial Safeguarding - Reasonable Assurance									
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee
2019/20-R3	When selecting contractors to include in a quotation/tender exercise, new contractors should be periodically invited, to re-test the market and ensure best value for money is being achieved	Medium	An approved list of Contractors will be prepared that will be updated on a 3 year basis, with options to extend for a further 2 years.	Jason Hoskins, Assistant Director of Estates, Environment and Capital Development	~~01/09/2020~~ ~~DECEMBER 2020~~ ~~MARCH 2021~~ Extension requested to 30 JUNE 2021. **Update 08 July 2021: Completion Date April 2022.**		this exercise is ongoing with a number of meetings being undertaken between procurement and estates identifying the needs of the framework	The process is still underdevelopment with a view that the sytems will be in place by the April deadline	Estates supported by procurement colleagues have engaged an alternative route to market through a professional services frame work which has seen the introduction of new suppliers supporting the delivery of the capital programme. The current market position is extremely challenging but the adopted approach has been hugely successful with recently tendered works having favourible returns including new suppliers. Procurement colleagues are seeking a longer term solution which is being explored.

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Priority
Low
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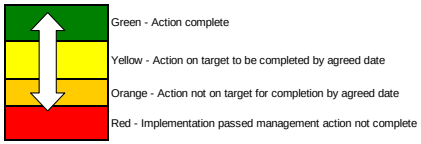
High

Velindre UNHS Trust

FINAL INTERNAL AUDIT 2019/2020 - VCC Control and Governance - Reasonable Assurance

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee
VT1920 11 VCC Final Internal Audit Report	Management should ensure that urgent action is taken to ensure that key staff within the Therapies Department are given appropriate access and training on DATIX in order to be able to maintain the information recorded and also produce reports for review.	Medium	Therapies Manager to meet with the DATIX team to ensure that the dashboard is correctly set up to run departmental DATIX reports. □ Ensure that all leads have relevant permissions and training. □ Dispense with additional records once above complete and rely wholly on DATIX system.	Lisa Love-Gould This action will be transferred to Kate Baker from 22 August 2021		Completed	Interim Deputy Head of Therapies, Siobhan Pearce is now in post (recent return from 12 months maternity leave). Therefore datix training is required for Siobhan. 2 out of the 4 Clinical Leads are on maternity leave and will require Datix training when they return. To review in May 2022.	DATIX training arranged fro Siobhan Perace and Nia Oakes (Interim Clinical Lead SLT) for January 2022. SP linking with John Kelland to ensure that leads / management staff have correct dashboard / report reviewing access.	Action is now completed and can be closed.

Audit Action



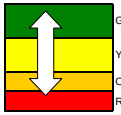
Priority
Low
Medium
High

Velindre UNHS Trust

Final Internal Audit Report 2020/2021 - Velindre Cancer Centre - Divisional Review - Reasonable

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee
		High	Datix and risk management training will be provided in conjunction with the role of out of the new Datix risk module, due to go live April 2021.	Lauren Fear, Director of Corporate Governance	Extention to 30 June 2022 requested.		Datix form finalised • Training to be completed by end Nov 2021 • Approach to migration of risks from version 12 of Datix module to version 14 of the module to be agreed and implemented in full for VCC and Corporate - WBS in plan to follow by end November • Updated to risk Policy package, including user guides etc, to be refreshed through Trust Board November 2021	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.

Audit Action Plan



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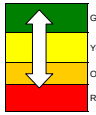
Priority
Low
Medium
High

Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Assurance Report							Date received at Audit Committee: 22 March 2021		
Ref	**Recommendation**	**Priority**	**Management Response**	**Responsible Manager/ Department**	**Agreed Implementation Date**	**Status**	**Update for October 2021 Committee**	**Update for January 2022 Committee**	**Update May 2022 Audit Committee**
4	Departmentally managed systems should comply with good practice for the management of ICT. Digital services should produce good practice guidance documentation for the Trust overall, with all departments required to comply for areas such as: • BYOD; and • Change control.		Revised governance arrangements (including the establishment of a Digital Programme Board) will set out the approach for how all departments are required to implement and manage ICT. Where relevant, appropriate documentation will be developed by the Digital Services team to ensure staff are aware of their responsibilities and that clear roles and responsibilities between the Digital Services team and other departments are clearly set out.	Deputy Chief Digital Officer	Quarter 4 2021/2022		New Trust governance procedures in the process of being established, yet to be formalised - anticipate new arrangements will be stood up in Q3 2021/22. Work to compile good practice guides yet to commence, but planned to be completed before year end.	Awaiting confirmation of revised Trust governance procedures.	Awaiting confirmation of revised Trust governance procedures.
5	Work on the digital strategy should be completed. This work should include an evaluation of the current position of the Trust in relation to both the external environment and current ways of working in order to provide a baseline position from which to work.		A refreshed Digital Strategy to be approved by the Trust Board following a process of engagement and consultation with stakeholders.	Deputy Chief Digital Officer	Quarter 3 2021/2022		In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022.	Digital Strategy scheduled to be presented for Trust Board approval in May 2022.
6	The development of the digital strategy should consider the wider digital strategy implications and the supporting digital infrastructure. Consideration should also be given to establishing a strategy governance and management group such as a Digital Programme Board to oversee, coordinate and prioritise digital strategy issues.		A new pan Trust Digital Board will be established for the Trust to oversee and coordinate the digital strategy.	Deputy Chief Digital Officer	Quarter 3 2021/2022		New Trust governance procedures in the process of being established, yet to be formalised - anticipate new arrangements will be stood up in Q3 2021/22.	Awaiting confirmation of revised Trust governance procedures.	Development of proposal to establish Digital Strategy Group to deliver digital strategy developed: to be discussed with Executive Management Board in May 2022 Internal discussions commenced with a view to establish an interim group who can perform this role.
7	The current position of the Trust should be assessed in relation to the target digital position and the required changes across the business, information, data, applications and technology domains identified, together with the benefits of each change and the implication of a lack of change.		An assessment of the target Digital position to commence with the approval of the Trust Annual Plan 2021/2022, and then subsequently reviewed with the launch of the new Digital Strategy and reflected in the Digital work plan and completion of the Integrated Medium Term Plan / Annual Plan for 2022/2023.	Deputy Chief Digital Officer	Quarter 4 2021/2022		In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022.	Digital Strategy scheduled to be presented for Trust Board approval in May 2022.
8	A holistic roadmap for delivery of a digital strategy should be developed that identifies all projects together with resource requirements, overlaps and synergies.		A Digital Roadmap will be incorporated into the new Digital Strategy and aligned to the Trust major programmes of work, for example Transforming Cancer Services, Velindre Futures.	Deputy Chief Digital Officer	Quarter 3 2021/2022		In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022. Roadmap will be developed to align with strategy.	**COMPLETED** Roadmap covering Digital Services work plan for 2022 developed and agreed / endorsed via divisional SMT/SLT. Longer-term roadmap to be aligned to Digital Strategy, due to be presented to Trust Board in May 2022.
9	Consideration should be given to aligning the ICT budget to the needs of the organisation and the digital strategy.		Digital Services budgets to be consolidated Quarter 1 2021/2022 Digital Strategy launched Quarter 3 2021/2022 Review of budgets to alignment with strategy Quarter 4 2021/2022	Deputy Chief Digital Officer	Quarter 4 2021/2022		Discussions with Finance now at an advanced stage. Work to align budgets anticipated to be completed in Q3, though formal alignment into a single cost centre may be timed to align with the confirmation of budgets for the new financial year.	Staff budgets for Digital Services now consolidated into a single cost centre (M038). Non-pay budgets to be aligned from 1st April 2022.	**COMPLETED** Budgets now aligned, first reporting under consolidated budget (M038) due from April 2022.
10	A full assessment of the current skills within digital services, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.		Skills and training analysis to be undertaken by the Digital Services team.	Deputy Chief Digital Officer	Quarter 4 2021/2022		In progress.	In progress.	**COMPLETED** Initial review completed, being kept under constant review via annual PADRs etc.

12	A suite of cyber security KPIs should be developed in order to show the status of cyber security and the progress of the team in managing issues.		KPIs are under development for the new Digital Services function. Cyber Security will be included as a core KPI.	Deputy Chief Digital Officer	Quarter 3 2021/2022		Initial draft set of KPIs developed - currently being refined as part of wider Trust PMF review.	Set of Board-level and team-reportable KPIs agreed in principle. Team-level KPIs include a suite of cyber security indicators. Work ongoing to refine the approach for recording and reporting the required data.	**COMPLETED** KPIs agreed, first Digital Services scorecard to be published in April 2022. Work ongoing to automate reporting.
13	SOPs should be developed that make clear the processes for AV software management and for web and email filtering.		Standard Operating Procedures are being reviewed and consolidated as part of the new Digital Services function. Appropriate AV SOPs will be aligned and developed to cover all Trust operations.	Deputy Chief Digital Officer	Quarter 2 2021/2022		Work is due to commence on standardising the SOPs for AV software management, web and email filtering.	In progress.	Work to standardise AV approach complete. Standard Operating Procedure drafted - aim to complete in Q1 22/23, for review / approval via QSPP Committee.
15	Work to develop the asset management and recording process within VCC should continue. This should include a process for identifying critical assets and regular assessment of the need for replacement of these. The Disposal procedure should be reviewed and updated.		Baseline asset management audit to be completed Common asset management approach to be adopted VCC and WBS disposal procedures to be consolidated	Deputy Chief Digital Officer	Quarter 1 2021/2022 Quarter 3 2021/2022 Quarter 1 2021/2022		An Asset Management baseline maturity assessment has been conducted outlining the current requirements to align to Asset management best practice. The report includes a 1 to 3 year plan to adopt best practice which is in review. Within the report it outlines the need to adopt a common asset management lifecycle approach which will be developed in the 1 to 3 year plan including purchase to disposal. It also reports a need to purchase a centralised asset management tool.	1) Completed. 2) In progress - see October 2021 update. Work to extend into 2022/23. 3) In progress - see October 2021 update. Work to extend into 2022/23.	1) Completed. 2) In progress - see October 2021 update. Work to extend into 2022/23. 3) In progress - see October 2021 update. Work to extend into 2022/23.
16	A SOP should be developed, with note that critical assets should be fully maintained with up to date patches and firmware, together with a regular assessment of the risk of failure fully.		Trust-wide patch management SOP to be developed.	Deputy Chief Digital Officer	Quarter 2 2021/2022		Patch management standardisation has progressed. The Velindre estate has onboarded to PDQ patch management software and as a result will align to the already existing patch management SOP in place at Welsh Blood Service. Work is being progressed to outline critical devices that may not be on the domain, but on our network. Suppliers will be engaged and expected to follow our patching standards accordingly.	Communications with various suppliers ongoing to discuss and refine patch management approach.	Patch management tool (PDQ) standardised across the Trust. Standard Operating Procedure drafted - aim to complete in Q1 22/23, for review / approval via QSPP Committee.
17	A single BCP for digital should be defined that identifies the business critical activities, based on a BIA, and which identifies key stakeholders. This should describe potential disruptive scenarios, the mitigations in place and the residual impact over time. The level of continuity provided should be described in terms of RTO / RPO and discussed with user departments. Options should be provided for departments to move to a greater continuity position if required and the level of provision should then be agreed with departments an executives.		In progress Business Impact Assessment for Infrastructure complete Digital Services business continuity plans to be developed and fully tested	Deputy Chief Digital Officer	Quarter 4 2020/2021 Quarter 4 2021/2022		Digital Services BIA completed - March 2021. Development of Digital Services MI Comms & Response procedure being drafted via Trust BC Group. BC arrangements across VCC under review - Digital Services are supporting discussions, as required. BC arrangements for WBS defined.	As per October 2021 update.	Digital Service BIA completed, due to be refreshed in 2022/23. Cyber Security and IT Business Continuity Incident Response Plans re-drafted, to align with national response plans. To be reviewed (for approval) in May 2022 QSPP Committee.
18	A formal Project Management SOP should be developed which sets out the requirements for managing projects, including how and when agile methodologies may be used.		Standard Operating Procedures for Project and Programme Management will need to be aligned with wider Trust Programme Offices. Work has commenced on the standardisation of roles and templates. SOP will be developed as part of this work programme.	Deputy Chief Digital Officer	Quarter 4 2021/2022		In progress - work aligned to the creation of a Transformation Office and alignment with the Programme Management Offices within each service / directorate. Awaiting confirmation of funding for the Trust wide function	As per October 2021 update.	As per October 2021 update.

Audit Action



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Priority
Low
Medium
High

Velindre UNHS Trust

Financial Audit Report - 2020/21 Velindre University NHS Trust							Date Received at Audit Committee: 14 October 2021	
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee
	Losses relating to a Structured Settlements have not been correctly recorded in the Trust's accounts. Note 26.3 within the Trust's 2021-22 Financial Statements should include losses relating to Structured Settlement cases and discussions should be held with Welsh Government for the prior year figures to be restated.	High	Agreed – Note 11 in the WRP accounts have always only ever included reimbursements and managed claims expenditure. We will include the losses relating to structured settlement cases in 2021-2022. Discussions will commence with Welsh Government with regards to a restatement of prior year figures.	Andy Butler, Director of Finance, NWSSP	2021/22 Accounts submission	Completed	We are still planning to incorporate losses relating to structured settlement cases within Note 26.3 in the 2021/ 22 Welsh Risk Pool accounts . Discussions have commenced with Welsh Government colleagues regarding the potential need to restate the prior year figures.	Losses relating to structured settlement cases will be included within Note 26.3 in the 2021/22 Welsh Risk Pool accounts. The note does not include a prior year comparative figure. Welsh Government have agreed the addition of a narrative disclosure to be included for comparative purposes. ACTION COMPLETE
	Coding of transactions for the production of the FR6 return and WGA (LMS2) return. We recommend that those officers posting transactions are reminded of the need to use the appropriate coding.	Low	We fully accept this recommendation and will remind all finance staff posting such transactions of the need to use the appropriate coding.	Claire Bowden, Head of Financial Operations	31st March 2022	Completed	A session has been held explaining the importance of correct coding. Further work is being done until the end of the financial year to make continued improvements.	Finance staff have been reminded on a number of occasions through the year, including the session described in the January 2022 update to the Committee. This was further emphasised in the Financial Management meeting held on 16th March 2022. ACTION COMPLETE

Audit Action Plan

Green - Action complete

Yellow - Action on target to be completed by agreed date

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Red - Implementation passed management action not complete

Priority
Low
Medium
High

Velindre UNHS Trust

Infection Prevention and Control Final Internal Audit Report							Date Received at Audit Committee: 14 October 2021	
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee
	Policies and Procedures (Operation). 1.1 The Corporate IPC Team should ensure that there is a programme of on-going review for IPC policies and SOPs, ideally on a three-year cyclical basis in line with good practice guidance.	Medium	1.1 The policy reviews were delayed due to re-prioritisation of IPC Team to ensure the Trust staff, patients & donors remained safe throughout the pandemic. As we have moved into wave 2 recovery there has been capacity for the team to commence the reviews. Two have been completed and the third commenced. All current out of date corporate IPC policies and procedures will be formally reviewed and changes approved.	Muhammed Yaseen, Head of Infection Prevention & Control	March 2022	Ongoing	The appropriate policies are being revised and the drafts will be circulated for comment at the Trust Infection Prevention and Control Management Group (IPCMG) meeting on 22nd January 2022.	Two of the three outdated policies were updated and approved by QSP on 24th March. The third MRSA policy is will be submitted to EMB on 24th April 2022.

Audit Action

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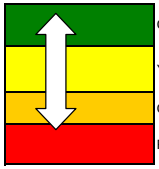
Velindre UNHS Trust

Digital Health & Care Record for Cancer (Canisc Replacement) — **Date Received at Audit Committee: 14 October 2021**

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee
	Process change not fully understood (Operation). The adjusted ways of working across all departments should be finalised and agreed across the Trust departments.	Medium	Following the established process for approving ways of working, all changes to operational process will be approved at a workstream and project board level prior to transition from Canisc to WPAS & WCP.	Paul Wilkins, Interim Director of VCC	29/05/2022	Completed	The majority of the new ways of working have been signed off by the by the operational leads and ratified by the Project Board. The remaining processes are dependent on the delivery of software from Digital Health & Care Wales.	**Closed** Ways of working have been mapped and agreed in principle. Specific details at a granular level are being finalised as part of routine programme implementation.
	Agreement of Full Functionality (Operation). The Trust should continue to seek approval for the further phases of development to ensure that the full functionality required is approved and delivered.	Medium	The national governance structure including the Cancer Informatics Programme Board will oversee the delivery of full functionality. The current programme is designed to run until November 2022, Velindre have representation on the programme board via the Chief Operating Officer.	Cath O'Brien, Chief Operating Officer	Nov-22	Completed	VUNHST continues to work wiith the Cancer Informatics Porgramme to ensure that all VCC requirements are delivered within the timeframe of November 2022 (when the current funding will cease).	**Closed** Go live date of November 2022 has been proposed by DHCW and VUNHST to the Cancer Informatics Programme Board (1.4.22). Action plan in place for delivery. The completion and go live pathway was reviewed for confidence in delivery within this timeline and progress will continue to be monitored through the VUNHST Project Board and Cancer Informatics Programme Board.
	Business Continuity Departmental Plan (Design). a. The Trust should ensure each affected department is aware of the changes and has considered the risk assessment in relation to changes in procedures and processes.	Low	a. Following the established process for approving ways of working, all changes to operational process will be approved at a workstream and project board level prior to transition from Canisc to WPAS & WCP.	Paul Wilkins, Interim Director of VCC	29/05/2022	Completed	The majority of the new ways of working and process maps have been signed off by the by the operational leads and ratified by the Project Board. The remaining processes are dependent on the delivery of software from Digital Health & Care Wales.	**Closed** Impact assessments are in progress and full plans for their completion are in place. The go live implementation plan will include consideration of the impact of change. These cannot be fully completed as subject to interative change through the life cycle of testing and user acceptance in line with standard procedure for implementation of software.

Audit Action



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Velindre UNHS Trust

Waste Management - Reasonable Assurance							Date Received at Audit Committee: 14 October 2021	
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee
	Policy & Procedures (Design). 1.1.a The new Trust-wide waste policy should ensure all key elements of WHTM 07-01 guidance are incorporated.	Medium	1.1.a Accepted - the WHTM will be incorporated in the revised Waste Management Policy.	Rhiannon Freshney, Environmental Development Officer	December 2021	Completed	COMPLETE - Included in the DRAFT Waste Management Policy, which is currently with te Estates Management Group for review.	COMPLETE - The Waste Management Policy is currently under EQIA review
	1.1.b Associated Division policy / procedural documents should be updated to ensure alignment with the overarching policy or removed from publication if no longer applicable.	Medium	1.1.b Accepted. Corporate policy documents will be updated in accordance with the Waste Management Policy. VCC and WBS procedural documents will be updated in accordance with the revised Waste Management Policy and procedures.	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	December 2021		Current Divisional Waste Management procedure has been updated and follows our Trust Policy, with the addition of audit waste Audit schedule. The WBS procedure will be updated to incorporate any changes in line with the Trust policy.	COMPLETE - VCC procedure aligned with Trust Policy Clinical waste Training and the WBS Clincal Waste disposal SOP is currently being reviewed by the WBS H&S and Environmental Compliance Manager along with relevant managers.
	Governance Structure (Operation). 2.1.a The new sustainability governance structure, including a suitable forum for central oversight of waste management, should be agreed and implemented as soon as possible.	Medium	2.1.a Accepted. The proposal for the Sustainability Management Board will taken to the Executive Management Board for consideration.	Jason Hoskins Assistant Director of Estates, Environment & Capital Development	January 2022		Draft terms of refeance in support of the Sustainability management Board have been drafted and will be submitted to EMB in January. If approved the Board will be established shortly after with consideration to how this forum supports the cycle of business.	Introduction of the proposed governance structure (Sustainability Board) has been put on hold. The adoption of the Board will be introduced along with the sustainability strategy in June.
	2.1.b Velindre Cancer Centre should further consider the implementation of an operational Estates forum at which waste management matters can be reported and scrutinised / discussed.	Medium	2.1.b Accepted. VCC will review the options regarding operational estates management.	David Harding, Operational Services Compliance Manager (VCC	January 2022	Completed	Awaiting the new Operational Estates Management group to be set up	COMPLETE - Operations Management Group has been established and future audits, action plans and concerns will be raised in this forma prior to escalation to Trust Meetings
	Training (Operation). 3.1.a The targeted action plan for environmental awareness training should be taken forward, as soon as possible noting ongoing Covid restrictions.	Medium	3.1a Accepted. An action plan for environmental awareness training will be developed.	Rhiannon Freshney, Environmental Development Officer	March 2022	Completed	Following issues identifying training records for Environmental Awareness being rectified, a comprehensive breakdown of staff non compliant staff has been produced. Work has now begun to create an action plan to improve compliance.	COMPLETE - targetted plan created and monthly compliance updates received from Education team.

	3.1.b Training needs assessments, and resulting training programmes, should be developed for Division staff handling clinical waste.	Medium	3.1b Accepted. A training needs analysis will be undertaken regarding clinical waste handling at Divisional level. Training programmes will be developed for clinical waste handling at Divisional level.	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	March 2022		VCC Operational Services have recenty re recenand Development tearecruited a new Training Supervisor, part of their role is to liease with the Education the Development TNA for waste handling will be incorportaed in their role. WBS will review the clinical waste training and ensure relevant staff are trained.	VCC - Currently working with Training Supervisor on Induction Handbook for Employees to include Waste Handling, and Segregation WBS - Clinical waste Training and the WBS Clincal Waste disposal SOP is currently being reviewed by the WBS H&S and Environmental Compliance Manager along with relevant managers. This will be fed into the Cynefin Group.
	Monitoring & Reporting (Operation). 4.1.a The Trust Corrective Action Register & Tracker should incorporate recommendations made in Division Pre-Acceptance audits.	Medium	4.1.a Accepted. The Trust Corrective Action Register will incorporate recommendations made in Divisions Pre-Acceptance Audits.	David Harding, Operational Services Compliance Manager (VCC)	October 2021	Completed	The Pre acceptance Audit (Upstream Waste Audit) took place between 25th and 29th October 2021, the results of the audit were 89.01% fully compliant, 10.99% Minor non conformity (sharps bins not signed of not closed within 3 months which is best practice however local arrangements have been implemeted to allow an enhanced time sacl to close bins, which is not reflective in this audit), and No Major non conformities(Incorrect segregation) these results were reported to our Waste Contractor Stericycle, and discussed in our highlight report in the Divisional Quality and Safety Meeting 9th Dec 2021, Divisional Infection Preventtion and Control meeting and the Divisional ISO14001 Audit 23rd Nov - 25th Nov 2021	
	4.1.b Pre-Acceptance audit outcomes should be reported centrally to the Trust Estates Assurance Forum (or replacement body). Reference to Division audit outcomes should also be made in the Trust Highlight Reports to the Quality, Safety & Performance Committee.	Medium	4.1.b Accepted. Pre-acceptance audit outcomes will be reported centrally to the Trusts Estates Forum (or replacement body) and made available to the QSP Committee.	Matthew Bellamy, Health & Safety Environmental Officer (WBS)	At date of next pre□acceptance audits	Completed	The audit outcomes are now reported into the Corrective Action Register which is received at the Estates Management Group (which sends a Highlight Report to QSP).	Complete - pre-acceptance audits are included the Joint Estates Management Group when received. The next Stericycle audit is in June.

Audit Action

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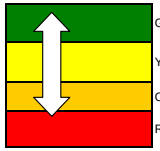
Priority
Low
Medium
High

Velindre UNHS Trust

Divisional Review - Risk Management - Final Internal Audit Report							Date Received at Audit Committee: 14 October 2021	
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee
	New Risk Management Framework (Design). 1.1 a. The Trust should • publish the new Risk Management Framework and supporting documents on its intranet as soon as possible; and • ensure the divisions are aware of the new Framework and its application in practice (see also matter arising 2). □	Low	1.1a Recommendation agreed	Lauren Fear Director of Corporate Governance	Extention to 30 June 2022 requested.		Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
	1.1 b. Divisional management should: • ensure local risk management procedures are updated to reflect the new Framework; and • ensure all relevant staff are aware of the updated procedures.	Low	1.1 b. Divisional response: • WBS: This is an established and documented process at WBS. The audit trail will be kept in Q-Pulse. •	Peter Richardson, Head of Quality & Regulation WBS	Extention to 30 June 2022 requested.		Relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Aligned Trust and WBS agreed and reflected in May Executive Management Board Risk paper
		Low	− The Quality & Safety Team is in the process of developing a divisional Standard Operating Procedure to align with the Trust Risk Management Framework. Once completed, this will be shared with Directorate leads for review and comment before review and sign off by the VCC Senior Leadership Team. The updated SOP will then be widely circulated to all relevant staff.	VCC Quality & Safety Officer	Extention to 30 June 2022 requested.		The SOP will be produced once the Revised Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales.	Aligned Trust and VCC agreed and reflected in May Executive Management Board Risk paper
	Risk Management Training (Design). 2.1 a. The Trust should ensure: • the new risk management training programme development is completed and rolled out as soon as possible; and • mechanisms are in place to capture attendance at risk management training. □	Medium	2.1 a. Recommendation agreed	Lauren Fear, Director of Corporate Governance	Extention to 30 June 2022 requested.		Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
	2.1 b. Divisional management should ensure that attendance at risk management training is monitored at appropriate forums.	Medium	2.1 b. Divisional response: • WBS: WBS Divisional Management will support the roll out of training once finalised and will capture all records of attendance for audit purposes.	Peter Richardson, Head of Quality & Regulation WBS	Extention to 30 June 2022 requested.		Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
		Medium	2.1 b.• VCC: − The training on the new risk management programme, including training materials, is currently in development and due to be finalised by 5th October 2021. − Training will be made available to all directorates and training compliance will be captured and monitored by Directorate leads and regularly reviewed by at the VCC Quality & Safety Management Group as an assurance measure. − The Senior Leadership Team will monitor training compliance by exception.	VCC Quality & Safety Manager	Extention to 30 June 2022 requested.		The SOP will be produced once the Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales.,	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.

	Consistency of approach to risk mangement (Design). 3.1 a. The Trust should implement a mechanism to ensure risk management practice is consistent between the divisions and good practice can be shared. 3.1 b. The Trust should ensure that WBS follows the risk scoring system set out in the Risk Management Framework when reporting to the Board and its Committees.	Low	3.1 Trust response: a & b Recommendation agreed.	Lauren Fear Director of Corporate Governance	Extention to 30 June 2022 requested.		Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
		Low	WBS: a. The WBS Risk Management Team is engaged with the Corporate Governance team to agree an approach to risk management practice that meets the specific regulatory needs of WBS and can be applied consistently across the Trust.	Peter Richardson, Head of Quality & Regulation WBS	Extention to 30 June 2022 requested.		Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
		Low	VCC: a. Further discussions needed with Trust Risk Management leads and in turn, Senior Leadership teams of VCC and WBS to agree consistent approach to risk management and sharing of good practice	Lauren Fear / Paul Wilkins / Alan Prosser	Extention to 30 June 2022 requested.		Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
	Scrutiny of Directorate Risk Registers (Operation). 4.1 a. The Divisional Management Teams should ensure directorate risk registers are monitored and scrutinised frequently at directorate meetings and that meeting minutes evidence this process. 4.1 b. Whilst we appreciate the challenges of the Covid-19 pandemic, the Trust should ensure that it always appropriately evidences governance processes at all levels of the organisation. This requirement should be communicated to the divisions and directorates.	Medium	4.1a WBS response: a. WBS will introduce a review of open risks consistently across all departmental OSG meetings. b. N/A – VCC action only.	Peter Richardson, Head of Quality & Regulation WBS	Extention to 30 June 2022 requested.		Recommended by March 2022. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.
			4.1 a & b. Risk registers will be added as a standing agenda item on all directorate meetings. Minutes will capture discussions had regarding risk.	All Directorate leads	Oct-21	Completed	VCC - Risk registers are being reviewed by each Directorate. This has now been completed and directorates have now been set up. This action is complete.	
		Medium	4.1 a & b. Governance processes for risk management to be standardised across the divisions and directorates providing assurance to the Quality & Safety Management Group. Modify and set up within Datix to enable dashboards to be produced by directorates	Sarah Owen, VCC Quality & Safety Manager Sarah Owen, VCC Quality & Safety Manager	October 2021 **Recommended March 2022** **February 2022**	Completed	VCC governance processes are in place. The risk registers are discussed at departmental level, where they are scruitnised. Any for escalation will be received and discussed at the VCC Quality & Safety Management Group. For Corporate and WBS - Recommended by March 2022 Timeline also reflects current service pressures The Q&S Team have been set up on datix to have the ability to push dashboards out to departments. This action is now closed.	

Audit Action Plan



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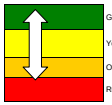
Velindre UNHS Trust

Divisional Review - Incident Management Final Internal Audit Report — **Date Received at Audit Committee: 14 October 2021**

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee
	Incident Reporting and Investigation Policy (Design). 1.1 a. As soon as the Datix O4W system is finalised, the Trust should: • review and update its Incident Reporting and Investigation Policy, incorporating updated definitions on incidents and the good practice identified in the WBS SABRE reporting flowchart; • ensure the updated Policy is approved by the Board; and • ensure the divisions are made aware of the new Policy.	Low	1.1 a. Trust Incident Policy to be reviewed and approved by the Board. Revised Policy to be tabled at EMB on 1st November 2021. The policy is to reflect the new Once for Wales system requirements and the WBS SABRE reporting flowchart. Both Divisional teams to support the policy development to ensure it meets divisional requirements, including definitions aligned to legislation and regulatory requirements specific to WBS.	Jennie Palmer Trust Quality & Safety Manager Quality leads at VCC & WBS	November 2021 **28 February 2022**	Completed	Policy to be completed by February 2022 for approval at EMB. Divisions unable to complete process flow charts and documents until policy approved. Scheduled for completion of the Incident Management policy has been changed to the 28th February 2022. Working to achieve this deadline.	Trust Incident Policy was approved at the last Trust QSP Committee. Action can be closed.
	1.1 b. Divisional management should • ensure local incident management SOPs are updated to reflect the updated Policy; and • ensure all relevant staff are aware of the updated SOPs	Low	1.1 b. Divisional response: WBS: − Related incident SOPs to be reviewed in line with new policy requirements. Revised SOPs to be issued. − Awareness/training to be provided to WBS staff in relation to new SOPs and recorded as training events in Q-Pulse in line with established processes.	Peter Richardson, Head of Quality & Regulation WBS Peter Richardson, Head of Quality & Regulation	April 2022 May 2022		To be completed once the Trust Incident Mangement policy has been reviewed and associated SOP's issued	Extension to May 2022 requested
		Low	1.1 b VCC: Divisional Quality and Safety Manager will write the incident management SOP to reflect any changes to the Trust Incident Reporting and Investigation Policy.	Sarah Owen, VCC Quality and Safety Manager	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.
		Medium	VCC: 2.1 a. The Divisional incident management SOP will reflect the requirement of staff to record incidents within the expected timeframe. Incident management SOP will be reviewed by SLT out of committee to ensure timeliness of action.	Tracey Langford, VCC Quality and Safety Office to facilitate	November 2021		Divisional Quality & Safety Officer will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.
	2.1 c. We understand the Datix O4W system will have the functionality to report on timeliness of recording in Datix. This should be incorporated into divisional reporting on incidents – see matter arising 4 also.	Medium	WBS: 2.1 c. Timeliness of incident reporting will be introduced into Operational Service Group, Regulatory Assurance and Governance Group, and Senior Management Team meetings. once reporting dashboards are available from Datix O4W (Expected Q3 2021/22)	Peter Richardson, Head of Quality & Regulation WBS	January 2022		On track to be implemented January 2022	
		Medium	VCC: 2.1 c. The Divisional incident management SOP will reflect the required reporting and escalation	Sarah Owen, VCC Quality & Safty Manager (VCC), supported by the Tracey Langford, Quality & Safety Officer (VCC)	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed and will ensure the required reporting and escalation processes are included.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.
		Medium	VCC: 3.1a. The Divisional incident management SOP will reflect the need for all staff to record incident investigations in DATIX and the closure process.	Sarah Owen, VCC Quality and Safety Manager	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.

	3.1 c. Divisional management should:ensure that the quality of incident investigations and compliance with the Policy are incorporated into their audit plans on a cyclical basis; and • consider whether a joint audit of investigations should be undertaken to support further identification of inconsistencies, good practice and/or training needs for incident management across the Trust.	Medium	3.1 c. WBS Quality team to engage with their VCC counterparts to agree a plan for reciprocal joint audits focussing on the quality of incident investigations	Peter Richardson, Head of Quality & Regulation WBS	March 2022		This action has been awaiting appointment of new Quality Manager at VCC. Initial introductions made and will be followed up during Janury 2022.	
		Medium	3.1. c. VCC: Formalise work to include Divisional incident activity to be visible on the Clinical Audit Plan.	Sara Walters, VCC Clinical Audit Manager / Sarah Owen, VCC Quality and Safety Manager	December 2021	Completed	A meeting has been arranged with Quality & Safety Team and Cllinical Audit Team for 07.01.2022 to instigate discussions.	A quality forum has been set up to include Quallity & Safety, Service Improvement and Clinical Audit. A successful pilot forum has been held for the Ambulatory and Assessment Units. This will be rolled out to the First Floor Ward. An evaluaton to next steps and resoruce requirements will be presnted to a future Quality and Safety Management Group.
	Incident Reporting and Scrutiny (Design). 4.1 a. Divisional management should ensure that incident reporting and scrutiny is undertaken regularly at divisional and directorate / OSG level. The approach should be consistent across the Trust, where appropriate.	Medium	4.1 a WBS response: a. WBS Quality Assurance team to produce a standard KPI template based on the Laboratories OSG for Incident reporting to be used by all Operational Service Group, Regulatory Assurance and Governance Group, and Senior Management Team reports. (also 4.1 c)	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021		Template will be introduced following approval at the January 2022 Regulatory Assurance and Governance Group meeting	
	4.1 b. Incident reporting at all levels should include:• defined KPIs (including targets) for incident management, for example, timeliness of recording and investigation closure, level of open incidents, recording of investigations and learning in Datix, etc;• trend monitoring on the above KPIs and other metrics, for example, incidents by type, severity and location; • KPIs and narrative around learning (see matter arising 5); and• the requirement to clearly identify of areas of concern.	Medium	WBS: 4.1 b. This template will take account of the KPI's identified in this audit and will incorporate them in the template once the reporting functionality is in place for Datix O4W.	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021		Delayed to February 2022, awaiting BI reporting tool for Datix OfW.	
	5.1 b. ensure that incident reporting at all levels (see matter arising 4 also) includes:• KPIs around recording lessons learned in Datix; and• the requirement to clearly identify concerns in trends and lessons for wider sharing (the new report template for Infection Prevention and Control performance could be used to develop this requirement).	Medium	WBS: 5.1 b. The WBS Donor and Patient Clinical Governance groups will amend their monthly incident report templates to include details incidents where lessons learned have not been recorded, and to allow for review and challengewhere appropriate. This is dependent on the reportingfunctionality being in place for Datix O4W.	Peter Richardson, Head of Quality & Regulation WBS	January 2022		Delayed to February 2022, awaiting BI reporting tool for Datix OfW.	

Audit Action Plan



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Velindre UNHS Trust

Board Committee Effectiveness — **Date Received at Audit Committee: 11 January 2022**

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for May 2022 Committee	
Matter arising 7	**Matter arising 7: Standing Orders (Operation)** 7.1 The Trust should update its website with the revised Standing Orders.		7.1 The revised Standing Orders will be uploaded to the Trust website.	Lauren Fear, Director of Corporate Governance & Chief of Staff	January 2022		Complete	

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Trust Assurance Framework — **Date Received at Audit Committee: 11 January 2022**

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for May 2022 Committee
Matter arising 1	**Matter arising 1: Completion of the TAF dashboard (Operation)** 1.1 The Trust should ensure the TAF dashboard is completed as planned by the target date (March 2022), including sources of assurance and action plans to address control / assurance gaps and deficiencies.		1.1 To complete, taking into account current service pressures, still aim for March, given high priority	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022		Complete
Matter arising 2	**Matter arising 2: Operational risk reporting (TRR) (Operation)** 2.1 The Trust should: a. ensure the review and refinement of the risks on the TRR is completed as planned by the end of March 2021; and		2.1 a. To complete, taking into account current service pressures, still aim for March, given medium priority	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022		Complete
Matter arising 3	**Matter arising 3: Transparency in decision-making (Operation)** 3.1 The Trust should ensure that all key decisions and supporting justifications are clearly recorded in Board or Committee papers / minutes, including those which represent a change to: • Board or Committee cycles of business; and • timeframes for significant projects or work streams.		3.1 Agree with action and will be implemented with immediate effect	Lauren Fear, Director of Corporate Governance & Chief of Staff	Immediately		Complete

Archwilio Cymru
Audit Wales

2022 Audit Plan – Velindre University NHS Trust

Audit year: 2021-2022

Date issued: April 2022

Document reference: 2918A2022

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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Contents

2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

4 I am required to issue a report on Velindre University NHS Trust's (the Trust's) financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. I lay them before the Senedd together with any report that I make on them. In preparing such a report, I will:

- give an opinion on the financial statements;
- give an opinion on the proper preparation of key elements of the Remuneration and Staff Report; and
- assess whether other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

8 I will also report on your charitable funds' accounts.

9 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

10 The following table sets out the significant risks that have been identified for the audit of the financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
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 240.31-33].	We will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
Inventory balance Our 2020-21 audit opinion was qualified as we did not attend any of the Trust's stock takes The Trust, through NWSSP, continue to have an integral role in procuring and distributing PPE, particularly to NHS Wales bodies and social care providers, in response to the pandemic. Whilst a reduction in the year-end inventory balance is expected within the 2021-22 financial statements the value of the stock holdings will continue to be material. A number of related audit risks exist, particularly in regard to our need to obtain sufficient audit assurance upon: • the 2021-22 opening inventory balance;	We will attend a number of stock counts at a number of the stores facilities operated by the Trust and develop additional audit procedures to obtain assurance that the inventory balance within the financial statements is materially correct.

Financial audit risks	Proposed audit response
• the 2021-22 stock taking arrangements and final inventory balance; • stock donations to assist countries and the associated accounting treatment; and • any valuation adjustments concerning obsolete or slow-moving stock have been appropriately considered in calculating the year-end balance.	
NHS pension tax liabilities The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money. This would then result in the qualification of our regularity opinion.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.
Break even duty NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position, this duty increases the risk that management judgements and estimates included in the financial statements could be biased in help achieve this financial duty. Where the Trust fails this financial duty, I will place a substantive report on the financial statements highlighting the failure.	The audit team will focus its testing on areas of the financial statements which could contain reporting bias.

Financial audit risks	Proposed audit response
Other areas of audit attention	
Capital expenditure The Trust has purchased Matrix House during 2021-22 and expenditure has continued to be incurred in relation to construction of the new Velindre Cancer Centre. There is a risk that the related capital expenditure has not been appropriately accounted for within the financial statements.	We will monitor the position as part of our ongoing audit work and review the accounting treatment within the financial statements.
NWIS / Laundry There have been two significant changes in regard to the functions hosted by the Trust during 2021-22. NWIS has transferred from the Trust to form Digital Health and Care Wales, and the laundry functions have transferred to the Trust from a number of Health Boards.	We will review the accounting treatment and disclosures in relation to these transfers.
IFRS16 Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.
Covid 19 There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have an impact on the risks of misstatement and the shape and approach to our audit.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.

Financial audit risks	Proposed audit response
Covid-19 – qualitative issues Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.

Performance audit work

11 In addition to my Audit of Financial Statements, I must also satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

12 My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

13 During 2020-21, I consulted public bodies and other stakeholders on how I will approach my duties in respect of the Well-being of Future Generations (Wales) Act 2015 for the period 2020-2025. In March 2021, I wrote to the 44 public bodies designated under the Act setting out my intentions, which include:

- carrying our specific examinations of how public bodies have set their well-being objectives, and
- integrating my sustainable development principle examinations within my local audit programme.

14 My auditors are liaising with the Trust to agree the most appropriate time to examine the setting of well-being objectives.

15 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: My planned 2022 performance audit work at the Trust

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the Trust in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).
All-Wales Thematic work	As part of my 2022 plan, I intend to undertake an assessment of the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. I will tailor this work to align to the responsibilities of individual NHS bodies in respect of workforce planning.
Locally focused work	I will also undertake performance audit work that reflects issues specific to the Trust. The precise focus of this work will be agreed with executive officers and the Audit Committee.
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

16 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

17 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

18 We will provide updates on the performance audit programme though our regular updates to the Audit Committee.

Fee, audit team and timetable

19 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

[1] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

Fee

20 As set out in our Fee Scheme 2022-23 our fee rates for 2022-23 have increased by 3.7% as a result of the need to continually invest in audit quality and in response to increasing cost pressures.

21 The estimated fee for 2022 is set out in **Exhibit 3**. This represents a 4.7% increase compared to your actual 2021 fee, which due to issues on the charitable funds work was marginally above the total estimated 2021 fee of £227,996 as communicated within our 2021 Audit Plan. However a refund on the financial statements work funded most of this overspend.

22 The 2022 fee increase reflects the overall increase in fee rates, the planned audit work to obtain the necessary assurance on the Trust's inventory balance, the certification of the S1 and S2 forms relating to the transfer of NWIS from the Trust to Digital Health and Care Wales and an increase in estimated audit costs (£12,167 to £15,000) for our Charitable Funds work.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[2]	Actual fee for 2021 (£)
Audit of Financial Statements	149,849	138,839
Charitable Funds	15,000	18,070
Performance audit work:	73,934	71,190
Total fee	**238,783**	**228,099**

23 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

24 Further information on my fee scales and fee setting can be found on our website.

[2] The fees shown in this document are exclusive of VAT, which is not charged to you.

Audit team

25 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Clare James	Engagement Director and Audit Director (Financial Audit)	07837 384617	clare.james@audit.wales
David Thomas	Audit Director (Performance Audit)	02920 320604	dave.thomas@audit.wales
Steve Wyndham	Audit Manager (Financial Audit)	02920 320664	steve.wyndham@audit.wales
Darren Griffiths	Audit Manager (Performance Audit)	02920 32051	darren.griffiths@audit.wales
David Burridge	Audit Lead (Financial Audit)	02920 677839	david.burridge@audit.wales
Katrina Febry	Audit Lead (Performance Audit)	07870 266701	katrina.febry@audit.wales

26 We can confirm that team members are all independent of you and your officers.

Timetable

27 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	January 2022 – April - 2022	April 2022
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Accounts Memorandum	February to June 2022	June 2022 June 2022 July 2022
Performance audit work: • Structured Assessment • All-Wales thematic work • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

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Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: April 2022

Document reference: APS202204

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.

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Audit Committee update:

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Our draft 2022 audit plan will be presented to the Audit Committee in May 2022.

2 Accounts and performance audit work are set out in this update, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

3 **Exhibit 1** summarises the status of our key accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2020-21 Charitable Funds Financial Statements	This audit is complete, and the Auditor General certified the accounts on 31 January 2022. A number of issues arose on the audit which delayed its completion. These issues have been discussed with management and positively responded to.
Audit of S1 and S2 forms	We have completed our audit of the S1 and S2 forms in relation to the transfer of assets and liabilities between the Trust and Digital Health and Care Wales (formerly NWIS). The certified forms were submitted to the Welsh Government on 16 March 2022.
Audit of 2021-22 Financial Statements	Our 2022 Audit Plan sets out the key issues relating to our financial audit work, and is included in the agenda pack for the May 2022 Audit Committee. Interim audit work is ongoing. We will commence the audit of the Trust's draft annual accounts on 29 April 2022 and will report our conclusions to the Audit Committee on 13 June

Area of work	Current status
	2022, ahead of the accounts submission deadline of 15 June 2022. We will report any substantial recommendations in an additional 2021-22 Financial Audit report which will be presented to Audit Committee in July 2022.
Audit of 2021-22 Charitable Funds Financial Statements	This work will be undertaken later in 2022.

Performance audit update

4 **Exhibit 2** sets out the status of our performance audit work included in our Audit Plan.

5 Ongoing difficulties to set up project interviews has caused delays in delivering our quality governance audit. We have endeavoured to continue to provide informal feedback in as timely a way as possible within the circumstances.

Exhibit 2 – Performance audit work

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
2020 Audit Plan		
Quality Governance Executive Director of Nursing, Allied Health Professionals	A thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. Including detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting.	**Ongoing** Draft report anticipated May 2022. Review was postponed in 2020 due to the pandemic. Fieldwork was restarted in 2021, although progress impacted due

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
and Health Science	Scoping was informed by the Joint Review of Quality Governance at Cwm Taf Morgannwg UHB.	to continuing need for the Trust to respond to the pandemic. Interviews and staff survey were delayed at the request of the Trust.
2021 Audit Plan		
Structured Assessment Director of Corporate Governance	Work focused on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically.	**Complete** Phase 1 – final report issued, presented to July 2021 Audit Committee Phase 2 – final report issued, presented to January 2022 Audit Committee
Local study	The budget for this work has been consumed by the Quality Governance (2020) work.	
2022 Audit Plan		
Structured Assessment Director of Corporate Governance	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	April – October 2022

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
All-Wales Thematic work Director of Corporate Governance / Executive Director of Organisational Development & Workforce	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	September 2022 – January 2023
Local study	Short piece of work either to review setting of Wellbeing and Future Generation Objectives or for a deeper dive module in an area covered by Structured Assessment.	Timing dependent on work undertaken

Good Practice events and products

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

7 Past materials are available via the GPX webpages, along with details of future events.

8 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

9 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. **Exhibit 3** provides information on the NHS-related or relevant national studies published in the last twelve months. It also includes all-Wales summaries of work undertaken locally in the NHS. The **bold** reports have been published since our last Audit Committee update.

Exhibit 3 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Joint working between Emergency Services	**January 2022**
Care Home Commissioning for Older People	**December 2021**
Taking Care of the Carers?	October 2021
A Picture of Healthcare	October 2021
Infographic on the NHS (Wales) summarised accounts for 2020-21	September 2021
Picture of Public Services 2021	September 2021
NHS Wales Finances Data Tool - up to March 2021	June 2021
Rollout of the COVID-19 vaccination programme in Wales	June 2021

Title	Publication Date
Welsh Health Specialised Services Committee Governance Arrangements	May 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021

10 **Exhibit 4** provides information on NHS-related or relevant national studies work in progress with indicative publication dates.

Exhibit 4 – NHS-related or relevant studies and all-Wales summary work currently in progress

Title	Indicative publication date
Orthopaedic services	2022
Unscheduled care	2022
NHS waiting times tool	2022
Recovery planning	2022
Welsh Community Care Information System follow up	2022
NHS quality governance	2022
Collaborative arrangements for managing local public health resources	2022

Title	Indicative publication date
Covid-19 response and recovery – third sector support;	2022

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AUDIT COMMITTEE

Trust response to the Audit Wales report 'Taking Care of the Carers'

DATE OF MEETING	3 May 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce
REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	27/04/22	PROPOSED TO BE NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Audit Wales published the Taking Care of the Carers report in October 2021describing how NHS bodies supported the wellbeing of their staff during the COVID-19 pandemic, with a focus on safeguarding staff at higher risk from COVID-19.

1.2 The report made eight recommendations, the first six for NHS bodies and the final two for Welsh Government. These are:

R1	Retaining a strong focus on staff wellbeing
R2	Considering workforce issues in recovery plans
R3	Evaluating the effectiveness and impact of the staff wellbeing offer
R4	Enhancing collaborative approaches to supporting staff wellbeing
R5	Providing continued assurance to boards and committees
R6	Building on local and national staff engagement arrangements
R7	Evaluating the national staff wellbeing offer
R8	Evaluating the All-Wales COVID-19 Workforce Risk Assessment Tool

1.3 All NHS bodies have been asked to return a Management Response to the first six recommendations. The response from Velindre University NHS Trust is attached for information prior to submission.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached management response was coordinated and signed off by the Healthy and Engaged Steering Group of 29 March 2022 and Is proposed to be noted by Executive Management Board on 27 April 2022.

2.2 All items except one are closed and part of normal working practices in the Trust.

2.3 One item is still in progress. This relates to the recruitment of a Clinical Psychologist for Staff and Teams. This role has a remit in providing wellbeing support and in evaluating the effectiveness of interventions. The post is currently being re-advertised following an unsuccessful interview process on 1 April 2022.

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	Governance, Leadership and Accountability
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

The Audit Committee is asked to **NOTE** the Management Response to the Taking Care of the Carers audit.

Archwilio Cymru
Audit Wales

Taking Care of the Carers?

How NHS bodies supported staff wellbeing during the COVID-19 pandemic

October 2021

This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998 and section 61(3) (b) of the Public Audit Wales Act 2004.

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If you require this publication in an alternative format and/or language, or have any questions about its content, please contact us using the details below. We welcome correspondence in Welsh and English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg

Contents

Summary report

Detailed report

Background

1 This report describes how NHS bodies have supported the wellbeing of their staff during the COVID-19 pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19.

2 It is the second of two publications which draw on the findings of our local structured assessment work with the aim of highlighting key themes, identifying future opportunities, and sharing learning. The first report Doing it differently, doing it right? - describes how NHS bodies revised their arrangements to enable them to govern in a lean, agile, and rigorous manner during the pandemic.

Key messages

3 NHS staff at all levels have shown tremendous resilience, adaptability, and dedication throughout the pandemic. However, they have also experienced significant physical and mental pressures due to the unprecedented challenges caused by the crisis.

4 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic. However, the unprecedent scale and impact of the COVID-19 pandemic brought the importance of supporting staff wellbeing into even sharper focus.

5 As a result, all NHS bodies in Wales placed a strong focus on staff wellbeing throughout the COVID-19 pandemic. At the outset of the crisis, each NHS body moved quickly to enhance their existing employee assistance arrangements and to put additional measures in place to support the physical health and mental wellbeing of their staff, as much as possible, during the pandemic. Key actions taken by NHS bodies to protect staff and support their wellbeing included:

- enhancing infection prevention and control measures;
- reconfiguring healthcare settings;
- facilitating access to COVID-19 tests and, more recently, COVID-19 vaccinations;
- creating dedicated rest spaces;
- increasing mental health and psychological wellbeing provision;
- strengthening staff communication and engagement; and
- enabling remote working.

6 All NHS bodies put arrangements in place to roll out the All-Wales COVID-19 Workforce Risk Assessment Tool (the Risk Assessment Tool) as part of their wider efforts to safeguard members of staff at higher risk from COVID-19. Each NHS body promoted the Risk Assessment Tool in a number of ways. However, Risk Assessment Tool completion rates via the Electronic Staff Record (ESR) have varied considerably between individual NHS bodies. All NHS bodies utilised measures from their wider suite of wellbeing arrangements to meet the individual needs of staff at higher risk from COVID-19 as identified by the Risk Assessment Tool.

7 The boards and committees of most NHS bodies maintained good oversight and ensured effective scrutiny of all relevant staff wellbeing risks and issues during the pandemic. However, arrangements for reporting Risk Assessment Tool completion rates and providing assurance on the quality of completed risk assessments could have been strengthened in most NHS bodies.

8 Whilst the crisis has undoubtedly had a considerable impact on the wellbeing of staff in the short-term, the longer-term impacts cannot and should not be ignored or underestimated. Surveys and work undertaken by a range of professional bodies highlight the increased stress, exhaustion and burnout experienced by staff, and point to the growing risk to staff of developing longer term physical and psychological problems without ongoing support.

9 A continued focus on providing accessible wellbeing support and maintaining staff engagement, therefore, is going to be needed in the short-term to ensure NHS bodies address the ongoing impact of the pandemic on the physical health and mental wellbeing on their staff.

10 However, the COVID-19 pandemic has also created an opportunity to rethink and transform staff wellbeing for the medium to longer term. Whilst supporting the wellbeing of the NHS workforce is more necessary than ever when the service needs to respond to a crisis, investing appropriately in staff wellbeing on an ongoing basis is equally as important as a healthy, engaged, and motivated workforce is essential to the delivery of safe, high-quality, effective, and efficient health and care services.

The resilience and dedication shown by NHS staff at all levels in the face of the unprecedented challenges and pressures presented by the pandemic has been truly remarkable. It is inevitable, however, that this will have taken a considerable toll on the wellbeing of NHS staff, who now also face the challenges of dealing with the pent-up demand in the system caused by COVID-19. It is assuring to see that NHS bodies have maintained a clear focus on staff wellbeing throughout the pandemic and have implemented a wide range of measures to support the physical health and mental wellbeing of their staff during the crisis. It is vital that these activities are built upon and that staff wellbeing remains a central priority for NHS bodies as they deal with the combined challenges of recovering services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures which are expected to be greater this winter than they were last year. Taking care of those who care for others is probably more important now than it has ever been before.

Adrian Crompton
Auditor General for Wales

Recommendations

11 Recommendations arising from this work are detailed in **Exhibits 1** and **2**.

Exhibit 1: recommendations for NHS bodies

Recommendations

Retaining a strong focus on staff wellbeing

R1 NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.

Considering workforce issues in recovery plans

R2 NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.

Recommendations

Evaluating the effectiveness and impact of the staff wellbeing offer

R3 NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.

Enhancing collaborative approaches to supporting staff wellbeing

R4 NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.

Recommendations

Providing continued assurance to boards and committees

R5 NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.

Building on local and national staff engagement arrangements

R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.

Exhibit 2: recommendations for the Welsh Government

Recommendations

Evaluating the national staff wellbeing offer

R7 The Welsh Government should undertake an evaluation of the national staff wellbeing services and programmes it commissioned during the pandemic in order to assess their impact and cost-effectiveness. In doing so, the Welsh Government should consider which other national services and programmes should be commissioned (either separately or jointly with NHS bodies) to ensure staff continue to be supported throughout the recovery period and beyond.

Evaluating the All-Wales COVID-19 Workforce Risk Assessment Tool

R8 The Welsh Government should undertake a full evaluation of the All-Wales COVID-19 Workforce Risk Assessment Tool to identify the key lessons that can be learnt in terms of its development, roll-out, and effectiveness. In doing so, the Welsh Government should engage with staff at higher risk from COVID-19 to understand their experiences of using the Risk Assessment Tool, particularly in terms of the extent to which it helped them understand their level of risk and to facilitate a conversation with their managers about the steps that should be taken to support and safeguard them during the pandemic.

Introduction

12 NHS bodies in Wales have faced unprecedented challenges and considerable pressures during the COVID-19 pandemic. Throughout this crisis, NHS bodies have had to balance several different, yet important, needs – the need to ensure sufficient capacity to care for people affected by the virus; the need to maintain essential services safely; the need to safeguard the health and wellbeing of their staff; and the need to maintain good governance. In order to respond to these needs effectively, NHS bodies have been required to plan differently, operate differently, manage their resources differently, and govern differently.

13 Our structured assessment work[1] in 2020 was designed and undertaken in the context of the ongoing pandemic. As a result, we were given a unique opportunity to see how NHS bodies have been adapting and responding to the numerous challenges and pressures presented by the COVID-19 crisis.

14 This report is the second of two publications which draw on the findings of our structured assessment work, and more recent evidence gathering to highlight key themes, identify future opportunities, and share learning both within the NHS and across the public sector in Wales more widely.

15 In our first report – Doing it differently, doing it right? – we discussed the importance of maintaining good governance during a crisis and describe how revised arrangements enabled NHS bodies to govern in a lean, agile, and rigorous manner during the pandemic. We also highlighted the key opportunities for embedding learning and new ways of working in a post-pandemic world.

16 In this report, we discuss the importance of supporting staff wellbeing and describe how NHS bodies have supported the wellbeing of their staff during the pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19. We consider the key lessons that can be drawn from the experiences of NHS bodies of supporting staff wellbeing during the COVID-19 crisis and conclude by highlighting the key challenges and opportunities for the future.

17 Whilst this report draws on the findings of our structured assessment work, it has also been informed by additional evidence gathered from each NHS body as well as information received from the Welsh Government, the British Medical Association (BMA), and the Royal College of Nursing (RCN) in Wales. Furthermore, as this report draws largely on the findings of our structured assessment work, we haven't engaged directly with NHS staff. Instead, we have referenced the findings from surveys undertaken by BMA Wales and others to provide insights into staff experiences during the pandemic.

1 A structured assessment is undertaken in each NHS body to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2004, to be satisfied they have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Individual reports are produced for each NHS body, which are available on our website.

Importance of supporting staff wellbeing

18 The workforce is an essential component of the Welsh healthcare system. The NHS in Wales employs around 88,000 full-time equivalent staff (**Exhibit 3**) and staff costs accounted for 50% of total NHS spending in 2020-21[2].

Exhibit 3: NHS staff by staff group (March 2021)[3]

Staff Group	FTE
Medical and dental staff	7,294
Nursing, midwifery, and health visiting staff	36,027
Administration and estates staff	21,380
Scientific, therapeutic, and technical staff	14,947
Health care assistants and other support staff	5,806
Ambulance staff	2,709
Other non-medical staff	96

Source: StatsWales

2 Total NHS spending in 2020-21 was £9.6 billion, of which £4.8 billion was spent on staff costs. (Source: Audit Wales)

3 General Medical and Dental Practitioners are excluded as they are independent NHS contractors.

19 All NHS bodies in Wales have a statutory duty of care to protect the health and safety of their staff and provide a safe and supportive environment in which to work. However, supporting staff wellbeing is also important for several other reasons:

- **patient outcomes** – there is a strong link between negative staff wellbeing and poor patient outcomes. Research shows that negative staff wellbeing and moderate to high levels of burnout are associated with poor patient safety outcomes[4]. The Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust also highlighted the association between poor staff wellbeing and lower quality of care[5]. Supporting positive wellbeing at work, therefore, enables NHS bodies to maintain higher levels of patient safety, provide better quality of care, and ensure higher patient satisfaction.
- **organisational outcomes** – there are considerable financial costs associated with poor staff wellbeing. According to Health Education England, the cost of poor mental health in the NHS workforce equates to £1,794 - £2,174 per employee per year[6]. Furthermore, the costs associated with staff absenteeism are significant. The Boorman Review calculated the direct cost of reported absence in the NHS across the UK was around £1.7 billion a year and the indirect cost of employing temporary staff to provide cover was estimated to be £1.45 billion a year[7]. Supporting positive wellbeing at work, therefore, enables NHS bodies to reduce the number of working days lost as a result of poor staff wellbeing and achieve greater cost savings.
- **employee outcomes** – a poor experience at work is associated with negative wellbeing which, in turn, leads to lower staff engagement and motivation, greater workplace stress, higher staff turnover, and poorer patient outcomes. Research shows that staff wellbeing is impacted negatively by a workforce that is overstretched due to absences and vacancies and supplemented by temporary staff[8][9]. Wellbeing is also negatively affected when staff feel undervalued and unsupported in their roles, feel overwhelmed by their workloads, and feel as though they have little control over their work lives[10]. Supporting positive wellbeing at work, therefore, enables NHS bodies to enhance staff engagement and motivation, minimise workplace stress, and retain more of their employees.

4 Hall et al (2016) Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review

5 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

6 Health Education England (2019) NHS Staff and Learners' Mental Wellbeing Commission

7 NHS Health and Wellbeing Review (2009) Interim Report

8 Rafferty et al (2007) Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records

9 Picker (2018) The risks to care quality and staff wellbeing of an NHS system under pressure

10 West and Coia (2018) Caring for doctors, Caring for patients

How health bodies supported staff wellbeing during the pandemic

20 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic. The results of the 2018 NHS Staff Survey show that 64% of respondents stated they had come to work despite not feeling well enough to perform their duties (compared to 57% in 2016), and 34% stated they had been injured or felt unwell as a result of work-related stress (compared to 28% in 2016). Furthermore, the sickness absence 12-month moving average for the 12 months ending March 2020 was the highest since data started to be collected in 2008.

21 However, the unprecedented scale and impact of the COVID-19 pandemic brought the importance of supporting staff wellbeing into even sharper focus at both a national and local level in order to:

- protect the health of staff by reducing the prevalence of COVID-19 in healthcare settings and minimising their exposure to the virus;
- reduce the risk of staff transmitting the virus to colleagues, patients, family members, and other members of the wider community;
- safeguard vulnerable groups of staff at higher risk from the virus, such as older people, people with underlying health conditions, pregnant women, and people from certain ethnic minority groups;
- support staff to adapt to new ways of working and adjust to different work settings;
- help staff to cope with the challenges, pressures, uncertainties, and stresses associated with the pandemic;
- ensure NHS bodies maintain sufficient staffing levels to sustain essential services and care safely for patients affected by the virus; and
- enable NHS bodies to restart, recover and rebuild services safely, effectively, and efficiently.

22 As a result, all NHS bodies in Wales placed a strong focus on staff wellbeing throughout the crisis in line with their operational plans and Welsh Government guidance[11].

11 WHC/2020/019: Expectations for NHS Health Boards and Trusts to ensure the health and wellbeing of the workforce during the Covid-19 pandemic

23 At the outset of the pandemic, each NHS body moved quickly to plan and deliver local packages of support as part of a wider multi-layered wellbeing offer to staff. The multi-layered offer, which grew and evolved over time, gave staff free access to a range of pan-Wales services and resources, including:

- **SilverCloud** – a digital mental health platform designed to help NHS staff manage feelings of stress, anxiety, and depression.
- **Health for Health Professionals Wales** – a free, confidential service that provides NHS staff, students, and volunteers in Wales with access to various levels of mental health support including self-help, guided self-help, peer support, and virtual face-to-face therapies with accredited specialists.
- **Samaritans Support Line** – a confidential bilingual wellbeing support line for health and social care workers and volunteers in Wales.
- **online wellbeing resources for NHS staff** – Health Education and Improvement Wales (HEIW) worked with key colleagues on the Health and Wellbeing Sub-Group of the national COVID-19 Workforce Cell to curate and make resources and access to specific specialist services available through its Covid-19 Playlist – NHS Wales Staff Wellbeing Covid-19 Resource. The Playlist also signposted staff to the wellbeing resources of their respective Health Boards and Trusts. The Health and Wellbeing Sub-Group has now transitioned into the National Health and Wellbeing Network which receives leadership and programme management support from HEIW.

24 In this section, we briefly describe the measures put in place by NHS bodies in Wales to support staff wellbeing at a local level, including their arrangements for safeguarding staff at higher risk from COVID-19.

Supporting physical and mental wellbeing

25 We found that all NHS bodies enhanced their existing employee assistance programmes and services (such as Occupational Health) and put additional arrangements in place to support the physical health and mental wellbeing of their staff, as much as possible, during the pandemic. For example:

- **enhancing infection prevention and control measures** – all NHS bodies, particularly the Health Boards and relevant Trusts, introduced enhanced infection prevention and control measures such as providing more hand hygiene facilities, supplying personal protective equipment (PPE) in line with national guidance[12], and increasing the frequency of cleaning and decontaminating surfaces, areas, and equipment.

12 The Auditor General for Wales has reported on the provision of PPE in a separate report titled Procuring and Supplying PPE for the COVID-19 Pandemic (April 2021).

- **reconfiguring healthcare settings** – all of the Health Boards and relevant Trusts reconfigured as much of their healthcare settings as possible to segregate COVID-19 and non-COVID-19 care pathways and minimise patient, staff, and visitor movements between areas. However, the design of older buildings made this more challenging in some NHS bodies.
- **facilitating access to COVID-19 tests and COVID-19 vaccinations** – all of the Health Boards and relevant Trusts put arrangements in place to enable frontline staff to access tests for COVID-19 and, more recently, COVID-19 vaccinations in line with JCVI (Joint Committee on Vaccination and Immunisation) guidance[13]. Although some NHS bodies encountered a few challenges facilitating access to COVID-19 testing at the outset of the pandemic due to limited lab capacity, the situation improved gradually over time as lab capacity increased and new rapid-testing technology became more widely available. In terms of vaccinations, overall uptake amongst healthcare workers is extremely high. As of 17 July 2021, 96.3% had received their first dose and 93.2% had received their second dose[14].
- **creating dedicated rest spaces** – most of the Health Boards and relevant Trusts established designated spaces for front-line staff to rest, recuperate, and focus on their welfare. These spaces, which were predominantly based on acute sites, were referred to as 'wellbeing rooms' or 'recharge rooms' in most areas.
- **increasing mental health and psychological wellbeing provision** – all NHS bodies increased the range, availability, and accessibility of their mental health and psychological wellbeing offer to staff. Examples include:
  - providing information and resources to promote self-care, enhance personal resilience, and support staff to adjust to new ways of working;
  - delivering therapeutic programmes, such as mindfulness and arts in health;
  - facilitating access to counselling and talking services to provide support for staff with mental health concerns such as anxiety, stress, and low mood; and
  - investing in specialised provision for members of staff experiencing the adverse effects of trauma and bereavement.

13 The Auditor General for Wales has reported on the provision of COVID-19 testing and the roll-out of COVID-19 vaccinations in two separate reports titled Test, Trace, Protect in Wales: An Overview of Progress to Date (March 2021) and Rollout of the COVID-19 vaccination programme in Wales (June 2021).

14 Source: Public Health Wales Rapid COVID-19 Surveillance

- **strengthening staff communication and engagement** – all NHS bodies strengthened their internal communication arrangements and used a broad range of channels and platforms to convey information and updates to their staff on a regular basis. In addition, all NHS bodies strengthened their staff engagement arrangements during the pandemic. As well as maintaining ongoing engagement with established employment partnerships and staff networks and groups, all NHS bodies surveyed their staff on a regular basis to better understand their needs and experiences as well as to capture their views on various matters, including the effectiveness of the local wellbeing provision.
- **enabling remote working** – all NHS bodies put arrangements in place to support remote working as part of their wider efforts to ensure and maintain physical distancing, for those staff for whom home working was appropriate. Although some NHS bodies encountered a few challenges rolling-out the necessary technology and software required to support remote working at the outset of the pandemic, these were overcome relatively quickly.
- **providing other forms of support** – a range of other support measures were implemented by NHS bodies, such as:
  - rolling out risk assessment tools, such as Stress Risk Assessment Tools and the All-Wales COVID-19 Workforce Risk Assessment Tool (this is discussed in more detail in the next section);
  - providing additional information and support to leaders and managers to enable them to engage, motivate, and support their teams effectively during the pandemic;
  - providing temporary accommodation for front-line staff living with individuals at higher risk from COVID-19; and
  - enhancing Chaplaincy services to ensure staff have access to pastoral support.

Detailed examples of health and wellbeing initiatives introduced by each NHS body during the pandemic are provided in the briefing produced by Welsh NHS Confederation titled Supporting Welsh NHS staff wellbeing throughout COVID-19.

26 The BMA has surveyed its members extensively during the pandemic. Whilst the results are not representative of the NHS workforce as a whole, they do provide useful insights into the experiences of medical staff during the crisis:

- BMA members responding to the surveys felt better protected from coronavirus in their place of work as the pandemic progressed. The proportion of members stating they felt fully protected was 27% (113 of 417) and 37% (100 of 274) in December 2020 and April 2021 respectively. The proportion of members stating they didn't feel protected at all was 11% (47 of 417) and 6% (16 of 274) in December 2020 and April 2021 respectively.
- A considerable number of BMA members responding to the surveys accessed wellbeing support services (provided by either their employer or a third party) during the pandemic – 43% (117 of 407) in May 2020, 38% (120 of 314) in July, and 38% (95 of 253) in August 2020. However, when asked if they knew how to access wellbeing/occupational health support if they required them, 45% (126 of 279) stated in April 2021 they either didn't know how to access these services or weren't aware what services exist.

27 Whilst it has been positive to see so many initiatives being developed and rolled-out during the pandemic, there is evidence to suggest that some staff experienced difficulties navigating their way around the plethora of initiatives to identify the ones that would best meet their needs. In light of this, the Welsh Government recently announced it would be launching a prototype Workforce Wellbeing Conversation Framework Tool to support NHS staff to pro-actively talk openly and honestly with their managers about their ongoing wellbeing needs and to sign-post them to the support available where appropriate[15]. Whilst this is a positive development, NHS bodies should also continue to engage with their staff to better understand their experiences of seeking and accessing support and adapt and improve their arrangements as necessary.

Safeguarding staff at higher risk from COVID-19

28 All NHS bodies put arrangements in place to roll out the All-Wales COVID-19 Workforce Risk Assessment Tool (the Risk Assessment Tool) as part of their wider efforts to safeguard members of staff at higher risk of developing more serious symptoms if they come into contact with the COVID-19 virus[16].

15 Written Statement - Minister for Health and Social Services (21 July 2021)

16 The Risk Assessment Tool, which was launched in May 2020, was developed by a multi-disciplinary sub-group reporting to an Expert Advisory Group established by Welsh Government. All NHS bodies were using other risk assessments tools prior to the roll-out of the national tool.

29 The Risk Assessment Tool is based on a large and growing body of data and research which shows that an individual is at higher risk from COVID-19 if they have a combination of the following risk factors:

- they are over the age of 50 (the risk is further increased for those aged over 60 and 70 years old);
- they were born male at birth;
- they are from certain ethnic minority groups;
- they have certain underlying health conditions (the risk very high for the clinically extremely vulnerable);
- they are overweight; and
- their family history makes them more susceptible to COVID-19.

30 The risk assessment process is completed in a number of stages with the aim of encouraging a supportive and honest conversation between a member of staff and their line-manager/employer around the measures that should be put in place to ensure they are adequately safeguarded and supported. The process is summarised in **Exhibit 4**.

31 We found that NHS bodies promoted the Risk Assessment Tool in a number of ways and put a range of measures in place to encourage and support their staff to complete it. The following arrangements and approaches were considered particularly important by NHS bodies:

- **senior management support** – strong and visible support for the Risk Assessment Tool by senior managers was considered important in terms of reassuring staff that the organisation was committed to the risk assessment process and supporting staff at higher risk from COVID-19.
- **utilising workforce data** – analysing and utilising workforce data was considered important in terms of identifying staff potentially at higher risk from COVID-19, planning appropriate packages of support, and facilitating targeted messaging around the importance of completing the risk assessment process. However, several NHS bodies told us they had concerns about the robustness of Electronic Staff Record (ESR) data.
- **support for line-managers** – ongoing information, advice, and support for line-managers, particularly from HR Officers/Business Partners, was considered important not only to help them fully understand their role in the risk assessment process but also to enable them to support their direct reports in a compassionate and supportive manner.

Exhibit 4: COVID-19 workforce risk assessment process

Step 1 – Checking risk	Member of staff completes the Risk Assessment Tool to check which risks apply to them.
Step 2 – Understanding the score	Member of staff calculates their score in order to understand the likely level of risk to them personally (low, high, or very high).
Step 3 – Identifying the right action	Member of staff discusses their score and other relevant factors with their line-manager (especially if they are in the high or very high-risk category) in order to identify the actions they can take personally and/or the support their employer can provide to ensure they are adequately protected.
Step 4 –Taking the right action	Agreed actions are implemented by the member of staff and/or their employer and reviewed on an ongoing basis to ensure they remain relevant and appropriate.

Source: All Wales COVID-19 Workforce Risk Assessment Tool Guidance for Managers and Staff (February 2021)

- **occupational health input** – information, advice, and support from occupational health practitioners was considered important for both line-managers and staff alike. Occupational health input was considered particularly important for members of staff with underlying health conditions who were not required to shield or who were returning to work after a period of shielding to ensure their needs were assessed and addressed appropriately.
- **joint working with staff networks and employment partnerships** – ongoing communication and joint working with established networks, employment partnerships, and individual Trades Unions was considered important for several reasons. Firstly, they were able to use their insights to advise NHS bodies on local approaches to rolling-out the Risk Assessment Tool and supporting staff wellbeing. Secondly, they played an important role in encouraging their members to complete the Risk Assessment Tool. Thirdly, they supported individual members of staff to complete the Risk Assessment Tool and, in some cases, provided advocacy and mediation for and on behalf of their members.

- **identifying staff champions** – identifying and utilising staff champions was considered important to provide encouragement, support, and reassurance to particular groups of staff at higher risk. Indeed, staff champions proved to be particularly important in NHS bodies that did not have the relevant staff networks in place. In these bodies, staff champions were used to reach-out and support individuals and groups of staff that were unaware they were potentially at higher risk as they didn't or couldn't access the relevant information and/or they were sceptical and/or anxious about engaging with the risk assessment process.

32 Over 62,000 risk assessments were completed via ESR and the Learning@Wales platform across the NHS in Wales between June 2020 and April 2021[17]. Staff had to complete paper versions of the Risk Assessment Tool prior to its roll-out via ESR in June 2020. In October 2020, the Welsh Government asked NHS bodies to request all staff to complete the Risk Assessment Tool via ESR. Completion rates via ESR in individual NHS bodies are shown in **Exhibit 5**.

33 As **Exhibit 5** shows, there is considerable variation in completion rates via ESR. There are several reasons for this:

- completing the Risk Assessment Tool via ESR has not been mandated by all NHS bodies such as Cardiff & Vale and Swansea Bay University Health Boards;
- staff in some NHS bodies that completed the paper-based Risk Assessment Tool when it was first rolled-out in May were not asked to repeat the assessment when it became available in ESR in June 2020;
- some staff are unable to access their ESR as they either work in roles that do not require the use of a computer or they do not have general access to a computer at their place of work;
- most NHS bodies have placed a greater focus on encouraging staff at higher risk to complete the Risk Assessment Tool rather than the workforce as a whole; and
- evidence from the member surveys undertaken by the BMA suggests that some staff were unaware of any risk assessment at their place of work or had been told explicitly they did not need to be assessed[18].

17 58,552 risk assessments have been completed via ESR and 3,770 have been completed via Learning@Wales between 15 June 2020 and 8 April 2021. Individuals that have completed the Risk Assessment Tool more than once via the ESR are counted more than once in the data. (Source: NHS Wales Shared Services Partnership)

18 The BMA asked its members: 'Have you been risk assessed in your place of work to test if you might be at increased risk from contact with Coronavirus patients in your current role?' The proportion that stated they were not aware of any risk assessment in their place of work was 33% (70 of 211) and 35% (61 of 175) in July and August 2020 respectively. The proportion that stated they had been told explicitly they did not need to be assessed was 7% (15 of 211) and 6% (11 of 175) in July and August 2020 respectively.

Exhibit 5: completion rates as recorded in ESR by NHS body

NHS Body	Number of recorded assessments	% of staff with a completed assessment
Aneurin Bevan University Health Board	3,071	24%
Betsi Cadwaladr University Health Board	19,195	52%
Cardiff & Vale University Health Board	857	5%
Cwm Taf Morgannwg University Health Board	15,487	58%
Health Education and Improvement Wales	134	29%
Hywel Dda University Health Board	6,965	48%
Powys Teaching Health Board	1,789	48%
Public Health Wales	1,019	73%
Swansea Bay University Health Board	174	2%
Velindre NHS Trust	6,716	81%
Welsh Ambulance Services Trust	3,145	67%

Source: NHS Wales Shared Services Partnership (15 June 2020 - 8 April 2021)

34 Whilst low completion rates via ESR does not necessarily equate to low use of the tool, it is difficult to know how many staff across the NHS in Wales have actually completed the Risk Assessment Tool due to the variable data collection and monitoring arrangements introduced by NHS bodies when it was launched.

35 We found that all NHS bodies adopted the ‘hierarchy of control’ approach to protect and support staff at higher risk from COVID-19. Under this approach, NHS bodies identified and utilised the most suitable measures from their wider suite of wellbeing arrangements to meet the individual needs of members of staff as identified through the Risk Assessment Tool.

These measures included:

- **engineering and administrative controls** – all NHS bodies put a range of engineering and administrative controls in place to safeguard staff at higher risk who were unable to work from home because of their role, and to support staff at higher risk returning to the workplace after a period of shielding. These included creating 'COVID-19 secure settings' (areas that posed a lower level of risk) by segregating COVID-19 and non-COVID-19 care pathways; staggering shift start and end times to reduce congestion; recalling staff on a rotational basis to limit the number of people in the workplace; and offering a phased return to the workplace.
- **personal protective equipment (PPE)** – PPE was provided in line with agreed guidelines to reduce or remove any residual risk to staff not eliminated by other measures. As stated in the Auditor General's report titled Procuring and Supplying PPE for the COVID-19 Pandemic, Shared Services, in collaboration with other public services, overcame early challenges to provide health and care bodies with the PPE required by guidance without running out of stock at a national level. However, the report also acknowledges that some frontline staff have reported that they experienced shortages of PPE and some felt they should have had a higher grade of PPE than required by guidance.
- **substitution measures** – working from home was not considered a viable option for all members of staff at higher risk. For some members of staff, such as those living with an abusive partner, working from home could potentially have had a greater negative impact on their overall health and wellbeing. As a result, NHS bodies put arrangements in place to enable and support staff in these situations to work in 'COVID-19 secure settings'. For members of staff unable to perform their normal duties from home due to the nature of the work, NHS bodies put arrangements in place to enable them to work in 'COVID-19 secure settings' or to be redeployed to other suitable roles which they could undertake either from home or in 'COVID-19 secure settings' with additional support, such as retraining.
- **elimination measures** – all NHS bodies put arrangements in place to enable and support the majority of staff at higher risk to work from home, particularly during official periods of shielding. Most staff at higher risk were also supported to continue working from home when shielding periods ended if this was considered appropriate and safe to do so, and if the arrangement worked effectively for both the employer and employee.

36 All NHS bodies also encouraged and supported staff at higher risk to access mental health and psychological wellbeing services to help them adjust to new ways of working and/or manage any anxieties or worries they experienced. Detailed guidance was also provided to line-managers on how to provide effective support to staff at higher risk during the pandemic. As NHS bodies move towards the recovery period, they should continue to engage with staff at higher risk to evaluate the impact of the support and interventions they are providing and amend or improve their arrangements as necessary.

37 We found that there are a number of advantages and disadvantages to the Risk Assessment Tool, as follows:

Advantages of the Risk Assessment Tool

- the tool has ensured consistency, reduced variability, and facilitated the sharing of learning across the NHS;
- the format of the tool is simple, easy to use, and enables staff to focus on the main factors which may place them at greater risk;
- the tool helps managers appreciate the importance of addressing risks to staff in a timely and sensitive manner as well as the importance of being a compassionate and supportive manager;
- the process, if done correctly, provides reassurance to staff and gives assurance to managers and leaders that staff risks are being managed appropriately;
- the tool has galvanised organisations into adopting holistic approaches to managing staff risks; and
- the tool has generated a greater awareness and understanding of the needs of certain groups of staff, particularly those underrepresented within existing organisational structures.

Disadvantages of the Risk Assessment Tool

- the tool has made some staff feel ‘targeted’ or ‘singled out’ for special treatment;
- there have been some concerns about the use of the acronym BAME (Black, Asian, and Minority Ethnic) in the tool because it places a greater emphasis on certain ethnic minority groups (Asian and Black) and exclude others (Mixed, Other and White ethnic minority groups);
- there have been some concerns that the tool’s scoring matrix does not give sufficient weighting to certain risk factors, such as ethnicity and Type 1 diabetes;
- the tool and process have been seen and treated as a ‘tick box exercise’ by a small number of managers and members of staff; that is, the tool was completed to maintain compliance, but no real action was taken in response to the score;

- the tool does not pick-up the whole picture in one place for all staff, particularly those required to complete other risk assessments (eg stress risk assessment); and
- the ongoing development and evolution of the tool has led to a sense of 'risk assessment fatigue' amongst some members of staff.

Maintaining oversight of staff wellbeing arrangements

38 At an operational level, we found that all NHS bodies had staff wellbeing planning cells/groups in place as part of their emergency command and control structures with responsibility for planning and overseeing the delivery of local staff wellbeing provision. These planning cells/groups were tasked with working with other relevant cells/groups, such as those with responsibility for PPE and staff communication and engagement, to ensure a co-ordinated approach to supporting staff wellbeing.

39 These planning cells/groups were also responsible for monitoring COVID-19 workforce related risks and indicators and escalating key concerns and issues to the relevant group(s) within the emergency command structure as appropriate. Whilst the majority of these planning cells/groups monitored similar indicators, such as absence rates due to illness or shielding, we found that only a small number were actively monitoring risk assessment completion rates. Furthermore, we found that only NHS body had arrangements in place at an operational level to assess and monitor the quality of completed risk assessments.

40 At a corporate level, we saw evidence in most NHS bodies of good flows of information to boards and committees to provide assurance and enable effective oversight and scrutiny of all relevant staff wellbeing risks and issues during the pandemic. However, we found there was scope across most NHS bodies to strengthen the arrangements for reporting risk assessment completion rates and providing greater assurances to boards and committees around the quality of completed risk assessments.

41 We found that the crisis generated a greater awareness at board-level in all NHS bodies around the importance of supporting staff wellbeing and, in particular, the importance of understanding and addressing the needs of particular groups of staff. In some NHS bodies, this led to the creation of new staff networks and advisory groups for specific groups of staff which have traditionally been underrepresented within existing corporate structures. However, one Health Board has taken this further by establishing an Advisory Group for staff from ethnic minority groups as a formal sub-group of the board to ensure a stronger voice and involvement within the organisation for black, Asian, and minority ethnic staff. Although the Advisory Group reports formally via the Health Board's Chair, the Advisory Group's Chair and Vice-Chair are invited to attend all board meetings.

Key challenges and opportunities for the future

42 NHS staff at all levels have shown tremendous resilience, adaptability, and dedication throughout the pandemic. However, they have also experienced significant physical and mental pressures due to the unprecedented challenges presented by the crisis, including:

- working longer hours and managing greater workloads;
- operating in rapidly changing, demanding, and intensive environments;
- managing fears, concerns, and anxieties about the risks to their own health as well as the risks to the health of their loved ones;
- seeing patients, colleagues and/or family and friends falling seriously ill or even dying with COVID-19;
- contracting COVID-19, and, for some, managing the longer-term effects of the virus (long-COVID);
- adjusting to new ways of working and, in some cases, adjusting to different roles;
- dealing with the resulting impact of shielding or working from home in terms of feeling isolated and alone and/or feeling guilty about not being able to support colleagues on the front-line; and
- adapting to wider social restrictions and managing their associated impacts, such as delivering home schooling, and providing enhanced care for elderly or vulnerable relatives.

43 The crisis has undoubtedly had a considerable impact on the wellbeing of staff. For example, surveys undertaken by RCN Wales, whilst not representative of the NHS workforce as a whole, highlight the impact of the pandemic on staff wellbeing. The results of the survey undertaken in June 2020, which received 2,011 responses, found:

- 75.9% stated their stress levels had increased since the beginning of the pandemic;
- 58.4% stated that staff morale had worsened since the beginning of the pandemic; and
- 52% stated they either strongly agreed or agreed with the statement ‘I am worried about my mental health’.

44 However, the longer-term impacts cannot and should not be ignored or underestimated. Indeed, the surveys undertaken by the BMA, whilst not representative of the NHS workforce as a whole, point to some of the challenges that remain in relation to staff wellbeing:

- in April 2021, 45% (126 of 279) of members stated they were suffering from depression, anxiety, stress, burnout, emotional distress, or other mental health conditions relating to or made worse by their place of work or study compared with 40% (298 of 735) in April 2020.

- in April 2021, 33% (92 of 279) of members stated their symptoms were worse than before the start of the pandemic compared with 25% (185 of 735) in April 2020.
- in April 2021, 36% (72 of 281) of members stated their current levels of health and wellbeing were slightly worse or much worse compared with that during the first wave between March and May 2020. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 43% (205 of 480) and 48% (224 of 467) respectively.
- on a scale of one to five (where 1 equalled very low/negative, and 5 equalled very high/positive), 32% (74 of 229) of members scored their morale as either a 1 or 2 in April 2021. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 45% (203 of 454) and 47% (195 of 402) respectively.
- in April 2021, 56% (157 of 282) of members stated their current level of fatigue or exhaustion was higher than normal from working or studying during the pandemic. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 60% (286 of 480) and 64% (297 of 467) respectively.

45 Surveys and work undertaken by other professional bodies also highlight the increased stress, exhaustion, and burnout experienced by staff. They also point to the increased risk to staff of developing longer term physical and psychological problems without ongoing support and opportunities for proper rest and recuperation.

46 Trends in sickness absence rates also point to some of the challenges that NHS bodies have faced during the crisis. After a gradual fall during 2015 to 2017, the sickness absence 12-month moving average has been rising and was 6.0% over the last year, mainly due to an increase from the April to June 2020 quarter during the pandemic. For the quarter ending 31 December 2020[19]:

- the sickness absence rate was 6.4%, up 1.3 percentage points compared to the quarter ending 30 September 2020.
- the NHS bodies with the highest sickness rates were Cwm Taf Morgannwg University Health Board at 8.5%, Welsh Ambulance Services NHS Trust at 8.4%, and Swansea Bay University Health Board at 8.3% (compared with 5.6%, 5.9%, and 6.2% respectively for the quarter ending 30 September 2020).

19 Source: StatsWales

- the staff groups with the highest sickness absence rates were the Ambulance staff group at 9.6%, the Healthcare Assistants and Support Workers staff group at 9.2%, and the Nursing, Midwifery and Health Visiting staff group at 8.1% (compared with 6.2%, 7.4%, and 6.5% respectively for the quarter ending 30 September 2020).

47 In the short-term, NHS bodies will face challenges in terms of managing seasonable absences which tend to be higher in the winter months as well as dealing with absences caused by staff requiring to self-isolate by the Test, Trace, Protect Service. However, they will also potentially face future challenges in terms of managing absence rates attributed to the longer-term physical and mental conditions caused by the pandemic unless they maintain and build upon their staff wellbeing arrangements.

48 The COVID-19 pandemic has undoubtedly brought staff wellbeing into sharper focus at both a national and local level. It has also shown that NHS bodies can respond rapidly and effectively to the challenges and pressures presented by a crisis. However, there is no doubt that the NHS workforce in Wales, which was already under pressure prior to the pandemic, is more emotionally and physically exhausted than ever before after the significant and unprecedented efforts of the last 18 months.

49 A continued focus on providing accessible wellbeing support and services and maintaining staff engagement, therefore, is going to be needed in the short-term to ensure NHS bodies address the ongoing impact of the pandemic on the physical health and mental wellbeing on their staff. Without such a focus, there is a risk the impact of the pandemic on the physical and mental health of staff will grow which could, in turn, compromise the ability of NHS bodies to deal effectively with the combined challenges of recovering and restarting services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures which are expected to be greater this winter than they were last year.

50 However, the COVID-19 pandemic has also created an opportunity to rethink and transform staff wellbeing for the medium to longer term. Whilst supporting the wellbeing of the NHS workforce is more necessary than ever when the service needs to respond to a crisis, investing appropriately in staff wellbeing on an ongoing basis is equally as important as a healthy, engaged, and motivated workforce is essential to the delivery of safe, high-quality, effective, and efficient health and care services.

51 We have prepared a checklist to accompany this report which sets out some of the questions NHS Board Members should be asking to obtain assurance that their respective health bodies have effective, efficient, and robust arrangements in place to support the wellbeing of their staff.

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Management Response – Taking Care of the Carers?

Health Body: Velindre University NHS Trust

Completion Date: March 2022

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
R1	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken	VUNHST implemented the COVID risk assessment tool from 2020 onwards and it is available to all staff through their ESR employee self-service. This is very easy for staff to access. Managers are encouraged to review COVID risks as part of normal line management as part of regular one to one meetings, Performance Appraisal and Development Review (PADR) discussions and wellbeing conversations. Staff who are identified as being vulnerable have been supported to continue working, through	Completed	Deputy Director of OD and Workforce

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	to safeguard and support staff identified as being at higher risk from COVID-19.	utilising remote working to its full extent and organising work to reduce personal contacts. The Trust has a Healthy and Engaged Steering Group that meets quarterly to drive actions and improvement in health and wellbeing, as well as staff engagement. This is chaired by the Executive Director of Organisational Development and Workforce. The Trust has an Employee Assistance Programme that is available 24/7 to staff and their family. A practical example of taking health and wellbeing seriously was the considered response to Omicron in January 2022. This provoked three different initiatives to directly help staff: 1. A listening event was held on 3 February 2022 where staff were invited to come and ask questions		

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
		or raise concerns, against the backdrop of Omicron. This highlighted issues to do with supporting staff who work remotely but also remembering the pressures on staff who do not. 2. A letter from the Executive Team extending thanks for all the efforts during the pandemic and reminding staff of wellbeing resources and support. This was posted to home addresses in February 2022 to ensure everyone saw the information without needing to access email. 3. Delivering a virtual learning event on Managing Remote Teams. This is a module of our management development programme which we were able to run as a stand-alone session in February 2022 for all managers.		

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
R2	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	The Trust has a strategic plan supported by a suite of enabling strategies, including a People Strategy. The People Strategy has Wellbeing as one of the six themes for the Trust. This has made the link between the wellbeing of staff and capacity and capability to deliver services. The Trust Integrated Medium Term Plan for 2022-23 sets out workforce activity in line with the People Strategy and as such includes a section on staff wellbeing. The Inspire management development programme includes content on managing teams remotely and mental health awareness. The Trust runs Mental Health First Aid training and REACT March on Stress training for staff in any job role.	Completed	Deputy Director of OD and Workforce

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
R3	**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Throughout the pandemic the Trust has maintained open dialogue with staff using listening events and other sessions. For example, there was a Staff Wellbeing during COVID event open to all staff on MS Teams on 3 February 2022. Feedback was gathered here on what worked well/not so well and how staff's wellbeing had been affected by COVID. to inform the next steps of support for staff and to shape ideas for Agile working. Data on the usage of the Employee Assistance Programme is analysed quarterly to identify themes or issues. The Trust is recruiting a Clinical Psychologist for Staff and Teams. Once in post, this person will work with the Workforce and OD team to evaluate services, programme and initiatives and make informed decisions about what to provide.	June 2022	Deputy Director of OD and Workforce

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
R4	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	The Trust is an active member of the HEIW Health and Wellbeing Network and is contributing to the development of national resources to support health and wellbeing. The Trust has an Employee Assistance Programme for staff. This provides services to enhance emotional wellbeing including counselling and mindfulness sessions which include telephone and video face-to-face consultations. It provides information to staff regarding support for carers and general health and wellbeing as well as signposting to finance and legal professionals. The Trust is working with NHS Shared Services Partnership Procurement team to re-tender for this in conjunction with other NHS bodies from April 2023. The Trust promotes external support resources including Samaritans, CALL Mental Health Helpline	Completed	Deputy Director of OD and Workforce

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
		for Wales, DAN24/7 Wales Drug and Alcohol Helpline and HHP – Health for Health Professionals		
R5	**Providing continued assurance to boards and committees** NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain	The Trust Assurance Framework has a risk relating to organisational culture and a key control specified is that the Health and Wellbeing of the Organisation is to be managed – with a clear plan to support the physical and psychological wellbeing of staff. The Trust holds Platinum Status in the Corporate Health Standard which recognise significant achievements in the Trust relating to health and wellbeing of staff and for its work on sustainable development and corporate social responsibility.	Completed	Deputy Director of OD and Workforce

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	effective oversight of key workforce performance indicators – this does not happen in all organisations at present.			
R6	**Building on local and national staff engagement arrangements** NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Trust has an open approach to engaging with staff and provides listening events and focus groups on a regular basis. The Local Partnership Forum meets quarterly with management to raise issues employee issues, including health and wellbeing. The Trust's Diversity Networks will be further developed in 2022 further enhancing this clear route for their feedback to be taken into account. The Trust will be encouraging use of its on-line platform, Work in Confidence, which offers staff a way to raise concerns in confidence. This will	Completed	Deputy Director of OD and Workforce

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
		further develop a culture of trust where people feel able to raise important issues that may be impacting on mental or physical wellbeing.		

Please indicate below how the Board Members Checklist will be used to inform debate within your organisation

The Board Members Checklist will help shape the agenda for discussion and action on Health and Wellbeing through the Healthy and Engaged Steering Group and Senior Leadership Teams and will ensure feedback and discussion at the Executive Management Board and the Board includes all essential aspects of Health and Wellbeing.

AUDIT COMMITTEE

DATE OF MEETING	3rd May 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Simon Cookson, Acting Head of Internal Audit
PRESENTED BY	Simon Cookson, Acting Head of Internal Audit
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR OF CORPORATE GOVERNANCE
REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Team	Various	IN SUPPORT

ACRONYMS	
IA	INTERNAL AUDIT

1. SITUATION/BACKGROUND

Internal Audit provide a progress report to each meeting of the Audit Committee in a standard format, together with any internal audit reports that have been finalised and agreed with the Executive Team.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Progress report to be considered by the Audit Committee as part of its ongoing responsibility to oversee the work of Internal Audit. Individual reports to be considered for their implications regarding the governance, risk management and control framework within the Trust and for the Audit Committee to ensure that the recommendations from them are being implemented by management.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	IA cover Quality and Safety in their work
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	IA reports can cover multiple Healthcare Standards
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

The Audit Committee is invited to receive the reports from Internal Audit, note their content and request further action, information or assurances if required.

Internal Audit Progress Report
Audit Committee

April 2022

Velindre University NHS Trust

NWSSP Audit and Assurance

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

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

Contents

1. Introduction

1.1 The purpose of this report is to:

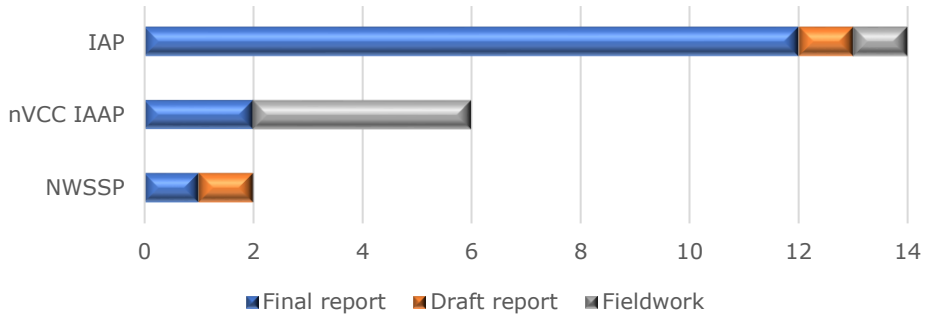
a. highlight progress of the 2021/22 Internal Audit Plan as of 19th April 2022 to the Audit Committee; and

b. provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2021/22 Internal Audit Plan

2.1 There are 16 reviews in the revised 2021/22 Internal Audit Plan (IAP), two of which are undertaken at NWSSP. In addition, there are six audits in respect of the new Velindre Cancer Centre (nVCC) Integrated Audit and Assurance Plan (IAAP).

2.2 Overall progress is shown below:



2.3 Since the January 2022 Audit Committee meeting, we have finalised six reports (four IAP and two nVCC IAAP) which will be presented at this meeting.

2.4 Detailed progress in respect of each of the reviews in the 2021/22 Internal Audit Plan is summarised in Appendix A.

3. Changes to the 2021/22 Internal Audit Plan

3.1 As reported to previous Audit Committees, two reviews in our original 2021/22 IAP were deferred (Quality & Safety Framework to 2022/23 and Private Patients to 2023/24) and two reviews were added as replacements (DBS Checks and Ways of Working).

3.2 However, due to the pressures within the Trust relating to the Covid-19 pandemic (Omicron variant) and the new Velindre Cancer Centre, the Ways of Working (Advisory) review has been cancelled. This was agreed with the Director of Corporate Governance.

4. Engagement

4.1 We have undertaken the following engagement activities during the reporting period:

a. regular meetings with the Executive Director of Finance;

b. 2022/23 planning meetings with the Chief Executive, Director of Finance and the Chair of the Audit Committee;

c. regular liaison with Audit Wales and Healthcare Inspectorate Wales;

d. observation of Board and Committee meetings;

e. audit scoping and debrief meetings; and

f. liaison with senior management.

4.2 We note that the Key Performance Indicator for the timely provision of management responses to our reports has dropped below target to 50% (target 80%). Management responses for six of the 12 reports issued in the year to date were not received within 15 working days. Of these six, four reports also missed Audit Committee papers deadlines due to these delays.

4.3 We have also experienced delays in completing audit fieldwork, particularly since the October 2021 Audit Committee. Whilst this has not prevented us from completing our work to date, it has led to increased time being spent on individual audits to obtain sufficient, reliable audit evidence, resulting in audits taking significantly longer, and being reported later, than planned.

4.4 Whilst we appreciate the Trust has experienced pressures from the Covid-19 pandemic and matters relating to the new Velindre Cancer Centre during 2021/22, this situation will not be sustainable in the longer-term. We will work with the Executive Directors and senior management to implement mechanisms to support improved engagement during 2022/23.

5. Recommendation

5.1 The Audit Committee is asked to NOTE the above and APPROVE the changes to the 2021/22 Internal Audit Plan.

Appendix A: Progress against 2021/22 Internal Audit Plan

Review	Status	Rating	Summary of matters arising			Audit Committee
			High	Medium	Low	
Infection Prevention & Control	Final report	Reasonable	-	4	-	October 2021
CaNISC Replacement	Final report	Reasonable	-	2	1	October 2021
Divisional review – Incident Management	Final report	Reasonable	-	4	1	October 2021
Divisional review – Risk Management	Final report	Reasonable	-	2	2	October 2021
Use of Technology – Fit for the Future	Final report	Advisory	-	-	-	January 2022
Board Committee Effectiveness	Final report	Reasonable	-	2	4	January 2022
Trust Assurance Framework	Final report	Reasonable	1	2	-	January 2022
Financial Systems	Final report	Reasonable	-	5	2	May 2022
Charitable Funds	Final report	Reasonable	-	4	6	May 2022
Scrutiny of Expenditure above £100,000	Final report	Reasonable	-	2	-	May 2022
Disclosure Barring Service Checks	Final report	Reasonable	-	2	2	May 2022
Follow-up	Draft report	Reasonable	1	2	-	July 2022
Wellbeing of Future Generations Act	Fieldwork	Advisory	-	-	-	July 2022
Ways of Working	Cancelled	Advisory				
Quality & Safety Framework	Deferred					
Private & Overseas Patients	Deferred					

Review	Status	Rating	Summary of matters arising			Audit Committee
			High	Medium	Low	
Capital & Estates						
Estates Assurance – Waste Management	Final report	Reasonable	-	4	-	October 2021
New Velindre Cancer Centre Integrated Audit and Assurance Plan:						
Contract Management	Final report	Reasonable	-	3	-	May 2022
Mutual Investment Model (MIM) Governance	Final report	Substantial	-	1	-	May 2022
MIM Procurement	Fieldwork					July 2022
Financial Reporting	Fieldwork					July 2022
Design and Change Management	Fieldwork					July 2022
Enabling Works	Fieldwork					July 2022
Reviews at other bodies (undertaken within NWSSP Plan)						
Purchase to Pay	Final report	Reasonable	1	2	3	NWSSP April 2022
Payroll	Draft report	Reasonable				TBC

Appendix B: Key Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22		March 2021	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]		12 of 12 100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]		6 of 12 50%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]		12 of 12 100%	80%	v>20%	10%<v<20%	v<10%

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

New Velindre Cancer Centre Development: MIM Governance

Final Internal Audit Report

February 2022

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_VEL_2122_03
Report status:	Final
Fieldwork commencement:	13 September 2021
Fieldwork completion:	24 November 2021
Draft report issued:	13 December 2021
Draft report meeting:	16 December 2021
Management response received:	25 February 2022
Final report issued:	28 February 2022
Auditors:	NWSSP: Audit and Assurance – Specialist Services Unit
Executive sign-off:	Steve Ham, Chief Executive Officer
Distribution:	Carl James, Director of Strategic Transformation, Planning, Performance & Estates David Powell, Project Director, TCS Mark Ash, Assistant Project Director (Commercials & Finance) Huw Llewellyn, Director of Commercial & Strategic Partnerships Andrew Davies, Principal Programme Manager, TCS Matthew Bunce, Executive Director of Finance Hannah Moscrop, Project Manager
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 Institute of Internal Auditors

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

Disclaimer notice - please note

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are Velindre University NHS 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.

Executive Summary

Purpose

The audit, forming part of the 2021/22 Integrated Audit Plan, was undertaken to determine whether appropriate governance arrangements were in place at the new Velindre Cancer Centre (nVCC) project as it enters the competitive dialogue phase of the Project Master Plan.

Overview

Substantial assurance has been issued on this area.

The principal governance arrangements for the current stage of project proceedings remain unchanged from the last audit review in 2020/21; with the exception of the introduction of six workstreams to provide advice / guidance to bidders during the competitive dialogue phase.

The membership of the current governance structure is appropriate including involvement from external parties providing specialist support / advice.

There remain some vacant posts in the overall project structure but the Trust is taking appropriate steps to recruit and bring to full complement.

The matters requiring management attention include:

- Timeliness of decision making to help manage stakeholder expectations; and
- Presentation of complete and appropriate referenced reports for endorsement / approval by Project Board.

Report Classification

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	 2020/21

Assurance summary [1]

Assurance objectives		Assurance
1	Follow Up	Substantial
2	Governance Arrangements	Reasonable
3	Roles and Responsibilities	Reasonable
4	Working Group Arrangements	Substantial

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1, 1.2	Effectiveness of Governance Arrangements	2	Operation	Medium

1. Introduction

1.1 This audit forms part of the 2021/22 Integrated Audit Plan and has sought to determine whether appropriate governance arrangements were in place at the new Velindre Cancer Centre (nVCC) project, as it enters the competitive dialogue phase of the Project Master Plan.

1.2 The invitation to participate in dialogue (ITDP) document was published on 2 September 2021 and the competitive dialogue process commenced on 8 September with briefing meetings for the six workstreams which have been established (to allow discussion on the bidder's proposed solution leading to the provision of high-quality bids for the Trust to evaluate). Completion of the competitive dialogue process is anticipated in mid-March 2022 with the receipt of the final tender from the respective bidders.

1.3 The key risk considered in the review was that the governance arrangements do not support effective decision making, contributing to poor management and the failure to achieve project objectives.

1.4 Noting the ongoing impact of Covid 19, the delivery of the integrated audit plan for 2021/22 included an increased element of remote working.

2. Detailed Audit Findings

Follow Up: Assurance that previously agreed management actions have been implemented.

2.1 The recommendations included in the nVCC: Governance & Financial Management report (issued April 2021: Substantial Assurance) were followed up as part of this review. The status of the agreed management actions was as follows:

	High	Medium	Low	Total
Closed	-	-	2	**2**
Superseded	-	-	-	**-**
Outstanding	-	-	-	**-**
Total	**-**	**-**	**2**	**2**

2.2 The detail in support of the above summary is included in **Appendix B**.

2.3 Recognising that appropriate action has been taken by management to close all agreed recommendations, **substantial assurance** has been determined.

Governance Arrangements: Assurance that the arrangements for the current stage of the project were adequately defined and enacted.

2.4 The nVCC Delegations Framework (updated September 2021) sets out the project governance structure for the nVCC project.

2.5 The accountability arrangements for the project remain unchanged to those reported in the 2020/21 nVCC: Governance & Financial Management report. The nVCC project accountability is to the Trust Board via the nVCC Project Boards, TCS Programme Delivery Board and the TCS Scrutiny Sub Committee.

2.6 Continued attendance by Internal Audit at the monthly Project Boards has observed that all outputs presented are appropriately scrutinised to assist the decision-making process.

2.7 However, at the date of reporting, observation from the latter Project Boards identified some issues regarding the effectiveness of the governance arrangements:

- Late decision making. Feedback through the Communications and Engagement updates cite that decisions are being made late which has an implication in managing expectations for sharing information / updating stakeholders (**MA1**).
- Status of reports presented for endorsement / approval. This is specific to a report (car parking) presented to the November Project Board for endorsement. Good governance was demonstrated by members of the Project Board not prepared to take the report to the Programme Delivery Board. The report prompted a detailed discussion with a number of questions raised and left unanswered (without access to further data). However, the question of preparedness of reports is raised (**MA1**).

2.8 Noting these minor issues regarding the effectiveness of the governance arrangements, **reasonable assurance** has been determined.

Roles and Responsibilities: Assurance that the roles and responsibilities were clearly defined and updated for the competitive dialogue process and readiness to proceed.

2.9 Roles and responsibilities were defined with the respective terms of reference for the governance structure; with the Delegations Framework further stipulating the strength and experience of the membership of the project teams which will benefit the need for timely decision-making requirements at the competitive dialogue stage.

2.10 It has been recognised that as the project progresses, there has been a need to expand some of the project resources. From attendance at the Project Board meetings, and review of the project risk register, it has been noted there has been

difficulty in recruiting to some areas raising the need for the Trust to approach recruitment agencies as well as advertising through the standard NHS recruitment process.

2.11 At the date of reporting, recruitment remained ongoing for the posts of:

- Senior Engagement Officer;
- Digital Technical Lead; and
- Clinical Lead.

2.12 Whilst noting the active steps currently being taken to fill these vacant posts until the roles are at full complement **reasonable assurance** has been determined.

Working Group Arrangements: Assurance that the working group arrangements were adequately structured and resourced, with sufficient involvement from the Trust to support the work of the Project Board.

2.13 Six workstreams had been established to engage in the competitive dialogue process:

Workstream	Responsibility
Financial workstream	To ensure the deal officers good value for money and a robustly sustainable financial model over the lifetime of the Project Agreement.
Legal Workstream	To ensure a legally robust agreement with an acceptable balance of risks.
Community Benefits Workstream	To ensure an agreement that meets all the authority Community Benefits requirements and maximises achievement of the additional and extended measures.
The Hospital (Design & Construction) workstream	To ensure a hospital design and a construction programme that fully reflects the Trust's Design Brief and improves on the Reference Design and original specification documents.
Facilities Management (FM) workstream	To ensure an agreement that meets and improves on the Service Level Specification and other FM related schedules.

Strategy and Quality Management (SQM) subgroup	To ensure an agreement that meets the range of SQM criteria required in the ITPD document.

2.14 Terms of reference are in place for each of the above with membership (including both internal Trust representation and external parties to provide specialist input / technical advice), frequency of meetings and quoracy defined appropriately.

2.15 The terms of reference clearly state that no decisions can be taken by the workstreams – they operate in an advisory capacity only, at the respective briefing meetings with the bidders, throughout the competitive dialogue process.

2.16 The competitive dialogue process started on 8 September 2021 with the first of the briefing meetings being held. Reporting of the workstream activity was to the Project Board through the Project Highlight report – providing the status of receipt of expected deliverables and attendance by bidders and the status of response to requests for clarifications received (70%, at the date of fieldwork, noting two meetings per workstream had been held).

2.17 At the current juncture of the project, there are appropriate working group arrangements in place which have commenced activity in accordance with the competitive dialogue timetable. **Substantial assurance** has therefore been determined.

Appendix A: Management Action Plan

Matter Arising 1: Effectiveness of Governance Arrangements (Operation)	**Impact**
Internal Audit attendance at recent Project Board meetings observed a couple of issues regarding the effectiveness of the governance arrangements in place. • Late decision making. Feedback through the Communications and Engagement updates cite that decisions are sometimes made late and such causes difficulties in managing expectations for the sharing of information / preparation of statements for release to stakeholders. Noting the sensitive nature of the nVCC development within the local community (and, at the date of fieldwork, the outcome of the judicial review), there is a need for timely and complete information to be considered and shared. • Status of reports presented for endorsement / approval. Specific reference is made to the car parking report which was presented to the November Project Board; and presented more questions than answers. Commendation is provided to the membership of the Board – good governance was evidenced in not taking the presented paper to the Programme Delivery Board [scheduled for the following day] given the extent of additional information / scenario development that had been highlighted through discussion. However, the question of preparedness is raised. Options should have been presented for discussion in the first instance providing an opportunity to gather further information / evidence where required and present a well-rounded, well-informed paper for endorsement / approval. It is recognised that not every report presented is the same – appropriate judgment should be applied to the expected route / timeframe for discussion.	Potential risk of: • Inappropriate decision making. • Achievement of project objectives impacted by inappropriate / late communications.

Recommendations		Priority
1.1 Recognising the external pressures of the project, matters for decision making should be taken to the appropriate forum in a timely manner to help manage stakeholder expectations.		**Medium**
1.2 Papers presented to Project Board for endorsement / approval should be full, complete and appropriately referenced to assist in a timely decision-making process.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Noted. The Project will endeavour to ensure that matters fr decision making are taken through the appropriate forum and documented for audit purposes.	Immediately	Assistant Project Director (Finance & Commercials) *in conjunction with the responsible reporting officer and Communications team*
1.2 Noted. The Project will ensure that all reports for endorsement / approval are full, complete and appropriately referenced.	Immediately	Assistant Project Director (Finance & Commercials) *in conjunction with the responsible reporting officer*

Appendix B: Follow up of previously agreed management actions

Previous matter arising 1: Governance – nVCC Project Initiation DOcument	
Original recommendation and management response	Original priority
The review and update of the nVCC Project Initiation Document should be finalised for endorsement by the Project Board. **Management response:** Agreed. The nVCC PID will be submitted to the Project Board for endorsement.	**Low**
Current findings	**Residual risk**
The revised nVCC PID was endorsed by the nVCC Project Board on 13 May 2021 and approved by the Programme Delivery Board on 16 June 2021. The document had been updated and strengthened for the inclusion of more specific measures. **Conclusion:** Closed.	N/A

Previous matter arising 2: Governance – Succession Planning	
Original recommendation and management response	Original priority
Succession planning for vacant posts should be considered in readiness for the next stage of the project. **Management response:** Agreed. The project reviews organisational structures for each phase of the Enabling Works and nVCC project(s). If any post becomes vacant, the project(s) will review the requirements of the project(s) and a decision on recruitment is made. In addition, the Project Director will consider internal staff development opportunities as part of the review.	**Low**
Current findings	**Residual risk**
From Internal Audit attendance at the Project Board meetings, it is recognised that there has been a recruitment campaign to appoint into vacant posts, with some appointments having been made. However, it is also noted that some posts (i.e. Digital) have been difficult to appoint to; but that steps are being taken for discussions with recruitment agencies, as well as the standard NHS jobs application route, to continue to look for appropriate candidates. **Conclusion:** Closed, recognising that whilst the requirements of the recommendation have been addressed by the Trust, the successful appointment of individuals into the vacant posts remains an ongoing process.	N/A

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.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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New Velindre Cancer Centre Development: Contract Management

Final Internal Audit Report

February 2022

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_VEL_2122_02
Report status:	Final
Fieldwork commencement:	13 September 2021
Fieldwork completion:	24 November 2021
Draft report issued:	13 December 2021
Draft report meeting:	16 December 2021
Management response received:	25 February 2022
Final report issued:	28 February 2022
Auditors:	NWSSP: Audit and Assurance – Specialist Services Unit
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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 Institute of Internal Auditors

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

Disclaimer notice - please note

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

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Executive Summary

Purpose

The audit, forming part of the 2021/22 Integrated Audit Plan, was undertaken to determine whether appropriate contractual arrangements were in place at the new Velindre Cancer Centre (nVCC) project, for technical and professional advisory services, as it enters the next stages of the Project Master Plan including competitive dialogue.

Overview

Reasonable assurance has been issued on this area.

To assist in the progress of the next stages of the project, the Trust has procured external support / technical advice to widen the areas of expertise available and strengthen the support provided through the competitive dialogue process and beyond.

The procurement process for these appointments has been appropriately endorsed and contract documentation in place and accepted by both parties. However, some weaknesses in the contract management process were identified.

The matters requiring management attention include:

- Timeliness of completion of contract documentation; and
- Reporting of contactor performance and key performance indicators.

Other recommendations are within the detail of the report.

Report Classification

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

Assurance summary [1]

Assurance objectives		Assurance
1	Follow Up	Reasonable
2	Appointment of Advisers	Reasonable
3	Contract Documentation	Reasonable
4	Fees	Reasonable
5	Monitoring and Reporting	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1, 1.2	Contract Documentation	1, 3, 4	Operation	Medium
2	Appointment Process	2	Operation	Medium
3	Contractor Performance and Key Performance Indicators	5	Operation	Medium

1. Introduction

1.1 This audit forms part of the 2021/22 Integrated Audit Plan and has sought to determine whether appropriate contractual arrangements were in place at the new Velindre Cancer Centre (nVCC) project, for technical and advisory services, as it enters the next stages of the Project Master Plan including competitive dialogue.

1.2 The invitation to participate in dialogue (ITDP) document was published on 2 September 2021 and the competitive dialogue process commenced on 8 September with briefing meetings for the six workstreams which have been established (to allow discussion on the bidder's proposed solution leading to the provision of high-quality bids for the Trust to evaluate). Completion to the competitive dialogue process is anticipated as mid-March 2022 with the receipt of the final tender from the respective bidders.

1.3 To assist in the progress of the next stages of the project, the Trust has procured external support / technical advice to widen the areas of expertise available and strengthen the support provided.

1.4 The key risk considered in the review was that the contractual documentation does not protect the interests of the Trust and / or inhibits the achievement of the key objectives of the project.

1.5 Noting the ongoing impact of Covid 19, the delivery of the integrated audit plan for 2021/22 included an increased element of remote working.

2. Detailed Audit Findings

Follow Up: Assurance that previously agreed management actions have been implemented.

2.1 The recommendations included in the nVCC: Advisers report (issued April 2021: Reasonable Assurance) were followed up as part of this review. The status of the agreed management actions was as follows:

	High	Medium	Low	Total
Closed	-	2	1	**3**
Superseded	-	1	-	**1**
Outstanding	-	-	-	**-**
Total	**-**	**3**	**1**	**4**

2.2 The detail in support of the above summary is included in **Appendix B**.

2.3 Whilst noting that one recommendation has been superseded by a new issue raised at this report, the others have been actioned appropriately. **Reasonable assurance** has therefore been determined.

Appointment of Advisers: Assurance that the appointment of advisers (for the current stage of the project) was in accordance with local / national guidance / regulations.

2.4 Management provided a schedule of areas of advice required for competitive dialogue for which procurement had commenced from April 2021 onwards; and the following sample was selected to confirm compliance with the objectives of this review:

Adviser role	Value (exc. VAT)	Procurement route
Specialist Design Adviser	£88k	Tender
Specialist Environmental Design & Community Benefits Adviser	£48k	Tender
Planning Consultancy	£48k	Direct award via framework
Civil & Structural Engineering	£48k	Direct award via framework
Equipment / Healthcare Planner	*As at the date of fieldwork, the procurement of these advisers remained ongoing. No further testing could be undertaken.*	Service Level Agreement (within NHS)
Overview Technical Advice (Facilities Management, Specialist Support)		Direct award via framework

2.5 The project team engaged in consultation with NWSSP: Procurement to obtain support for the proposal of the procurement approach to take for the identified advisers and ensuring value for money was obtained.

2.6 The tender exercises reviewed were advertised through an appropriate platform; with evaluation papers prepared (incorporating a scoring matrix) for all tenders received and issue of an acceptance letter to the preferred adviser. For one appointment, however, it was noted that the date of the acceptance letter pre-dated that of the evaluation form (**MA1**).

2.7 The frameworks used [SEWTAPS (managed by Cardiff Council) and NHS SBS Construction Consultancy Services 2 Framework] permitted the Trust to appoint advisers who had previously undertaken works at both the nVCC and Enabling Works projects; with continuity of service identified as a key component to ensuring value for money.

2.8 The use of the above procurement routes was further endorsed with a paper presented to the TCS Programme Scrutiny Committee.

2.9 As cited in the table above, the procurement process remained ongoing for two of the preferred advisers. The status of each has been routinely reported to Project Board with anticipated conclusion by October 2021 but this was not achieved. As the competitive dialogue process continues to progress, there is a need to ensure all required advisory services are in place (**MA2**).

2.10 Whilst the weakness in date recording for the internal acceptance process is minor, the Trust should ensure the procurement exercises for advisory support are finalised. Therefore, **reasonable assurance** has been determined.

Contract Documentation: Assurance that contract documentation had been completed in a timely manner.

2.11 For all selected advisers, reference was made to the contract documentation in place.

2.12 Signed contract documentation was in place for all, however two (Specialist Design Adviser and Civil & Structural Engineering adviser) were signed circa 1.5 months after the effective start date of the contract (**MA1**). The signing of contract documentation, in a timely manner, has been raised as a reporting issue previously (see **Appendix B**).

2.13 Noting the above, **reasonable assurance** has been determined.

Fees: Assurance that the corresponding contract fees have been determined and approved in advance of work progressing.

2.14 The value of the contract award was approved by the Trust Board (and reported via the quarterly contract management report to Project Board) for the adviser appointments reviewed.

2.15 However, there was a discrepancy noted in the contract value reported for the Specialist Design Adviser - £88k as per the signed contract documentation; and £72k as reported to the Project Board (**MA1**).

2.16 For the two procurement exercises sampled, which have yet to be finalised, it was confirmed that no payments have been made.

2.17 Recognising the discrepancy in reporting, **reasonable assurance** has been determined.

Monitoring and Reporting: Assurance that adequate monitoring / reporting of outputs against plans and agreed fee schedules was demonstrated.

2.18 There had been no change to the monitoring and reporting arrangements as noted in the 2020/21 nVCC: Advisers report. Contract management status remained a standing agenda item at the monthly Project Board meetings; with a full contract management report, detailing expenditure to date and contractual issues for consideration, reported on a quarterly basis.

2.19 Highlight reports were presented at interim meetings.

2.20 Balanced scorecards, to measure contractor performance, and key performance indicators are to be reported on a quarterly basis. At the date of fieldwork, there had been no reporting of such data for the financial year to date (**MA3**). Further, there should be monitoring of the key outputs for each contractor and progress against the same.

2.21 Whilst noting the regularity of contract management reporting, there was an absence of performance monitoring. **Reasonable assurance** has therefore been determined.

Appendix A: Management Action Plan

Matter Arising 1: Contract Documentation (Operation)	**Impact**
Of the four adviser appointments reviewed, the finalisation of the contract documentation (signed by both parties) was completed in a timely manner for two. The remaining two (Specialist Design Adviser and Civil & Structural Engineering adviser) were signed circa 1.5 months after the effective start date of the contract. Whilst this is an improvement on the time period (5 months) reported in the 2020/21 nVCC advisers report, it does achieve the agreed management action of finalising and signing all contract documentation within 30 days by both parties (see **Appendix B**). It was also noted that the agreed contract sum (£88k) for Specialist Design Adviser did not reconcile with that reported to Project Board (£72k). Whilst the contract documentation for the Environmental Architecture and Community Benefits Adviser had been signed by both parties in a timely manner, it was noted that the acceptance letter (to confirm success in the procurement process) had been signed and dated before the date of the evaluation paper (prepared immediately following the procurement review process). Management has acknowledged that this discrepancy is possibly due to an automatic generation of dates when the document is open. Therefore, it is recommended that such functionality is not used for procurement processes / contract documentation due to the importance to maintain a full and detailed audit trail.	Potential risk of: • contractual dispute due to incorrect information recorded; and • the Trust not being afforded the full protection intended by a contractual document.
Recommendations	**Priority**
1.1 The appointment process should be managed to ensure accuracy of the information reported to management i.e. contract value and timing of evaluation / acceptance.	**Medium**

1.2 Contract documentation should be signed in a timely manner and prior to the commencement of works.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Noted. The Project will improve the management of the contractor appointment process by implementing a quality assurance process that signs off contract documentation.	Immediately	Assistant Project Director (Finance & Commercials)
1.2 Noted. The Project has improved processes to improve the timeliness of signing contract documentation to ensure that all documentation is signed within 30 days.	Immediately	Assistant Project Director (Finance & Commercials)

Matter Arising 2: Appointment Process (Operation)		**Impact**
It has been identified, and endorsed, that the nVCC Project needs to procure the relevant specialist technical advisers such as Landscape Architect, Environmental Architect and Community Benefits Adviser, Mechanical & Engineering, Civil & Structural Engineering, Equipment & Healthcare Planning etc. to support the nVCC competitive dialogue process. At the date of fieldwork, the nVCC Project Board (November 2021) reported that the procurement exercises for the Equipment / Healthcare Planner and Overview Technical Advice were due to be completed in October 2021. This completion date was not achieved; yet the competitive dialogue process is currently underway. Both appointments have been identified as required to support the nVCC competitive dialogue process – a process which is currently underway with briefing meetings being held with preferred bidders.		Potential risk of: • inappropriate advice / guidance provided during the competitive dialogue process due to lack of input from specialist advisers; and • the expected advice / guidance not being provided for the whole duration of the competitive dialogue process.
Recommendations		**Priority**
2.1 The procurement exercises, which have been ongoing since April 2021, should be finalised as soon as possible.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 The Project has now concluded all appointments of TA's for the nVCC Project; and appointed Technical Project Manager and Cost Consultants.	Actioned since fieldwork	Assistant Project Director (Finance & Commercials)

Matter Arising 3: Contractor Performance and Key Performance Indicators (Operation)		**Impact**
Balanced scorecards, to measure contractor performance, and key performance indicators are to be reported to the Project Board on a quarterly basis. Review of the papers, and attendance at the November Project Board, confirmed presentation of the Contract Management Report for Q2. The report stated information was provided for each of the contracts including performance and KPIs. However, the only reference provided in the report was to the regularity of the contract management reports – rather than the contractor performance and quarterly KPIs (for longer standing adviser appointments) confirmed as reported to the Project Board (at the date of the last review). There was also no evidence of expected key outputs, by contractor, and monitoring of progress against the same. It is noted that the long-standing adviser is one of the procurement exercises sampled, at this review, which has yet to be finalised.		Potential risk of: • Proactive performance management not taking place. • Poor performance going unaddressed.
Recommendations		**Priority**
3.1 Reporting on contractor performance and Key Performance Indicators should be undertaken in line with expectation.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Noted. The Project will ensure that balanced scorecards for appropriate contractors will be reported to the Project Board on a quarterly basis.	Immediately	Assistant Project Director (Finance & Commercials)

Appendix B: Follow up of previously agreed management actions

Previous matter arising 1: Procurement Route: Single Tender Actions	
Original recommendation and management response	Original priority
Sufficient time should be afforded to following a competitive procurement exercise to ensure value for money can be demonstrated to the Trust. **Management response:** Agreed. The project notes that sufficient time will be provided to ensure, where appropriate, a competitive or appropriate procurement exercise is undertaken so that value for money can be demonstrated by the Trust.	**Medium**
Current findings	**Residual risk**
Review of the latest contract update (as presented to the Project Board) noted that there are two references to single tender actions - advanced site clearance and site security, both for Enabling Works.. In both instances, it has been noted that whilst a tender exercise and mini competition, respectively, were undertaken, no viable responses were received therefore taking the Project Board down the route of single tender action. **Conclusion:** Closed.	N/A

Previous matter arising 2: Letters of intent	
Original recommendation and management response	Original priority
Letters of intent should only be utilised on an exception basis at future appointments to the nVCC. **Management response:** Agreed. The project will only ever utilise a letter of intent in exceptional circumstances and ensures that robust governance is undertaken regarding the use of such a letter.	**Low**
Current findings	**Residual risk**
Review of the latest contract update (as presented to Project Board) and sample testing of contracts let since April 2021, noted no letters of intent have been issued. **Conclusion:** Closed.	N/A

Previous matter arising 3: Contract Documentation	
Original recommendation and management response	Original priority
Contract documentation should be finalised and signed in a timely manner by both parties. **Management response:** Agreed. All contract documentation will be finalised and signed within 30 days by both parties.	**Medium**
Current findings	**Residual risk**
Of the contracts reviewed, one was signed more than 30 days after the contract start date. **Conclusion:** Superseded – see **MA1**	See **MA1**

Previous matter arising 4: Contract documentation	
Original recommendation and management response	Original priority
The contract for the Design: nVCC adviser should be finalised and retained centrally. **Management response:** Agreed. The contract for the Design: nVCC adviser will be finalised and retained centrally.	**Medium**
Current findings	**Residual risk**
The contract for the adviser was signed on 4 May 2021 and has been retained centrally. **Conclusion:** Closed	N/A

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.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Financial Systems
Final Internal Audit Report
February 2022

Velindre University NHS Trust

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Contents

Review reference:	VT-2122-05
Report status:	Draft
Fieldwork commencement:	22nd November 2021
Fieldwork completion:	14th December 2021
Draft report issued:	21st December 2021 / 18th January 2022
Debrief meeting:	10th December 2021 / 12th January 2022
Management response received:	22nd December 2021 / 3rd February 2022
Final report issued:	10th February 2022
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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 Institute of Internal Auditors.

Acknowledgement

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

Executive Summary

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance that core financial systems are operating effectively. We considered the key controls over the following areas:

- non-pay expenditure; and
- fixed assets.

We also followed up on our three 2020/21 high and medium priority matters arising, all of which concerned debt management.

Overview

We have provided **reasonable assurance** over this area.

Whilst we did not identify any significant matters arising, we wish to bring to management's attention the need to:

- investigate late payment of invoices and the resulting late payment fees with NHS Wales Shared Services Partnership (NWSSP) (matter arising 1);
- ensure continued focus on aged Private Patient debt (prior year recommendation 1); and
- identify appropriate action to address aged unallocated and unidentified receipts.

All matters arising identified throughout the audit are detailed in Appendices A and B.

Report Classification

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

Assurance summary[1]

Assurance objectives		Assurance
Non-pay expenditure		
1	Timely and appropriate authorisation of requisitions	Substantial
2	Timely receipting goods and services	Substantial
3	Timely and appropriate invoice approvals	Reasonable
4	Management information – exception reporting	Reasonable
Fixed Assets		
5	Fixed assets register	Substantial
6	Authorisation of additions and disposals	Reasonable
Follow-up of 2021/22 recommendations[2]		
7	Debt Management (follow up)	Reasonable

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

[2] The scope of the follow-up work provides assurance against the implementation of the agreed actions from the high and medium priority actions in the 2020/21 Financial Systems Internal Audit Report. It does not provide assurance against the full scope and objectives of the original audits

1. Introduction

1.1 Our 2021/22 review of Financial Systems sought to provide Velindre University NHS Trust (the Trust) with assurance that core financial systems are operating effectively.

1.2 The 2021/22 review covered:

- non-pay expenditure; and
- fixed assets.

1.3 We also followed up on the high and medium priority prior year recommendations, all of which relate to debt management.

1.4 The key risks considered in this review were:

- non-compliance with appropriate financial control procedures;
- non-compliance with the Public Sector Payment Policy (PSPP) or No PO No Pay Policy;
- misstatement of fixed assets; and
- income due to the Trust may not be received (linked to follow-up work).

2. Detailed Audit Findings

Non-pay expenditure

Audit objective 1: requisitions are appropriately authorised on a timely basis in line with the Authorised Signatory List (ASL)

2.1 iProcurement is the function in the Oracle financial system that is used to electronically approve requisitions through a workflow. When the requisition is raised and approved, the system automatically records a date stamp and the name of the person who carried out the activity. The approval hierarchy is embedded within Oracle.

2.2 Each division has an ASL. We were informed the divisional ASLs are subject to an annual review which usually takes place in February each year (note: this was out of scope for this review, so no testing was undertaken on the annual ASL review).

2.3 We tested a sample of 25 requisitions to ensure they were approved on a timely basis (i.e., prior to goods/services being received) and that the approver in Oracle was on the ASL. We found one retrospective requisition where the requisition was placed after the invoice was received. However, we have not raised a finding regarding this, because there are sufficient detective and monitoring controls in place to ensure retrospective orders are kept to a minimum (see audit objective 4). No further issues were noted in this testing.

Conclusion:

2.4 No matters were identified for reporting in this area. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 2: goods and services received are receipted on a timely basis

2.5 Receipting of goods and services is carried out in Oracle, resulting in an electronic record in the system evidencing the date of receipt and the person who received the items.

2.6 We selected a sample of 25 purchases which were completed in the year to date (April to November 2021) and reviewed the timelines of receipting. We did not identify any matters for reporting.

Conclusion:

2.7 We did not identify any matters for reporting in this area. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 3: invoices are approved on a timely basis in line with the Authorised Signatory list (where purchase orders are not required)

2.8 The All Wales No PO No Pay Policy identifies exceptions where requisitions / purchase orders are not required. This includes pharmacy, NHS organisations, nurse bank agency and utilities and call charges, amongst other items.

2.9 In our sample of 25 such invoices we did not find any issues regarding timeliness of authorisation or in our tracing of the invoice approvers to the ASL.

2.10 Out of the 25 invoices, we identified:

- eleven invoices with a due date of less than 30 days which had not been paid by their due dates; and
- of the eleven, one invoice included a late payment fee for two previous invoices, indicating a potential ongoing issue with late payments – we were informed the fee had been not accounted for as a loss and it was unclear why there was a delay in payment (it was not due to a lack of timeliness in authorisation). See matter arising 1 in Appendix A.

2.11 We also found one invoice that was a proforma invoice for shelving (estimated value £57) against which full payment had been made. We appreciate there may be times when payment of proforma invoices is acceptable (for example, a payment on account relating to an ongoing project). However, this did not appear to be the case for this item. See matter arising 3 in Appendix A.

Conclusion:

2.12 We identified one medium priority matter arising regarding late payment of invoices and a further low priority finding around payment of proforma invoices. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: management information for non-pay expenditure performance is regularly monitored and includes exception reporting such as invoices on hold, retrospective orders, receipts invoiced not booked, etc

2.13 The Finance team reviews exception reports for the following:

- invoices awaiting authorisation – weekly;
- invoices on hold - weekly;
- No PO No Pay – weekly; and
- Retrospective Requisitions – monthly (provided by Procurement Services at NWSSP).

2.14 We reviewed a sample of exception reports (five weeks for the weekly reports and three months for the monthly reports), noting they were available and distributed on a timely basis. We also saw evidence demonstrating actions taken for a sample of line items in the reports.

2.15 We were informed that the exception report review process is undertaken informally by the Finance team. Whilst there is a standing agenda item at the formal monthly finance management meetings which allows for any matters for escalation from these reviews, our review of a sample of three months' meeting minutes showed that no matters had been raised at the meetings.

2.16 However, we noted that the exception reports contained aged items, including items over one year old. For example, the average value of the invoices on hold reports tested was £11.4m, consisting of an average of 234 line items with 28 items over one year old. See matter arising 2 in Appendix A.

Conclusion:

2.17 We identified one medium priority matter arising regarding aged items on the exception reports reviews. Therefore, we have provided **reasonable assurance** over this audit objective.

Fixed Assets

Audit objective 5: the fixed asset register is complete and accurate (physical verification)

Fixed Asset Register

2.18 The Trust uses a system called Real Asset Management (RAM) for its fixed asset register (FAR). Except for Assets Under Construction (AUC, see below), RAM contains all fixed asset details, including depreciation.

2.19 We were informed that RAM is unable to hold information for AUC. Therefore, the Finance Business Partner maintains a separate list for AUC. These assets are input to RAM once construction work is completed.

2.20 We were also informed that, because most additions take place during quarter four, the Finance Business Partner does not input any additions to RAM until this time. Our review of the capital expenditure reports (see below) for 2021/22 to the time of our review identified that the only additions identified were AUC.

2.21 Whilst RAM is not updated until quarter four, all capital expenditure is recorded throughout the year in the Oracle capital ledgers.

2.22 Fixed asset disposals are also not recorded until quarter four (see objective 6 below).

Fixed Asset Reconciliation

2.23 The Financial Control Procedure (FCP) for the Management of Non-Current / Fixed Assets and Maintenance of Asset Register (the Fixed Asset FCP) requires a monthly reconciliation between the fixed asset register (i.e., RAM) and the general ledger. However, because RAM is not updated until later in the year, these monthly reconciliations do not take place until month eight at the earliest. This approach is considered reasonable given the profile and nature of the Trust's capital expenditure, therefore the FCP should be updated to reflect this. See matter arising 4 in Appendix A.

Capital Expenditure Reports

2.24 The Finance Business Partner provides monthly capital expenditure reports to budget holders and scheme leads, requesting these individuals review the reports and respond if any issues are identified.

Asset Physical Verification

2.25 The Trust undertakes an annual physical verification exercise of its fixed assets. We were informed that it aims for a target of 80% coverage (by number of assets) which is accepted by the Audit Wales external audit team. However, the target coverage is not stated in the Fixed Assets FCP. See matter arising 4 in Appendix A.

2.26 The verification process is undertaken over a three-month period, usually ending in December. The 2021/22 process was in progress at the time of our fieldwork.

2.27 Where practical, assets are tagged with barcodes (due to the pandemic we were unable to undertake on site testing to verify this). We understand barcode readers were previously used in the physical verification process. The readers linked into RAM, providing evidence the asset was verified and a corresponding date stamp.

2.28 We were informed that the Trust is in the process of rolling out iPads in place of the barcode readers. However, due to a combination of the pandemic and technical issues with the iPads, an electronic approach to verification was not possible this year. Therefore, the Finance Business Partner sent spreadsheets containing the assets to be verified to the divisions.

2.29 At the time of writing, we were informed that the 2021/22 divisional spreadsheets had been returned and the Finance team was in the process of working through the responses.

2.30 We were informed that the Finance team intends to be in a position to use the electronic process to verify assets next year.

Conclusion:

2.31 We did not identify any significant matters for reporting in this area. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 6: fixed asset additions and disposals are appropriately authorised

Additions

2.32 Additions are approved through formal bids submitted to Welsh Government for major capital schemes and through the Trust's discretionary capital processes for less significant works / additions. The latter includes scrutiny and approval at the divisional then Trust Capital Planning Groups prior to final approval via the Executive Management Team and Board.

2.33 We selected a sample of five Capital Programmes (totalling £6.99m) and agreed the allocation details to the relevant funding letters from Welsh Government. We note that one of the Capital Programmes was NHS transfer from Digital Health and Care Wales (DHCW), and as such, this allocation was not supported by a funding letter. However, we managed to review a confirmation e-mail from the DHCW Finance Manager regarding this case.

2.34 For discretionary capital, we selected a sample of five schemes (totalling £0.6m) from the capital expenditure reports and traced them back to the list approved at Board (as this is a key controls review, no further testing was taken on the discretionary capital bidding process). No exceptions were noted in this testing.

Disposals

2.35 The Fixed Assets FCP requires the divisions to complete and approve forms to inform the Finance team of fixed asset disposals and transfers. However, we identified that these forms are often completed and reported retrospectively when disposals are identified through the annual fixed asset verification process. At the time of our audit, 20 disposals had been identified through the 2021/22 verification exercise.

2.36 We understand some of the 20 may have been identified for disposal rather than already physically disposed of at the time of the verification. However, there is a risk that disposals may not have been appropriately approved and the Trust may not receive value for money from the assets' net residual value. See matter arising 4 in Appendix A.

Conclusion:

2.37 We identified one medium priority matter arising relating to non-compliance with the FCPs for asset disposals. Therefore, we have provided **reasonable assurance** over this area.

Follow-up on prior year recommendations

Audit objective 7: the Trust has taken action to address the high and medium priority recommendations in our 2021/22 Financial Systems

2.38 A summary of progress on the prior year recommendations is detailed in the table below. Full details of our findings and recommendations are included in Appendix B.

Prior year finding	Previous rating	Direction of travel	Current rating
1. Private Patient Debt	High		Medium

Private Patient Services has been an area of focus for the Trust over the previous twelve months and we understand significant work has been undertaken to improve processes in this area. Additionally, the Trust commissioned an independent review, the results of which are due to be circulated shortly, along with an action plan to address the findings.

As this is a follow-up review, our audit focused on our prior year recommendation around aged Private Patient debts. Therefore, we did not audit the wider work undertaken in this area and our conclusion relates solely to aged Private Patient debt.

Action has been taken and is ongoing to address the Private Patient debt balance per our prior year recommendation, resulting in a decrease in the balance over six months old (September 2021: £183,000; September 2020: £207,000). The Private Patient Office has worked through the aged debt balance by year, starting with the oldest. We were informed that, at the time of writing, consideration was now being given to debts from 2020 and 2021.

Recognising the action taken, the position at the time of the audit and the importance of ensuring this work is completed on a timely basis, this recommendation remains **open** with a reduction in the priority

Prior year finding	Previous rating	Direction of travel	Current rating
rating to **medium priority**. Aged Private Patient debts should remain an area of focus until an acceptable position is reached. We have provided recommendations to support this in Appendix B.			
2. Unallocated and Unidentified Receipts	Medium	↑	Medium
The Trust has taken action to clear some of the older balances within the aged unallocated and unidentified receipts balance. However, the overall balance remains largely consistent with the prior year (September 2021: £1.2m; September 2020: £1.4m) and there has been an increase in the balance over one year old (September 2021: £345,000; September 2020: £264,000). We understand that the Trust has prioritised debt recovery over the allocation of aged unallocated / unidentified receipts. The recommendation remains **open** at **medium priority**. We have provided updated recommendations in Appendix B to support the Trust in handling these balances.			
3. Management of Aged Debts	Medium	↑	Low
General Aged Debt: action has been taken resulting in a significant reduction in balances over six months old (September 2021: £1.6m; September 2020: £4.5M) and the Trust recognises further work is required to continue to improve the general aged debt position. Charity Aged Debt: work was ongoing at the time of our audit to clear the aged Marie Curie and Macmillan balances. At December 2021, both balances were significantly improved on the prior year. The Trust acknowledged that further work is required to clear the remaining aged Macmillan balance and that there is room for improvement in the process for handling charity debtors. Based on the action undertaken and improvements made, this recommendation remains **open**, but reduced to **low priority**. We have provided recommendations to support enhancements to the process in Appendix B.			

Conclusion:

2.39 Whilst all three prior year recommendations remain open, action has been taken to address previous matters arising and reduce the related risk. Therefore, we have provided **reasonable assurance** over the follow up of prior year recommendations.

Appendix A: Management Action Plan

Non-pay expenditure	
Matter arising 1: Late payment of invoices (Operation)	**Impact**
In our sample of 25 invoices, we identified eleven with a due date of less than 30 days that had not been paid by their due dates (note: all had been paid within the 30-day PSPP target). For one of the eleven invoices (BT), we identified that it included a late payment fee (£80). The fee was an aggregation of late fees from two previous invoices, potentially indicating an ongoing issue with timely payment of such invoices. We were informed this late fee has not been accounted for as a loss. The Trust authorised the invoice on a timely basis. Therefore, it appears the late payment was due to a delay in processing by NWSSP Accounts Payable. It was not clear why there was a delay in the payment of any of the eleven invoices identified. Our testing on the timely authorisation of non-PO invoices and timely receipt of goods/services did not identify any issues.	Potential risk of: • financial loss; and • incorrect loss accounting and reporting.
Recommendations	**Priority**
1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary; 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

Management response		Target Date	Responsible Officer
1.1	a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Complete	N/a
	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	Financial Planning & Reporting Manager

Matter arising 2: Exception reporting (Operation)	Impact
We reviewed a sample of exception reports (five weeks for weekly report and three months for monthly reports) for non-pay expenditure covering invoices awaiting authorisation, invoices on hold, No PO No Pay and retrospective requisitions. Whilst we saw evidence action is taken to address items on the reports, we noted that they contained aged items, including items over one year old, as summarised in the table below:	Potential risk of: • exceptions not resolved on a timely basis;

	Average number of line items	Average value of reports tested (£'000)	Average number of line items over 365 days	Average Value of line items over 1+ year (£'000)	Date of oldest item
Invoices on hold	234	11,354	28	7,047	31/08/2017
Invoices awaiting authorisation	823	6,276	8	30	05/03/2020
No PO No pay	471	(251)	45	144	20/09/2018
Retrospective requisitions	188	271	N/A	N/A	N/A

There is standing agenda items on the monthly finance management meeting agenda for Procurement and Accounts Payable issues, providing opportunity for the Finance team to raise any significant matters for escalation from the exception reports. However, we found that no matters had been raised in the sample of three months meetings tested.

Recommendations	Priority
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; b. take action to address the aged items on the exception reports; and c. formally monitor progress in clearing aged items at an appropriate forum to ensure action is effectively implemented.	Medium

Management response	Target Date	Responsible Officer
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.	31/03/2022	Financial Planning & Reporting Manager

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	31/03/2022	Financial Planning & Reporting Manger
c.	The recommendation is accepted. This will be added to the standard agenda of the Financial management meeting under PSPP.	31/03/2022	Financial Planning & Reporting Manager

Matter arising 3: Authorisation of proforma invoices (Operation)	Impact
We selected 25 invoices (from the No PO No Pay exceptions list) from the period April to mid-November 2021 and reviewed the related invoices. We found that one was a proforma with an estimated balance of £57 for shelving, against which payment had been made in full. It was not clear: • if a formal invoice had also been received and paid (i.e., a duplicate payment); • if the related goods had been received; and • why the proforma had been approved for payment. Whilst we appreciate there may be times when payment of proforma invoices is acceptable (for example, when it relates to a payment on account relating to an ongoing project), steps should be taken to assure that only valid invoices are paid and not estimates.	Potential risk of: • financial loss through duplicate payments.

Recommendations	Priority
3.1 The Trust should: a. remind its authorised signatories only to approve proforma invoices for payment under appropriate circumstances; and b. consider producing documented guidance on authorisation of proforma invoices. 3.2 The Finance team should investigate the specific circumstances of the exception noted in our testing (details have been provided) to understand: a. whether a duplicate payment has been made; b. whether the goods were received; and c. why the proforma was authorised for payment, liaising with NWSSP Accounts Payable if necessary.	Low

Management response	Target Date	Responsible Officer
3.1 a. The recommendation is accepted. A reminder will be issued to all staff.	28/02/2022	Head of Financial Operations

	b. The recommendation is accepted. Consideration will be given to producing documented guidance on authorisation of proforma invoices.	31/03/2022	Head of Financial Operations
3.2	a. The recommendation is accepted. The item has been investigated and no duplicate payment made.	Completed	Head of Finance Business Partnering
	b. The recommendation is accepted. The item has been investigated and goods received.	Completed	Head of Finance Business Partnering
	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 developed for proforma invoices	Completed	Head of Finance Business Partnering

Fixed Assets

Matter arising 4: Compliance with Fixed Assets FCP (Operating effectiveness)	Impact
The Trust is not complying with some key aspects of the Fixed Assets FCP: **Fixed Asset Disposals** The FCP requires the divisions to complete and approve forms to inform the Finance team of fixed asset disposals and transfers. However, we identified that these forms are often completed and reported retrospectively when disposals and transfers are identified through the annual fixed asset verification process. For example, at the time of our audit, the Finance team had received only a couple of approved disposal forms for 2021/22 to date. However, the verification exercise (ongoing at the time of the audit) identified 20 assets as disposals. We understand some of the 20 may have been identified for disposal rather than physically disposed of at the time of the verification. However, there is a risk that disposals may not have been appropriately approved and the Trust may not receive value for money from these assets' disposals (e.g., their net residual value). **Fixed Asset Register - reconciliations** The FAR is not updated throughout the year, rather, the Finance team updates the FAR in quarter four. We understand this to be due to a combination of technicalities in the system (around Assets Under Construction and indexation) and that most capital additions are not purchased until later in the year. As such, the reconciliation between the FAR and general ledger is not undertaken until month eight onwards (the FCP requires monthly reconciliations). However, we note that additions are recorded via the capital account codes in Oracle and a separate list is maintained to capture Assets Under Construction. Given the mitigating controls (capital account codes and AUC spreadsheets reconciled monthly to general ledger) and the nature of the Trust's capital spending profile, the approach to updating the FAR in quarter four is considered reasonable. **Target Asset Verification Coverage** We were informed that the Trust's target coverage for the annual asset verification is 80%. However, this is not documented in the Fixed Assets FCP. We understand the coverage target is accepted by Audit Wales from an external audit perspective.	Potential risk of: • misappropriation of assets; and • not achieving value for money in asset disposals.

Recommendations	Priority
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. 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%. b. The Audit Committee should approve the updated FCP.	Medium

Management response	Target Date	Responsible Officer
4.1 The recommendation is accepted. Reminders will be provided at the Capital Planning Group and Divisional Business Planning Group meetings.	28/02/2022	Financial Planning & reporting Manager
4.2 a. The recommendation is accepted and the FCP will be updated.	28/02/2022	Financial Planning & reporting Manager
b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee. .	31/05/2022	Financial Planning & reporting Manager

Appendix B: Progress on 2020/21 financial systems recommendations

Previous Matter arising 1: Pursuance of Private Patient (PP) debts (Operating effectiveness)	
Original recommendation and management response	Original priority
Private Patients Office must implement a formal action plan to chase up aged Private Patients invoices which is subject to regular monitoring. **Management response:** The recommendation is accepted. The Head of Out-Patient, Medical Records & Private Patient Services and Private Patients Manager are in the process of agreeing an action plan. This will be in place by 15/02/2021. *Head of Out-Patient, Medical Records & Private Patient Services, 15/02/2021*	High
Current findings	**Residual risk**
Private Patient Services has been an area of focus for the Trust over the past twelve months. We were informed significant work has been undertaken to improve processes in this area, including improvements in the invoicing / billing process and recruitment to a permanent post focusing on invoicing and debt management. Additionally, a separate independent review of the Trust's Private Patient Services has been undertaken. We understand that the final report is due to be circulated shortly and that the Trust is developing an action plan to address the findings of the independent consultant. The scope of our audit was to follow up on our prior year recommendation regarding aged Private Patient debt. Therefore, we have not audited or reviewed the wider work undertaken by the Private Patient Office. Accordingly, our findings and conclusion relate solely to aged Private Patient debt. We plan to undertake a wider review of Private Patient Services as part of our 2022/23 Internal Audit Plan. As per our previous year recommendation, the Private Patient Office developed an action plan to address aged Private Patient debts. We were informed the action plan was subject to monitoring through monthly meetings with the Finance team (no formal actions or minutes were maintained for these meetings). At the time of our audit, the Private Patient Office had identified all actions in the Private Patient debt action plan as being completed and closed. From our review of the action plan, the action taken includes:	Income due to the Trust may not be received. Ineffective use of staff time throughout the need to consistently chasing older debts.

- re-contacting individuals and insurers to chase debts;
- weekly reporting to the Head of Service on aged debts, monthly meetings with the Private Patient Manager and Finance team, and monthly updates to the Velindre Cancer Centre Senior Leadership Team;
- review of SLAs to assess the likelihood of recouping aged debt;
- review of the Private Patient Standard Operating Procedures for debt collection;
- training provided to the Private Patient Administrator; and
- reviewing options for automation within the debt collection process.

Due to concerns regarding aged Private Patient debts, the Independent Members requested this be added as a standing item on the Audit Committee agenda and were expecting written reports to be brought to the Committee meetings. However, whilst a written update report was presented to the July 2021 meeting, the October 2021 meeting only received a verbal update and Private Patient debt was not on the January 2022 agenda (although we note discussions were held due to there being an open action on the action log and Private Patient debt written off in the losses and special payments report). Audit Committee members remain concerned about Private Patient debt.

We undertook a review of the Private Patients aged debt to assess the effectiveness of the actions taken by the Private Patients Office:

£'000	Sep-21	Sep-20	Movement	Comment
Total debt	473	335	138	We were informed the increased total debt is predominantly due to increased activity (from the return to "normal" services in the pandemic) and more proactive billing (i.e., billing on a more timely basis with more detailed descriptions on the invoices to support debt collection). We understand that the Trust sees this increase as a positive step forward.
Debt greater than six months	183	207	(24)	Due to the actions taken by the Private Patients Office to address aged balances. We understand the Private Patients Office has worked through the aged debt by year, starting with the oldest. At the time of writing, we were informed it is now focusing on debts from 2020 and 2021, with a target for clearance of eight weeks.
Debt 31-180 days	130	65	65	We understand the increase in this balance is due to the increase in activity. We were informed that focus has been given to clearing the aged debt balance and that, once the work is complete on this, the Private Patients Office will ensure focus remains on collection of current balances.

Conclusion:

We acknowledge that significant work has been carried out in Private Patients Services beyond our prior year recommendation. These actions may positively impact upon the aged debt balance. However, it is too soon to see the impact and auditing these actions fell outside of the scope of this review.

Action has been taken to address the aged Private Patient debt balance per our prior year recommendation and work continues in this area. Recognising the position at the time of the audit and the importance of ensuring this work is completed on a timely basis, the recommendation remains **open** with a reduction in the priority rating to **medium**.

Recommendations	Revised Priority
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. 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

Management response	Target Date	Responsible Officer
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.	31 March 2022	Head of Outpatient, Medical Records and Private Patient Services

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.	30 April 2022	Head of Outpatient, Medical Records and Private Patient Services

Previous matter arising 2: Unallocated and Unidentified Receipts (Operating effectiveness)	
Original recommendation and management response	Original priority
The Corporate Finance team should regularly liaise with Finance Divisional Leads and Budget Holders ensuring regular monitoring and action planning in respect of unallocated and unidentified receipts. **Management response:** Unallocated and unidentified receipts are those received by the Trust that cannot be readily allocated to a specific invoice or debtor account. Work continues, acknowledging there is no financial risk to the Trust. The recommendation is however accepted. The Accounts Receivable Financial Control Procedure described action to be taken in this area and that will be reviewed and amended as required. *Head of Financial Operations, 31/03/21*	Medium

Current findings	Residual risk
We were informed that work has been undertaken to address the unallocated and unidentified receipts balance, including: • monthly discussions between the Finance team and divisional finance leads on specific aged balances; • review or development of related FCPs: – we understand the Accounts Receivable FCP was reviewed, but no changes were considered necessary; and – to strengthen its debt management processes, the Private Patient Office developed its own Standard Operating Procedure (SOP) for unallocated and unidentified receipts. Note: this SOP has not been subject to formal Audit Committee approval (as a finance process, the Standing Orders require approval at Audit Committee). Additionally, we understand recruitment is underway to fill two of the three debt management posts that have been covered by agency staff for the past six years. We undertook a high-level review of the Accounts Receivable FCP and Private Patient Office SOP and did not identify any issues with the design of the process relating to unallocated and unidentified receipts.	Inaccuracies in or skewing of the aged debt profile. Inefficiencies in the recovery of aged debts. Potentially unsustainable action in the management and reduction of aged unallocated and unidentified receipts. Potential fraud risk if the Trust fails to identify payments received in error.

We undertook a review of the aged unallocated/unidentified receipts balances to assess the effectiveness of the actions taken:

£'000	Sep-21	Sep-20	Movement	Comment
Total balance[3]	1,206	1,371	(165)	Whilst there has been a reduction in the total balance, balances over one and six years have increased since the prior year. We were informed some older aged balances have been cleared, but that the Finance team prioritises debt recovery over the aged unallocated/unidentified receipt balances. We understand that the Trust has tried to use agency staff to focus on addressing these balances, but that this was unsuccessful.
Balance over one year old	345	264	81	
Balance over six years old	94	17	77	

We recognise the value of current ('in month') receipts can fluctuate significantly due to large receipts received very close to month end which are not allocated at the time the monthly report is produced; our review of the current monthly balance evidenced larger current items are being matched. Our discussions with the Head of Financial Operations highlighted, that processes are in place to manage the current unallocated/unidentified receipts balance, including proactively sending back payments that can't be allocated (where possible) and inclusion of unallocated balances on debtor statements sent to all debtors. As this is a follow-up review, we did not undertake any testing on these processes.

The Head of Finance Business Partnering acknowledged that a formal reconciliation of the Long Term Agreement (LTA) cash receipts could be undertaken more frequently (for example, monthly rather than the current periodic review) to ensure the aged balances do not build up again. The unallocated and unidentified receipts contain large value payments in respect of LTA's, which are routinely reviewed each month for allocation to the LTA, and subject to the full LTA reconciliation against specific categories of service provision.

Conclusion:

We acknowledge that action has been taken to address some of the older unallocated or unidentified receipts. However, the overall position remains consistent with the prior year and action is required to address the aged unallocated/unidentified receipts balance. Therefore, this matter arising remains **open** at **medium priority**.

Recommendations	Revised Priority
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	Medium

[3] We note that these balances are accounted for separately from the debtors ledger, therefore may net off against some of the aged debt identified in previous findings 1 and 3.

ii. based on the above discussions, take appropriate action to address the aged unallocated/unidentified receipts balance.

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.

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).

Management response	Target Date	Responsible Officer
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.	30/06/2022	Head of Financial Operations
b. The recommendation is accepted. Monthly reconciliations of LTA money due and received are now standard practice.	Completed	Head of Finance Business Partnering
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.	30/04/2022	Head of Outpatients, Medical Records and Private Patient Services

Previous matter arising 3: Management of Aged Debts (Operating effectiveness)	
Original recommendation and management response	Original priority
a. **General aged debt:** The Corporate Finance team should regularly liaise in a formal capacity with Finance Divisional Leads and all staff that are the leads for chasing specific debt categories to monitor and produce action plans to recover aged debts and consider agreeing an approach going forward for future invoices raised that will hopefully minimise queries / delays in payments. b. **Aged charity debt:** Marie Curie and Macmillan debtor balances must be subject to regular monitoring and formally documented action plans should be in place to chase up outstanding balances and ensure payment of invoices. **Management response:** a. **General aged debt:** The first recommendation is accepted. The Accounts Receivable Financial Control Procedure described action to be taken to engage with finance divisional leads and other staff involved in recovery of debts, and that will be reviewed and amended as required to fulfil the requirements of this recommendation. *Head of Financial Operations, 31/03/2021* b. **Aged charity debt:** The second recommendation is also accepted. Regular monitoring and formally documented action plans will be out in place to chase up and ensure payment of invoices. *Head of Finance Business Partnering & Head of Financial Operations, 28/02/2021*	Medium
Current findings	**Residual risk**
General Aged Debt We understand that the Corporate Finance team now meets monthly with Finance Divisional Leads and all staff responsible for chasing specific debt categories to monitor aged debt. Whilst these minutes are not formally minuted, actions are noted against the monthly aged debt reports. We undertook a review of the non-NHS Wales aged debt to assess the effectiveness of the action taken:	Income due to the Trust may not be received. Inefficiencies in non-NHS charity debt management.

£'000	Sep-21	Sep-20	Movement	Comment
Total debt	42,000	45,000	(3,000)	Similar level to prior year.
Debt greater than six months	1,600	4,500	(2,900)	The decrease demonstrates the work undertaken by the Finance team to address aged debt balances.
Debt 91-180 days[4]	800	527	273	Increased on prior year. However, we were informed that the work is ongoing to continue to improve the ageing profile of debts.

Charity Aged Debt – Marie Curie and Macmillan

The Finance team developed an action plan for the reduction of aged Macmillan and Marie Curie debt balances in March 2021 with a completion deadline of end of September 2021. We were informed this was monitored informally within the Finance team and actions were completed in line with the plan.

Work was ongoing to clear the aged Marie Curie and Macmillan balances at the time of our audit. This work involved investigating balances to match to invoices and follow-up on unbilled balances with the charities. As at the beginning of December 2021, information provided by the Finance team showed:

- Macmillan (September 2020 balance: £116,700): 70% of the aged balance from the prior year audit had been cleared and action is being taken to address the remaining 30%. After the most recent allocations review (undertaken in November 2021) only 4 items over one year old remain unresolved. A total of 47 items were outstanding at this point, down from 155 in the previous year; and
- Marie Curie (September 2020 balance: £76,600): all aged balances over six months have been cleared and action is ongoing to ensure current balances are matched and collected.

Discussions with the team identified that these balances are difficult to manage due to the complexities of the process required by the charities to "prove" the income is owed to the Trust and match payments to invoices. The Head of Finance Business Partnering acknowledged that action is required to ensure these balances remain controlled and there is room for improvement in the process for handling charity debtors. We have provided further recommendations below.

Conclusion:

Work has been carried out to collect aged debts and to clear the non-NHS charity debt balances (specifically for Marie Curie and Macmillan), with significant improvements seen in these balances. Recognising the continued ongoing work to further improve general aged debts and the need to ensure charity debts remain controlled, the matter arising remains **open**, but reduced to **low priority**.

[4] Balances adjusted to remove stock invoices payable to NWSSP by other NHS Wales organisations which are managed through the Welsh Government arbitration process. The actual balances are: September 2021 £2.1m (£1.3m of NWSSP stock invoices) vs September 2020 £688,000 (£161,000 of NWSSP stock invoices).

Recommendations	Priority
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; 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

Management response	Target Date	Responsible Officer
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	31/03/2022	Head of Finance Business Partnering
b. The recommendation is accepted. Consideration will be given to identifying and monitoring formal key performance indicators with clear targets for general debts.	31/03/2022	Head of Financial Operations

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. **Follow up:** All recommendations implemented and operating as expected.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Scrutiny of Expenditure over Chief Executive's Limit

Final Internal Audit Report

April 2022

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

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Review reference:	VEL-2122-07
Report status:	Final
Fieldwork commencement:	9th February 2022
Fieldwork completion:	3rd March 2022
Draft report issued:	4th March 2022
Debrief meeting:	8th March 2022
Management response received:	4th April 2022
Final report issued:	7th April 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Emma Rees, Interim Deputy Head of Internal Audit Krisztina Kozlovszky, Principal Auditor
Executive sign-off:	Matthew Bunce, Director of Finance
Distribution:	Lauren Fear, Director of Corporate Governance & Chief of Staff Emma Stephens, Head 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 Institute of Internal Auditors.

Acknowledgement

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

Executive Summary

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance that the newly implemented scrutiny process for expenditure over the Chief Executive's limit is operating effectively.

Overview

In July 2021, the Trust implemented a new process for formally scrutinising expenditure over the Chief Executive's limit (currently £100,000) prior to Board submission which has actively continued to be strengthened and built upon throughout the year via effective engagement with key leads throughout the Trust. This has resulted in an improvement in the quality of proposal documentation submitted to the Board for approval.

We have provided **reasonable assurance** over the audited areas.

Whilst we did not identify any significant matters arising, we wish to bring to management's attention the need to continue to:

- actively review and develop the guidance on how to complete proposal documentation to enhance the quality and consistency of proposals; and
- strengthen the evidence of pre-Board scrutiny undertaken including, meeting minutes and developing clear guidance for divisional 'out of committee' approvals.

We also recommend that the Trust shares the learning identified in this audit with those responsible for completing and scrutinising proposals via the established mechanisms for regular and ongoing engagement with service leads in place.

All matters arising identified throughout the audit are detailed in Appendix A.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Documentation of proposals for expenditure above £100,000	Reasonable
2	Scrutiny prior to Board Approval	Reasonable
3	Review and monitoring of approved proposals	Substantial

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

1. Introduction

1.1 Our review of 'Scrutiny of Expenditure over Chief Executive's Limit' was undertaken in accordance with the 2021/22 Audit Plan, approved by the Audit Committee in March 2021.

1.2 The Chief Executive is responsible for the overall performance of the executive functions of Velindre University NHS Trust (the Trust). The current authorisation limit for the Chief Executive is set at £100,000. Any revenue / capital spending above this limit is subject to Board approval.

1.3 In July 2021, a new process was implemented for expenditure over the Chief Executive's Limit (£100,000) to enhance the scrutiny of such expenditure prior to presentation to the Board for approval, and to support the Board in decision-making.

1.4 As part of this new approach, the reporting template to the Board has been significantly revised to require more comprehensive detailed information to support the Board in its decision-making process, together with the introduction of a formalised pre-Board scrutiny process that did not exist previously.

1.5 This has strengthened the governance and system of internal control for expenditure and resulted in an improvement in the quality of proposal documentation submitted to Board for approval.

1.6 Our assessment took into consideration:

- the Trust's work on the development of the new process for expenditure over the Chief Executive's limit (£100,000); and
- the impact of the Covid-19 pandemic.

1.7 The key risks considered on this review were:

- inadequate scrutiny and approval of expenditure above the Chief Executive's Limit (£100,000);
- failure to implement the Trust's Strategic objectives; and
- increased financial costs or reputational damage.

1.8 The audit excluded:

- scrutiny of expenditure below the Chief Executive's approval limit;
- proposals for expenditure above £100,000 which are currently under development and, as such, have yet to be scrutinised and approved;
- the business proposal for the new Velindre Cancer Centre – as this was subject to review in our 2020/21 Integrated Audit Programme; and
- proposals for expenditure above £100,000 which pre-date the new Trust process.

2. Detailed Audit Findings

Audit objective 1: proposals for expenditure above the Chief Executive's Limit (£100,000) are formally documented using the Trust's standard template

2.1 In July 2021, a new process was implemented for expenditure over the Chief Executive's limit (i.e., expenditure over £100,000). This was developed in conjunction with the relevant service leads to support its effective implementation, raise awareness to promote learning and ongoing cascade training as required. Throughout the implementation, the Trust has assessed how the new process works in practice through continued collaborative engagement with the relevant service leads. This has allowed for additional streamlining and refining to support the decision-making process.

2.2 By the time of our audit (February 2022), 22 proposals had been approved by the Board under the new process.

2.3 This new process requires that a proposal is scrutinised via defined routes (dependent on the nature of the expenditure) prior to Board submission and that the information about the proposal submitted to the Board is consistent across all proposals. We were able to confirm that there is a template in place to ensure consistency of reporting. See Audit Objective 2 for details of the pre-Board scrutiny element of the process.

2.4 We reviewed the proforma and noted that it includes ten distinct elements, supported by guidance notes. We analysed these elements in line with their related guidance notes and found that the guidance in some areas could be further developed to continue to enhance the support provided on how to fill in the template.

Template sections	Guidance may benefit from further enhancement
1. Description of goods / services / works	No
2. Strategic Fit	No
3. Options considered	**Yes**
4. Benefits	**Yes**
5. Risks & Mitigation	**Yes**
6. Procurement Route	**Yes**
7. Financial Analysis	No
8. Project Management	**Yes**
9. Director / Sponsor declaration of compliance	No
10. Approvals	**Yes**

2.5 We selected a sample of five proposals approved by the Board under the new process in 2021/22, and note that the quality of the proposals varied, despite all being presented in the same format. We found variation of quality in the following sections of the form:

- consideration and presentation of options;

- risks descriptions;
- benefits identification, realisation and measurement;
- support to preferred option; and
- number and level of approvals documented on the form (note: our testing on approvals for the sample of five showed that all had been approved via an appropriate route, it was just not always documented on the form and, therefore, not clear for the Executive Management Board (EMB) and Trust Board that appropriate scrutiny had taken place).

2.6 We note that the sections with varying quality align to the areas of guidance that would benefit from further enhancement. See matter arising 1 in Appendix A.

2.7 Furthermore, we found that all five proposals sampled were made in relation to a reactive need (e.g., a contract expired, or machines reached the end of their useful life / broken down etc) rather than proactive planning. We were informed that this mainly happened because of a lack of resources due to the pandemic and limited procurement capacity at the time to facilitate a clear view of pipeline of contracts. It is expected that going forward, the mix of the proposals will change. Whilst we understand that there were mitigating factors for the more reactive decisions at the time, it would make sense to monitor this area and ensure decision-making is as proactive as possible in the future. See matter arising 1 in Appendix A.

Conclusion:

2.8 We identified one medium and one low priority matters arising regarding strengthening the proposal guidance and monitoring the proposals. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: effective scrutiny of such proposals is evidenced prior to submission to the Board

2.9 The proposals are required to be approved using a 'three stage gate forum' model prior to their Board submission. These approvals include the following:

- Head of Procurement;
- Director / Sponsor;
- Divisional approvals through three stage gate forums, i.e.:
  - Business Planning Group or local equivalent;
  - Divisional Senior Management Team; and
  - Executive Management Board.

2.10 Per discussions with the Head of Corporate Governance, we were informed that the forums are required to review and scrutinise all aspects of the proposals.

However, this is not documented in the guidance. See matter arising 2 in Appendix A.

2.11 We selected five approved proposals and reviewed evidence of scrutiny and approval prior to their Board submission. All proposals tested had been approved via an appropriate scrutiny route, although we note that the scrutiny route for proposals submitted by corporate departments (rather than divisional proposals) is not specified by the proposal guidance documentation. See matter arising 2 in Appendix A.

2.12 We reviewed meeting minutes and out of committee correspondence from the 'three stage gate forums' where the sampled proposals were approved and found that evidence to support the scrutiny of the proposals could be strengthened.

2.13 In most cases, the minutes only included references that the proposals were approved rather than any evidence that the proposals were challenged and discussed. However, we were informed that in some instances, the approving body was content with the quality and information provided and thus this explained why there was no evidence for active discussion / challenge in the meeting minutes.

2.14 In the cases of the out of committee approvals (two of the five tested), we found that proposals were approved through email correspondence. However, this did not include responses from all members of the forums and did not provide sufficient evidence of the scrutiny that was undertaken.

2.15 Whilst we appreciate the need for fast-track 'out of committee' approvals in certain circumstances, we also note that the current guidance does not make a reference to the divisional out of committee approval process. See matter arising 2 in Appendix A.

Conclusion:

2.16 We identified one medium priority matter arising regarding improving evidence of scrutiny undertaken. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: approved proposals for expenditure above £100,000 are subject to on-going review and monitoring at an appropriate forum within the Trust.

2.17 We were informed by the Head of Corporate Governance that each project is subject to divisional governance and monitoring arrangements. This ensures that monitoring arrangements are aligned with the specific needs of each proposal and issues are only escalated when appropriate.

2.18 We note that from our sample of five proposals, four were in the process of being implemented at the time of our audit and one had not commenced. Of the four being implemented, all were subject to formal monitoring appropriate to the nature of the proposal. However, we note that the intended post-approval monitoring

mechanisms were not defined in the proposal documents upfront. We also found that the current guidance only refers to the approval process and does not cover post-approval monitoring. See matter arising 1 in Appendix A.

2.19 While we found no issues with the current level of monitoring in relation to our audit sample, we note that some of the reviewed proposals were only recently approved and launched. As such, the assurance provided in this area is limited to the short timeframe in which monitoring activity has been undertaken.

Conclusion:

2.20 We identified one low priority matter arising regarding developing guidance on including intended post-approval monitoring mechanisms in proposal documents. Therefore, we have provided **substantial assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Proposals Documentation (Design and Operation)	Impact
a. Proposal template and related guidance (Design) A template with ten distinct sections is in place for proposals of expenditure over £100,000. We reviewed each element of the template in conjunction with the related guidance notes. We found that in five out of ten areas the guidance notes could be further developed to provide enhanced guidance on how to fill in the template. We also noted that it was in these five areas where completion of the proposal forms tested varied in quality (see point b below). These areas for further enhancement are:	Potential risk of: • inadequate information or inconsistency of information quality in proposals; • inability to effectively scrutinise proposals.

Options considered (Section 3)	The minimum number of options were not defined in the guidance (e.g., "do nothing" is an option and should be included in the analysis). There were also no requirements to present the options in a structured way and perform any scoring analysis on them.
Benefits (Section 4)	The subheadings in this section made a reference to a split view between quantifiable and non-quantifiable benefits. However, no examples were provided to support them. Furthermore, both the template and the guidance required a list of benefits for the preferred option only and there were no references to include how benefits would be measured.
Risks and Mitigation (Section 5)	This section requires making a reference to risks and related mitigation in case the proposal is not approved (e.g., "do nothing option"). As such, it ignores risks associated with the remaining options. Furthermore, there is no requirement to perform a risk analysis or categorise the related risk (e.g., low / medium / high level).
Procurement route (Section 6)	While the guidance specifically states that some parts of this section must be completed in collaboration with the Procurement team, the guidance does not provide any explanation regarding the potential procurement routes suggested by the template and the level of detail required here.
Project Management (Section 8)	This section does not include guidance defining the requirement to identify the project management approach, including proportionate mechanisms for monitoring proposal implementation.
Approvals (Section 10)	The template is structured for three divisional sign offs (these include 1. Business Planning Group or local equivalent 2. Divisional Senior Management Team and 3. Executive Senior Management Board). However, the guidance does not specify whether all three sign offs are mandatory. It also does not specify the scrutiny route for proposals from corporate (as opposed to divisional) teams.

b. Proposals (Operation)

In our sample of five proposals, we found that all proposals were prepared using the approved template format. Therefore, information was reported to the Board in a consistent format.

However, we found that the quality of the information included in the proposals varied, particularly in the following areas:

- the different options for consideration were not structured (e.g., the options were not numbered or clearly separated from each other). In one case, a "do nothing" option was not documented. In two other cases, the number of options were limited to two options, and this included the "do nothing" option.
- some of the risk descriptions were vague and did not include any "uncertainty element" or reference to a "possibility of event". In addition, risks were not categorised / scored to clarify the level of risk to the Trust;
- how benefits would be measured was not defined in any of the reviewed proposals;
- there was no, or only limited analysis in relation to the preferred option. In most cases, risks and benefits, included in the proposals, were related to the preferred option only;
- the "project management" field was left blank or was not filled with quality information, including proportionate mechanisms for monitoring implementation (note: we did not identify any matters for reporting in our testing on post-approval monitoring); and

  the procurement section contains two elements, a 'tick box' section identifying the procurement route and a free text section to elaborate on the procurement strategy – in the sampled proposals, the latter element often just repeated what was in the tick box section, rather than providing further details. Whilst this may be appropriate in some cases (e.g., if a full tender exercise were intended), further justification would be beneficial if a less preferred route (e.g., Single Tender Action) was intended.

We note that the above areas of inconsistency are in areas where we identified the need further enhancement in the guidance.

We also found that all selected proposals were made in relation to a reactive need (e.g. a contract expired, or a machine reached its useful life spam / broken down etc) rather than proactive planning. We were informed that this mainly happened because of a lack of resources due to the pandemic and limited procurement capacity at the time to facilitate a clear view of pipeline of contracts. It is expected that going forward, the mix of the proposals will change. Whilst we understand that there were mitigating factors for the more reactive decisions at the time, it would make sense to monitor this area and ensure decision-making is as proactive as possible in the future.

Recommendations	Priority
1.1 a. The Trust should enhance the user guidance for the proposal forms, including, but not limited to the following: • determine the minimum number of options that should be included in a proposal (including "do nothing option"); • additional guidance on: - risk identification and analysis; - benefits identification and measurements; • the requirement to provide supporting justification for the procurement route, particularly if a less preferred option (e.g., Single Tender Action) is proposed; • clarify the approval route for proposals submitted by corporate (as opposed to divisional) teams; b. The Trust should share the learning identified throughout this audit with those responsible for completing and scrutinising proposals via the established mechanisms for regular and ongoing engagement with service leads in place	Medium
1.2 Furthermore, we suggest that all proposal documentation should include details of future monitoring to be completed at a divisional level.	Low
1.3 The Trust should consider maintaining a register of proposals for expenditure above £100,000 to monitor the type of proposals being made (e.g., proactive / reactive proposals, what areas they relate to etc…). This will enable the Trust to identify any trends / recurring issues and take appropriate proactive action to address them.	Low

Management response	Target Date	Responsible Officer
1.1a The guidance will be enhanced further to: - specify the minimum number of options required inclusive of the 'do-nothing' option - provide additional guidance / expectations on risk identification and analysis - include the requirement to provide supporting justification of the procurement route - clarify the corporate approval routes.	31/05/2022	Head of Corporate Governance

Management response (continued)	Target Date	Responsible Officer
1.1b Management has already shared the high-level findings with the key service leads to support continued development and enhancement of the process. This will be disseminated further through the established local mechanisms once the final report is confirmed.	Complete	
1.2 The guidance will be enhanced to require details of any planned future monitoring arrangements proportionate to the scheme proposal.	31/05/2022	Head of Corporate Governance
1.3 Management will consider the development of register of proposals to support future monitoring of expenditure.	31/05/2022	Head of Corporate Governance

Matter arising 2: Pre-Board Scrutiny Evidence (Design)	Impact
The proposals are required to be approved using a 'three stage gate forum' model prior to their Board submission. Per discussion with Head of Corporate Governance, we were informed that the forums are required to review and scrutinise all aspects of the proposals. However, this is not documented in the guidance. We reviewed meeting minutes and out of committee correspondence from the 'three stage gate forums' where the sampled proposals were approved and found that evidence to support the scrutiny of the proposals could be improved. In most cases, the minutes only included references that the proposals were approved rather than any evidence that the proposals were challenged and discussed. In addition, some of the evidence stated "noted" instead of "approved". In the case of the out of committee approvals (two out of five of our sample proposals), we found that proposals were approved through email correspondence. However, this did not include responses from all members of the forums and did not provide sufficient evidence of the scrutiny undertaken. Whilst we appreciate the need for fast track 'out of committee' approvals in certain cases, we also note that the current guidance does not make a reference to an out of committee approval process.	Potential risk of: • inability to demonstrate effective scrutiny prior to Board approval;
Recommendations	**Priority**
2.1 We recommend that: a. the proposal guidance should reinforce the need to fully complete all sections of the proposal prior to submission to EMB and Trust Board; b. the scrutiny role and responsibilities of the forums should be clearly defined in the proposal guidance, including that the scrutiny process should assess the quality of information against the guidance requirements; c. meeting minutes (or equivalent) should clearly demonstrate that scrutiny and discussions were undertaken over each proposal; d. the proposal guidance should include the process for fast-track approval (e.g., an out of committee approval) and the supporting audit trail required to evidence scrutiny and approval of such proposals. The proposal documentation should also be clear that an out of committee approval approach was used.	Medium

	Management response	Target Date	Responsible Officer
2.1	a. The guidance will be enhanced further to reinforce the need to fully complete all sections of the proposal prior to the submission to EMB and Trust Board. This is supported by feedback and engagement with service leads that has already taken place on a regular basis since the new scrutiny process was established to support its continued development.	31/05/2022	Head of Corporate Governance
	b. The guidance will be enhanced further to outline the scrutiny role and responsibilities of the assessing forums i.e. they are required to review all aspects of the form for completeness, accuracy and quality of information provided.	31/05/2022	Head of Corporate Governance
	c. Separate guidance / information will be provided to the relevant meeting secretariat within the divisions to specify the exact requirements and expectations for documenting any discussion and scrutiny applied of the scheme proposals. This is already in place for corporate services.	31/05/2022	Head of Corporate Governance
	d. The guidance will be enhanced to include reference to the agreed out of committee approval process / arrangements in place.	31/05/2022	Head of Corporate Governance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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DBS Checks
Final Internal Audit Report
April 2022

Velindre University NHS Trust

GIG CYMRU NHS WALES
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Review reference:	VEL-2122-03
Report status:	Final
Fieldwork commencement:	21st January 2022
Fieldwork completion:	25th March 2022
Draft report issued:	1st April 2022
Debrief meeting:	5th April 2022
Management response received:	12th April 2022
Final report issued:	14th April 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Emma Rees, Interim Deputy Head of Internal Audit Krisztina Kozlovszky, Principal Auditor
Executive sign-off:	Sarah Morley, Director of OD and Workforce
Distribution:	Amanda Jenkins, Head of Workforce Nicola Williams, Director of Nursing, AHP's and Health 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 Institute of Internal Auditors.

Acknowledgement

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

Executive Summary

Purpose

To ensure the Trust has appropriate arrangements in place in relation to Disclosure and Barring Service (DBS) checks and that national DBS standards / requirements are complied with.

Overview

We have provided **reasonable assurance** over this area.

We wish to bring the following matters arising to management's attention:

- the need to implement robust mechanisms to ensure the accuracy of DBS check requirements in job descriptions (to ensure the DBS checks carried out on successful candidates are appropriate); and
- the need to develop a written policy on the correct handling and safekeeping of DBS certificate information (to ensure compliance with the DBS Code of Practice) and provide guidance to Trust staff on the recruitment process (including DBS checks).

All matters arising identified throughout the audit relating to the audit scope are detailed in Appendix A.

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	DBS check requirements are determined and advertised	Reasonable
2	DBS checks for new employees	Reasonable
3	Adherence to data protection requirements	Reasonable
4	Monitoring of DBS-related actions arising from the HIW report	Reasonable
5	Review of DBS checks for existing staff	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Job Descriptions	1	Design	Medium
2	Trust Recruitment and DBS Policy / Procedure	2, 3, 4	Design	Medium

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

Note:

During the audit, we identified the following matter and raised it with the with the Executive Director of Nursing, AHP & Health Science:

We found that management could not locate the Trust's original baseline review against the 22 non-DBS related recommendations included in the Healthcare Inspectorate Wales (HIW) January 2019 report (the HIW report) into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. Additionally, we noted that the baseline review had not been reported to any forum within the Trust, and it appears no formal monitoring has taken place to ensure actions to address the recommendations were completed. This is detailed further in paragraphs 44-45 of section 2.

As it is outside the scope of this audit, it does not impact upon the assurance rating, and we have not raised a matter arising in Appendix A.

1. Introduction

1.1 The Disclosure and Barring Service (DBS) is an executive non-departmental public body, sponsored by the Home Office. The service is responsible for the processing and issuing of DBS checks on people based on request.

1.2 A DBS check is an official record stating a person's criminal convictions, which helps employers make safer recruitment decisions and prevents unsuitable individuals from working with vulnerable groups, including children. As an employer, it is illegal to request DBS checks for any role that does not require one.

1.3 Organisations who employ people in occupations that are eligible to ask an exempted question as part of the Rehabilitation of Offenders Act 1974 may be held legally liable for safeguarding issues that arise if appropriate check for the role are not undertaken.

1.4 It is the Trust's responsibility to identify which posts require DBS checks, in line with guidance from NHS Employers. Staff should not start work in a role that has been identified as having a DBS requirement unless confirmation of a DBS check has been received.

1.5 Responsibility for checking DBS certificates for new staff falls is as follows:

- to the NHS Wales Shared Services Partnership (NWSSP) Recruitment Services team where NWSSP administers the recruitment process – for ease, we refer to this as 'general recruitment' throughout the report. This is the most frequently used approach to recruitment within the Trust; and
- to the Trust where NWSSP is not involved in the recruitment process – this is referred to as 'direct recruitment' / 'direct hire'. It is the approach taken for some medical staff and was also used during April-May 2021 for recruitment to Covid-19 recovery posts.

1.6 Following the Healthcare Inspectorate Wales (HIW) January 2019 report (the HIW report) into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W, the Trust's Safeguarding & Public Protection Management Group commissioned a high-level baseline review of the Trust's systems regarding DBS checks. It was identified that further assurance and actions were required. This included a review of existing staff to ensure appropriate levels of DBS checks had been undertaken. We were informed that this review was largely complete at the time of planning our review.

Associated risks

1.7 The key risks considered in this review were:

- potential patient or donor harm;
- inappropriate storage of personal data; and

- potential reputational damage.

Limitations of scope

1.7 The audit excluded:

- DBS check activities undertaken by NWSSP Recruitment Services (we tested the confirmation received by the Trust from NWSSP that these checks had been undertaken);
- the wider recruitment process, including checks on rights to work in the UK;
- review of the registration process and payments for DBS checks; and
- DBS checks for volunteers – the Trust stood down its volunteers at the beginning of the Covid-19 pandemic and this is yet to resume.

2. Detailed Audit Findings

Audit objective 1: DBS check requirements (basic, standard and enhanced) are determined and advertised in line with job role requirements. Role specific requirements are subject to regular review

2.1 Job vacancies are advertised on the NHS Jobs website. The job role requirements are documented in the job description (JDs), which usually includes specification of the DBS check required for the role.

2.2 We selected a sample of 25 new starters and, through review of the related JDs, found that not all JDs included sufficient descriptions of the required DBS checks:

- seven JDs indicated a need for Enhanced DBS checks. However, no further detail was included as to whether this check should be with the Barred list or without the Barred list as specified by the legislation;
- four JDs included unclear, mixed messages regarding the necessary checks;
- in four cases we found that the JDs stated that no DBS checks were required. However, the other parts of the JDs included reference to direct contact with patients, which would indicate the need for DBS checks. We were informed that the DBS requirements stated in the JD was right for these roles and that the error was in the paragraphs describing patient contact (we understand these paragraphs did not appropriately articulate the actual job requirements); and
- two JDs did not include any references to whether DBS check were required (we were informed these posts did not require any DBS checks).

2.3 Additionally, in our testing on DBS checks for existing staff (see audit objectives 4 and 5 for full details), we identified 12 instances in our sample of 25 employees where JDs contained similar issues to the above. This included four instances where

the role required a DBS check, but the JD stated no DBS check was required (*note: we confirmed all four employees now have an appropriate DBS check in place due to the Trust's project to review DBS checks for all existing staff*).

2.4 Furthermore, we were informed that, during the project, the Trust also identified instances where staff did not have the appropriate level of DBS check in place and JDs did not identify the appropriate checks required. However, whilst the appropriate DBS checks were subsequently undertaken as part of the project (see testing in audit objective 5), we understand the JDs were not updated to correct the errors identified.

2.5 We were informed that there is an opportunity to re-assess and correct the DBS requirements at the pre-employment check stage. However, the findings from our sample of 25 new and 25 existing staff and the Trust's findings in their retrospective review indicate that errors in JDs regarding the DBS check requirements are not always identified or corrected at this pre-employment check stage.

2.6 Whilst we identified issues with the JDs, in our testing on a sample of new staff (detailed under audit objective 2) we did not identify any instances where the level of DBS check was inappropriate for the role.

2.7 See matter arising 1 in Appendix A.

2.8 We note that, aside from the recent project, role specific requirements are not subject to regular reviews. However, we also note that the NHS Employers guidance on DBS check requirements has not changed since 2014. We were informed that, should this guidance change, the Trust would undertake a review of all role specific requirements.

Conclusion:

2.9 We identified one medium priority matter arising regarding ensuring appropriate DBS disclosure requirements are included in JDs prior to roles being advertised. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: DBS checks for new employees are requested and reviewed in a timely manner prior to the employee commencing work

Trust recruitment policies and procedures

2.10 NWSSP Recruitment Services has formal policies in place to ensure that there is a consistent process to carry out pre-employment checks (including DBS checks) for general recruitment.

2.11 However, the Trust does not have any policy or procedures for its own staff who are involved in recruitment, for example, recruiting managers, Workforce team members and staff involved in direct recruitment. This was identified by the Trust

in response to the recommendations of the HIW report, however this had not been progressed at the time of our audit. As a result, in December 2021, the Workforce team requested that the Safeguarding and Public Protection Management Group (SPPMG) add this to the risk register until the document is developed.

2.12 We have provided guidance on areas arising from this audit that should be considered in the development of the Trust's policies and procedures in matter arising 2 in Appendix A.

DBS Countersignatory

2.13 The DBS Code of Practice requires that registered bodies maintain up to date countersignatories. Whilst the current Director of OD & Workforce is named as one of the Trust's countersignatories, we identified that the individual named as the lead signatory is the previous Associate Director of Workforce & OD, see matter arising 3 in Appendix A.

DBS check requirements

2.14 DBS checks are carried out as part of set pre-employment checks for all successful applicants. In the case of internal transfers (i.e. staff already employed or engaged by an NHS Wales organisation), the NWSSP procedures allow for DBS certificates dated within the previous three years to be used, rather than requiring a new check to be undertaken.

2.15 Where NWSSP is responsible for checking DBS certificates as part of the pre-employment checks, it provides the Trust with confirmation that the certificate was reviewed, and the certificate number and date when it transfers the starter's personnel file to the Trust. If a positive disclosure is made on the certificate, details of the disclosure will also be provided to the Trust.

2.16 We note that, in practice, it may take a long time to complete a DBS check for a new employee, which could delay the recruitment process. If the employee needs to start immediately, the recruiting manager is required to complete a formal risk assessment and make sure that the necessary safeguarding is put in place to ensure a safe working environment. Risk assessments are also required to be completed if any positive disclosures are made on a DBS certificate.

DBS checks for new staff

2.17 We reviewed a sample of 25 new starters and found that the Trust had confirmed appropriate DBS certificates had been obtained prior to employment commencing for 24 starters in the sample. No positive disclosures were identified on the related certificates, so no risk assessments were required.

2.18 For the remaining starter in the sample (a direct hire), we note that the Trust had used the gov.uk DBS Update Service to check the individual's DBS position. While we understand this approach is best practice given the 'live' nature of the update

service, we note that there was no guidance within the Trust as to when it is appropriate to use this service. See matter arising 2 in Appendix A.

2.19 We also reviewed details of ID checks for our sample of new starters and note that there was sufficient evidence to support these checks being carried out at the pre-employment stage.

Use of Trac for direct recruitment

2.20 Data from Trac is fed into the Electronic Staff Record (ESR) system when NWSSP has completed the pre-employment checks, issued the contract of employment and handed the personnel file to the Trust.

2.21 We checked data held in Trac for the 25 new starters in our sample and found that in four cases there was no data in Trac because Trac was not used. We understand this is because the Trust directly recruited these individuals (i.e. NWSSP was not involved in the recruitment process). The Trust does not currently have guidance on the use of Trac in the direct recruitment process. See matter arising 2 in Appendix A.

NWSSP backlog in processing new starter personnel files

2.22 We also found that seven out of the 25 sampled showed incomplete records in Trac. We were informed by NWSSP Recruitment Services that, whilst appropriate pre-employment checks are being undertaken, it is dealing with a backlog in completing Trac files for new starters due to the Covid-19 pandemic. As a result, records in Trac have not been finalised, personal files have not been populated and sent to the Trust, and formal employment contracts have not been issued to some of the successful candidates who are already working for the Trust.

2.23 While this backlog was formally communicated to the Trust in quarter four of 2021/22, at the time of our audit there was no formal monitoring in place within the Trust over the timeliness of resolution of the backlog by NWSSP.

2.24 At the end of the audit (late March 2022), the Head of Workforce informed us that it appears 61 new starters remained impacted by the NWSSP backlog (i.e. their personnel files have not been provided by NWSSP). There is a risk that some employees may not be subject to the required level of pre-employment checks (including DBS checks), or these checks may not be carried out at the right time.

2.25 We were also informed that the feed between the two systems (Trac and ESR) does not always transfer 100% of the required data. As such, data fields in ESR could remain blank and require manual completion. We were informed, that this is an All Wales matter which is currently looked at by Welsh Government.

2.26 We compared data stored in the two systems for our sample and found some differences. We understand that some of these differences related to the NWSSP backlog noted above and some were due to the interface issue. We were informed that the Workforce information teams monitor BI monthly and any missing

information is ratified between the information and payroll teams. However, we found that this process was not formally documented *(note: this issue did not prevent us from completing our audit work and, for the seven such staff in our sample we were able to confirm that appropriate DBS checks were in place*).

2.27 There is a risk that ESR may not contain accurate data on DBS checks undertaken.

2.28 See matter arising 4 in Appendix A.

Conclusion:

2.29 We identified one medium priority matter arising regarding the need for Trust policies and procedures covering recruitment (including DBS checks) and two low priority findings concerning the impact of the NWSSP backlog and Trac-ESR transfer issues, and out of date countersignatories. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: DBS data is held in line with data protection regulations

General recruitment

2.30 Where the recruitment process is completed by NWSSP, NWSSP is responsible for checking DBS certificates and handling the DBS data until the personnel file is transferred to the Trust. Within Trac, NWSSP records the type of DBS check carried out, the certificate number, the date of the document and the high-level result of the check, and that the certificate has been viewed as part of the pre-employment check.

2.31 We further note that the high-level status of the DBS check is also documented in the personal file of the successful candidate. This file is usually populated by the Recruitment Team at NWSSP after the hiring process is completed and emailed across to the Workforce team at the Trust for filing purposes.

2.32 The recruiting manager at the Trust is only contacted if there is a positive disclosure on a DBS certificate. In this situation, NWSSP will provide an extract from the certificate detailing the disclosure for the Trust to take appropriate action.

2.33 We understand that, in line with common practice, NWSSP does not retain copies of the DBS certificates and does not provide a copy to the Trust.

Direct recruitment

2.34 In the case of direct recruitment (which forms a small proportion of the Trust's overall recruitment), the Trust is responsible for ensuring it verifies appropriate DBS checks are carried out prior to employment.

2.35 Formal data retention policies are in place at the Trust to ensure compliance with the data protection regulations. However, we did not find any DBS specific reference within these documents. The DBS Code of Practice requires that all registered bodies must have a written policy on the correct handling and

safekeeping of DBS certificate information. The Code of Practice also requires this information be provided to individuals at the point of requesting them to complete a DBS application form or asking consent to use their information to access any service DBS provides (for example, the online update service).

2.36 During our fieldwork, we were emailed copies of two DBS certificates for direct hires, within the medical workforce. We were informed that the Trust's six-year retention rule for personnel data would be applied to such DBS certificates. Whilst the DBS Code of Practice does not specify a length of time for the retention of DBS certificates, it is common practice for organisations to note the pertinent details from the certificates, rather than to retain copies.

2.37 See matter arising 2 in Appendix A.

Conclusion:

2.38 We identified one medium priority matter arising regarding the lack of Trust policy on handling and safekeeping DBS certificate information for direct hires. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: recommendations made from the baseline review against the HIW report are monitored at an appropriate forum to ensure timely implementation

2.39 In January 2019, a Special Review was published by Healthcare Inspectorate Wales (HIW), which examined the former Abertawe Bro Morgannwg University Health Board's handling of allegations into a former employee's action. As a result of these findings, several safeguarding and governance recommendations were made which all NHS Wales organisations are required to consider.

2.40 The HIW report included 24 recommendations in total, of which two related to DBS checks:

HIW report recommendations	Trust response
1. Welsh Government (WG) should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.	**N/A** Matter remains subject to discussions on a national level, so action not yet required by the Trust.
2. The health board must ensure all staff, where required by their role, receive a DBS check and address the following:	
• As a priority, DBS checks are conducted for members of staff who have not previously received a CRB/DBS check. The status of DBS checks is considered	**Action taken addresses recommendation** Agreed actions: • Commence the checking process for those for whom there is no record on file of having been previously vetted, and; • ensure all other staff who currently have a DBS check on file, have been checked at the appropriate level.

HIW report recommendations	Trust response
	The outcome of this process is covered further below and tested under audit objective 5.
• The approach to renewing DBS checks for staff is carefully considered to ensure they are up-to-date and updated when staff change role.	**Action taken partially addresses recommendation** Current national guidance does not require that DBS checks are renewed (see point 1 above). The Trust is following this guidance until a formal announcement is made by Welsh Government. It is not clear how the Trust has considered DBS checks where staff change roles where this does not include a formal recruitment process, although were informed this is not something that happens frequently within the Trust. This could be covered in the policy / procedure document being developed. See matter arising 2 in Appendix A.
• The status of DBS checks is considered as part of the safeguarding process, and in particular, when allegations are made against staff.	**No action required; recommendation addressed by an existing policy** The Trust has a Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and Those in a Position of Trust (updated in April 2020). Whilst it does not specifically state DBS check status should be reviewed as part of the safeguarding process, it provides guidance around consulting with and obtaining guidance from the DBS and around referral to the DBS. To achieve this would require the status of a DBS check to be identified as part of the process.
• The responsibility for conducting DBS checks for redeployed staff and volunteers is clarified within health board policies	**Not clear how action taken addresses recommendation** The Trust does not have a policy or procedure regarding DBS checks for redeployed staff or volunteers (although we were informed that the Trust has neither redeployed staff nor volunteers at present). This could be covered in the policy / procedure document being developed. See matter arising 2 in Appendix A.

2.41 The Trust's proposed actions were approved by the Executive Management Board (EMB) in April 2021. A detailed action plan to review DBS checks for existing staff was then developed and progress has been regularly reported to the Safeguarding and Public Protection Management Group (SSPMG) and EMB. High-level assurance updates on progress were also provided to the Quality, Safety and Performance Committee via the SSPMG highlight report.

2.42 Whilst the project took longer than anticipated (original timescale was three months but it subsequently took seven months), this was reported to EMB. By November 2021, the bulk of the work to review DBS checks for existing staff had been completed and with appropriate DBS certificates (or DBS update service results) being obtained where gaps were identified (e.g. where the required check was not in place, or the check obtained was not sufficient).

2.43 As of February 2022, we were informed the actions outstanding were:

- completion of a small number of checks from the original process (six enhanced checks awaiting documentation and one standard check not started);

- completion of the review for staff on long-term sick leave or maternity leave upon their return to work (four employees); and
- proceeding through the disciplinary process for staff who did not have an appropriate DBS check in place but did not engage in the process to November 2021 (at the time of writing, six staff members were in the formal process, as outlined by the All Wales Disciplinary Policy).

2.44 These final actions were in progress at the time of our audit, and we were informed that there is a timetable in place to complete this work. Reporting on progress has continued at EMB, although we understand the frequency of reporting will be now reduced to reflect the stage of the project.

Conclusion:

2.45 Whilst the main priority of the HIW report recommendations (the retrospective DBS check review) was addressed by the Trust and monitoring was undertaken on this, we identified a medium priority finding relating to areas the Trust's recruitment policy / procedure document should provide guidance in response to the HIW recommendations. Therefore, we have provided **reasonable assurance** over this audit objective.

2.46 *Note: whilst testing of the actions taken against the 22 non-DBS check related actions was outside the scope of this audit, during our audit we identified that:*

- *the original baseline review document could not be located;*
- *aside from the DBS-related actions, the baseline review was not reported to any forum within the Trust; and*
- *it appears no formal monitoring has taken place to ensure actions to address the recommendations were completed.*

2.47 *As a result of the Audit, this matter was raised with the Executive Director of Nursing. AHP & Health Science. She informed us that she will request a formal review of the HIW report recommendations to verify progress to date and identify if any further action is required. The report will be taken to the Trust Safeguarding & Vulnerable Adult Group and reported to Executive Management Board & Quality, Safety & Performance Committee. As this was out of scope for this review and does not impact upon the assurance rating, we have not raised a formal recommendation in Appendix A.*

Audit objective 5: consideration of the review of DBS checks for existing staff

2.48 As part of this audit, we selected 25 existing employees who were subject to the review of DBS checks as part of the project outlined under audit objective 4. Our testing found that appropriate DBS checks were now in place for 23 of the 25 employees in the sample.

2.49 For the remaining two employees:

- one individual is on maternity leave, therefore the checking process will be undertaken upon their return to work; and
- the specifics of the other individual's role are being discussed between the Workforce team and the individual's manager to ensure an appropriate check is obtained.

2.50 The Workforce team was aware of the status of each of the above individuals (see paragraph 2.43).

Conclusion:

2.51 We did not identify any matters for reporting in this area, therefore we have provided **substantial assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Job Descriptions (JDs) (Design)	Impact
In our testing of 25 new starters, we found that not all the related JDs included sufficient descriptions of the required DBS checks. Our findings are that: • in seven cases where Enhanced DBS checks were required, this was not broken down into further details, i.e. whether the DBS check was required with the Barred list or without the Barred list, as specified by the legislation; • four JDs included unclear messages regarding the required DBS checks (CAJE 2019/0146 – Therapy Radiographer, CAJE QA136 – Medical Laboratory Assistant, CAJE 2019/0058 – Maintenance Technician, CAJE 2020/0120 – Radiotherapy Bookings Team Leader) – e.g. the unnecessary lines from the template JD had not been deleted; • in four cases we found that the JDs stated no DBS checks were required. However, the JDs also included reference to direct contact with patients, which would indicate the need for DBS checks. We were informed that the DBS requirements stated in the JD was right for these roles and that the error was in the paragraphs describing patient contact (we understand these paragraphs did not appropriately articulate the actual job requirements); and • two JDs did not include any references as to whether DBS checks were required (Rotational Biomedical Scientist (BMS) – Band 5 – the related job description did not have any CAJE number, and CAJE 2016/0070 - Research & Development Facilitation Officer, Band 5) – we were informed these posts did not require any DBS checks. Additionally, in our testing on DBS checks for existing staff, we identified 12 instances in our sample of 25 employees where JDs contained similar issues to the above. This included four instances where the role required a DBS check, but the JD stated no DBS check was required (*note: we confirmed all four employees now have an appropriate DBS check in place due to the Trust's project to review DBS checks for all existing staff*). Furthermore, we were informed that, during the project, the Trust also identified instances where staff did not have the appropriate level of DBS check in place and JDs did not identify the appropriate checks required. However, whilst the appropriate DBS checks were subsequently undertaken as part of the project (see testing in audit objective 5), we understand the JDs were not updated to correct the errors identified.	Potential risk of: • inadequate DBS checks may be undertaken for new staff; • risk to patient / donor safety or potential for patient / donor harm; and • potential financial impact as a result of unnecessary DBS checking.

We were informed that there is an opportunity to re-assess and correct the DBS requirements at the pre-employment check stage. However, the findings from our sample of 25 new and 25 existing staff and the Trust's findings in their retrospective review indicate that errors in JDs regarding the DBS check requirements are not always identified or corrected at this pre-employment check stage.

We understand JDs are the responsibility of the recruiting manager. We were informed that the Trust's Workforce team is developing awareness sessions for recruiting managers. However, there is currently no mechanism in place to verify the quality and accuracy of JDs prior to advertisement.

Whilst we identified issues with the JDs, in our testing on a sample of new staff we did not identify any instances where the level of DBS check was inappropriate for the role.

Recommendations	Priority
1.1 The Trust should implement a robust mechanism for ensuring the quality of JDs prior to advertisement, including ensuring appropriate DBS check requirements are included. This could be through a requirement that Workforce reviews all JDs prior to advertisement, or through Workforce spot checks to identify areas where further advice, guidance or support for recruiting managers may be needed.	Medium

Management response	Target Date	Responsible Officer
1.1 i. As part of the Attraction, Recruitment and Retention Group for the Trust, a task and finish group will be set up to streamline processes and ensure all documentation is relevant and with the correct responsible persons. One specific objective of the Task and Finish group will be to review the current process for writing Job Descriptions, including a manager's guide for ensuring the appropriate information is included and DBS requirements are correctly noted. **Action: Review current process for writing job descriptions and develop a manager's guide.**	October 2022	Head of Workforce
ii. A second written standard operating procedure will be written to add DBS quality check within Job Evaluation process. This will ensure Job Descriptions have correctly identified the DBS requirement of the role during the quality assurance checking stage before job descriptions are signed off for recruitment. **Action: Write a standard operating procedure to add the DBS quality check to the Job Evaluation process**	June 2022	Workforce Manager (Job Evaluation Lead)

Matter arising 2: Trust Recruitment and DBS Policy / Procedure (Design)	Impact
The Trust does not have any policies or procedures covering recruitment, for example, to support recruiting managers, Workforce team members and staff involved in direct recruitment. This was identified by the Trust in response to the recommendations of the HIW report. However, it had not been progressed at the time of our audit. As a result, the Workforce team requested that the SPPMG add this to the risk register until the document is developed. Regarding DBS checks, there is no local guidance that covers: • how and when to carry out DBS checks and safeguard the related certificates; • how long DBS data should be retained; • when a DBS certificate is required and when the gov.uk DBS Update Service may be used; and • details on how DBS data should be destroyed, when this action should be carried out, and by whom. The DBS Code of Practice requires that such information be documented in a formal policy/procedure. During our fieldwork, we were emailed copies of two DBS certificates for direct hires. We were informed that the Trust's six-year retention rule for personnel data would be applied to such DBS certificates. Whilst the Code of Practice does not specify a length of time for the retention of DBS certificates, it is common practice for organisations to note the pertinent data from the certificates rather than to retain copies. We also identified the following areas which are not currently covered in any Trust policy or procedure: • when Trac should be used for direct recruitment; • roles and responsibilities of individuals within the Trust involved in general and direct recruitment; • the process for ensuring DBS checks are updated should a staff member change roles where this does not include a formal recruitment process; and • the responsibility for conducting DBS checks for redeployed staff and volunteers.	Potential risk of: • inappropriate handling of DBS data, leading to a breach of the DBS Code of Practice or data protection regulations; and • staff changing roles, redeployed staff and volunteers may not have adequate DBS checks, leading to a risk to patient / donor safety or potential for patient / donor harm.

Recommendations	Priority
2.1 The Trust should: a. develop its local policy / procedure for recruitment (including DBS checks) as a matter of priority, considering the points raised in our finding and the requirements of the DBS Code of Practice;	Medium

b. ensure the policy / procedure is communicated to all relevant staff and is made available on the intranet; and

c. put in place a mechanism to monitor compliance with the Trust's new policy.

	Management response	Target Date	Responsible Officer
2.1	a. (i) The DBS project group recommended the development of a DBS policy as part of next steps in December 2021 and, because development of the policy was not completed within the original anticipated timeframe, included this on the Safeguarding Risk Register. A draft policy is already in development following this recommendation. **Action: Complete the development of the DBS Policy**	September 2022	Head of Workforce / Senior Nurse Safeguarding & Public Protection
	(ii) The Trust's Attraction, Recruitment and Retention Group will consider the development of the Trust's Recruitment Policy. This is a wider project that needs to encompass the ongoing work on Talent Management, Organisational Values, Workforce Planning, Education Commissioning and Student Streamlining and have involvement from key stakeholders in the process. **Action: Develop a Trust Recruitment Policy**	April 2023	Head of Workforce
	b. The Trust's intranet is currently under development and the previous cascade system will end in June 2022. It is expected the next intranet will be available to staff from July 2022 and the Workforce and OD page will include all policies and procedures. **Action: Communicate DBS policy to staff via staff communications and intranet.**	July 2022	Project Manager – Workforce Planning
	c. Alongside the development of a new policy, toolkits, guidance and standard operating procedures will be developed, hence the need for engagement from all stakeholders in the process. **Action: Standard operating procedure for the monitoring of compliance with the DBS Policy**	July 2022	Head of Workforce

Matter arising 3: Out of Date Countersignatory (Operating effectiveness)	Impact
The DBS Code of Practice requires that registered bodies maintain up to date countersignatories. Whilst the current Director of OD & Workforce is named as one of the Trust's countersignatories, we identified that the individual named as the lead signatory is the previous Associate Director of Workforce & OD.	Potential risk of: • non-compliance with the DBS Code of Practice, which could result in the suspension or cancellation of registration.

Recommendations	Priority
3.1 The Trust should update its DBS countersignatories and ensure this remains up to date in the future.	Low

Management response	Target Date	Responsible Officer
3.1 **Action: The Trust will contact DBS to update countersignatories for the Trust**	May 2022	Director of OD & Workforce

Matter arising 4: Backlog in NWSSP Completion of Personnel Files (Operating effectiveness)	Impact
Through reviewing a sample of 25 starters, we found that seven of the sample showed incomplete records in Trac, despite having started employment with the Trust. We were informed by NWSSP that, whilst appropriate pre-employment checks are being undertaken, it is dealing with a backlog in completing Trac files for new starters due to the Covid-19 pandemic. As a result, records in Trac have not been finalised, personal files have not been populated and sent to the Trust, and formal employment contracts have not been issued to some of the successful candidates. While this backlog was formally communicated to the Trust in quarter four of 2021/22, at the time of our audit there was no formal monitoring in place within the Trust over the timeliness of the resolution of the backlog by NWSSP. At the end of the audit (late March 2022), the Head of Workforce informed us that it appears 61 new starters remain impacted by the NWSSP backlog (i.e. their personnel files have not been provided by NWSSP). We were also informed that the feed between Trac and ESR does not always transfer 100% of the required data. As such, data fields in ESR could remain blank and require manual completion. We were informed, that this is an All Wales matter which is currently looked at by Welsh Government. We compared data stored in the two systems for our sample and found some differences. We understand that some of these differences related to the NWSSP backlog noted above and some were due to the interface issue. We were informed that the Workforce information teams monitor BI monthly and any missing information is ratified between the information and payroll teams. However, we found that this process was not formally documented. There is a risk that ESR may not contain accurate data no DBS checks undertaken. However, we understand there is a process in place within the Workforce team to review whether all the necessary pre-employment checks have been completed by NWSSP. However, we found that this process was not formally documented. (*note: this issue did not prevent us from completing our audit work and, for the seven such staff in our sample, we were able to confirm that appropriate DBS checks were in place*).	Potential risk of: • lack of formal contractual relationship with employees; • incomplete DBS data on new employees; • inadequate, untimely or no DBS checks being undertaken by NWSSP on new starters, and this not being identified by the Trust; and • risk to patient / donor safety or potential for patient / donor harm.

Recommendations	Priority
4.1 The Trust should: a. monitor NWSSP's resolution of the backlog to ensure this is undertaken on a timely basis; and b. formally document the process carried out by the Workforce team to check that appropriate pre-employment checks are completed by NWSSP.	Low

Management response	Target Date	Responsible Officer
4.1 a. Workforce team will continue to track and monitor the files from the backlog of NWSSP files. As of 07th April 2022 it was identified this has reduced from 61 outstanding to 20 outstanding. NWSSP will send outstanding files to managers and contracts to employees. **Action: Outstanding personal files to be sent to managers**	September 2022	Workforce Manager (with support from NWSSP Recruitment Services)
b. Action: A standard operating procedure will be written for monthly checks of new starter files undertaken within the workforce team.	June 2022	Workforce Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Charitable Funds
Final Internal Audit Report

April 2022

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:	VT-2122-08
Report status:	Final
Fieldwork commencement:	15th February 2022
Fieldwork completion:	5th April 2022
Draft report issued:	6th April 2022
Debrief meeting:	17 March 2022
Management response received:	21st April 2022
Final report issued:	21st April 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Emma Rees, Interim Deputy Head of Internal Audit Johanna Butt, Principal Auditor
Executive sign-off:	Matthew Bunce, Director of Finance
Distribution:	Stephen Coliandris, Financial Planning and Reporting Manager Alaric Churchill, Charity Director
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 Institute of Internal Auditors.

Acknowledgement

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

Executive Summary

Purpose

To review whether the operational procedure is compliant with policies of the Trust as trustee.

Overview

We have issued reasonable assurance on this area.

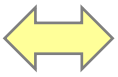
Whilst we have not identified any significant matters arising, we wish to bring to management's attention to the need to ensure expenditure is approved by an appropriate individual prior to being committed.

Management should also ensure that implementation of the two previous recommendations that remain open is supported by appropriate evidence.

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

Details of our follow-up on 2018/19 recommendations regarding Charitable Funds are included in Appendix B.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2018/19

Assurance summary[1]

Assurance objectives		Assurance
Income		
1	Procedures for receiving charitable fund income	Substantial
2	Receipting of monetary donations	Reasonable
3	Banking and recording of income received	Substantial
4	Donations / legacies with restrictions on the fund's use	Substantial
Expenditure		
5	Expenditure is appropriate, authorised and within the terms of the relevant fund	Reasonable
Follow-up of 2018/29 recommendations[2]		
6	Implementation of previous medium priority recommendations raised.	Reasonable

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

[2] The scope of the follow-up work provides assurance against the implementation of the agreed actions from the medium priority actions in the 2018/19 Charitable Funds Internal Audit Report. It does not provide assurance against the full scope and objectives of the original audit.

1. Introduction

1.1 Charitable Funds is the term given to money that is donated to Velindre University NHS Trust (the Trust) and which is administered through a registered charity, Velindre University NHS Trust Charity (the Charity). The Trust is the Corporate Trustee of the Charity and has appointed the Charitable Funds Committee to oversee the management of its funds.

1.2 During the year ended 31 March 2021, the Charity received income of £2.683m (2019/20: £2.8m). This included a one-off donation of £0.5m from the Moondance Foundation and £0.524m in legacies.

1.3 For the same period, the Charity's expenditure was £2.763m (2019/20: £2.753m). This represented an underspend of £1.101m on planned expenditure mainly due to timing issues arising from vacancies against projects or reduced activity due to the Covid-19 pandemic.

1.4 As of 31 March 2021, the Charity's investment portfolio position was £5.99m (2019/20: £5.154m). The Investment Performance Review Sub Committee supports the Charitable Funds Committee in advising the Trust's Board on investment policy and performance.

1.5 For the period April to December 2021, the Charity had received donations of £1.768m and had expenditure of £2.385m.

Associated risks

1.6 The key risks considered in this review were:

i. non-compliance with operational policies as well as legislation and The Charity Commission guidelines;

ii. charitable funds income may be incorrectly recorded and / or accounted for;

iii. charitable funds income is not being maximised; and

iv. charitable funds expenditure may be inappropriate, excessive or be incorrectly recorded and not in line with the principles of the policy.

Limitations of scope

1.7 The following limitations in scope:

i. whilst some charitable donations may have been received via frontline staff, we will not visit wards as part of this review due to the continuing pressures from the pandemic;

ii. we have not verified that the minimum procurement thresholds for quotes and competitive tendering arrangements have been adhered to. However, we did establish whether the delegated authorisation levels required in order to authorise expenditure against Velindre NHS Trust Charitable Funds was appropriate; and

iii. we have not reviewed Gift Aid.

Covid-19 impact

1.8 We understand from discussions with management that the fundraising team were significantly impacted by the Covid-19 pandemic and that the Trust continues to have staffing issues within the fundraising and the finance teams.

2. Detailed Audit Findings

Audit objective 1: The Trust established procedures for receiving charitable funds income during the pandemic.

2.1 Policies are available to staff on the Trust's intranet site. We reviewed the policies and procedures relating to Charitable Funds. With the exception of 'CFC 04 - Charitable Funds Investment Policy' which was reviewed and approved in September 2021, all other Charitable Funds policies were found to be past their review date of September 2021. However, we were informed that management took the decision not to update the policies and procedures at that point due to them not being considered business critical in light of the Covid-19 pandemic and staffing issues. We understand there have been no changes to the procedure for receiving income during the pandemic. See **matter arising (MA) 1 in Appendix A**.

2.2 We understand from discussions with key staff that it was not necessary to draft additional procedures during the pandemic and that the controls and procedures have remained the same throughout. We also note that during the pandemic that the Velindre Cancer Centre were not accepting donations at their offices.

2.3 In addition to the policies and procedures there is a 'quick guide' in place on the Trust's intranet page that details how to apply for funds and includes hyperlinks to the relevant forms that need to be completed and key dates that applications need to be submitted by.

Conclusion:

2.4 We did not identify any significant matters for reporting in this area. Noting this, we have provided **substantial** assurance over this audit objective.

Audit objective 2: Monetary donations, including funds raised by staff (where applicable) were receipted in line with the Trust's Charitable Funds Policies and Procedures.

2.5 The Trust has several internal procedures in place for income. All income received is recorded on the donation database and there is a specific procedure for this, namely, the 'Database Donation Entry instructions' procedure.

2.6 The Velindre Fundraising website provides guidance on the process to be followed if someone wishes to donate monies to Velindre NHS Trust, including one-off

donations; leaving a bequest in a will; making regular donations; setting up a tribute fund; and wedding favour donations.

2.7 The Trust provided a report of all income received for the period 1st April 2021 to 14th February 2022 (the income report). We selected a sample of 25 transactions to include a selection of income received from donations, legacies and events.

2.8 Our testing identified 13/25 instances where an acknowledgement letter was not sent to the donor or was not available during the audit. We were informed that acknowledgment letters are not provided for all donations. We reviewed the procedure for 'Database Donation Entry instructions' and found that it details the process for sending out an acknowledgement letter, but it does not detail the instances where a letter is not required. See **MA4 in Appendix A**.

2.9 We understand that the donations database is used to generate charitable board fundraising reports. As such it is important that donation information is accurately recorded on the database. For our sample, the majority of funds received were posted to 6000 'Hospital General Purposes Fund'. However, 4/25 had been posted to specific funds and it was not clear from the supporting documentation provided why these had not been posted to the 'Hospital General Purpose Fund'. See **MA5 in Appendix A**.

2.10 Additionally, the fundraising event that the donation relates to is recorded in the 'Notes' section of the donation database. We identified 4 instances where the fundraising event noted was incorrect or we were unable to confirm whether it was correct based on the audit evidence provided. See **MA6 in Appendix A**.

Conclusion:

2.11 We identified three low priority matters arising in this area concerning acknowledgement letters and accuracy of recording in the charitable funds database (two findings). Noting this, we have provided **reasonable** assurance over this audit objective.

Audit objective 3: Charitable funds income received is banked promptly, securely and in full and recorded and accounted for correctly.

2.12 We selected a sample of 25 transactions from the income report to include a selection of different methods of payment including direct to the bank, cheques and cash. We confirmed, with reference to the bank statements, that all income selected had been banked in full.

2.13 The report showed that approximately 67% of income received was direct to the bank and as such is banked promptly and securely.

2.14 The remaining 33% was made up of cheques, postal orders and cash. Cash made up 3% of the income received on the report. We understand from discussions with staff that cash is held securely in a safe until deposited in the bank. *Note: verification of the security of cash and cheques prior to banking was out of scope for the review due to the Covid-19 pandemic.*

2.15 15/25 income transactions in our sample related to cash and cheque donations. We obtained the cash sheets to review the timeliness of banking. Where dates had been entered on the form, we calculated the timeliness from date paid to date banked. These were found to be banked within an average of 4 working days.

2.16 Monthly bank reconciliations are undertaken, and these will highlight any differences between the fundraising database and the bank statements. Testing on bank reconciliations was out of scope for this audit, although we saw evidence of the bank reconciliations in our testing on the banking of income.

Conclusion:

2.17 We did not identify any matters for reporting in this area. Noting this, we have provided **substantial** assurance over this audit objective.

Audit objective 4: Donations are not accepted as restricted funds unless it is in line with the strategic objectives of the Trust.

2.18 The Trust confirmed that there have been no restricted funds received since 1st April 2021. Where donor letters had been provided as audit evidence, in our sample testing under audit objectives 2 and 3, we did not identify any instances where there was a request to restrict the funds.

2.19 Acknowledgement letters sent to donors include the standard wording "*Without any imposition of trust, we will attempt to comply with your wishes as to the use of the donation. Unless specified, your donation will be paid into our general Donations Fund which is used to support all our services, projects and appeals*".

2.20 However, we have recognised under audit objective 2 that acknowledgement letters were not sent or were not available for 13/25 of sample transactions. We were informed by management that not all donors would receive an acknowledgement letter, but this is not clear from the 'Database donation entry instruction' guidance. We have reflected this in our assurance rating for audit objective 2.

Conclusion:

2.21 We did not identify any matters for reporting in this area. Noting this, we have provided **substantial** assurance over this audit objective.

Audit objective 5: Charitable funds expenditure is appropriate, authorised and in line with the charitable objectives.

2.22 The Trust provided an expenditure report for the period 1st April 2021 to 14th February 2022. We selected a sample of 25 expenditure transactions to include a cross section of expenditure types.

2.23 The Trust's intranet site includes a Charity fundholder coding structure which details each fund number which corresponds to the Oracle cost centre and details the appropriate authorisers for each fund.

2.24 All expenditure items in our sample had been authorised by an appropriate individual.

2.25 However, we identified the following matters regarding expenditure:

- retrospective authorisation of expenditure: orders should be placed on the Oracle system and authorised prior to the goods and services being received. We identified three Purchase Orders (POs) where the invoice date preceded the date of the PO. As such, approval was not sought prior to committing to spend;
- reimbursement of expenses incurred in March 2020 with missing supporting documentation: flight costs in respect of South Wales Sierra Leone Cancer Care link were re-imbursed without having evidence of the flight booking and / or plane ticket. Also, this expense was incurred in March 2020 but not submitted for payment until May 2021. We were informed that the delay in submission was due to the pandemic.

2.26 See **MAs 2 and 3 in Appendix A**.

Automatic accruals

2.27 4/25 of the transactions selected related to errors in automatic accruals which we confirmed had been appropriately cleared in January 2022.

2.28 These were also identified by Audit Wales (AW) as part of their end of year audit for 2020-21. Their ISA260 report for 2020-21 detailed that they identified an error relating to automated accruals being over-stated by £49,190. This was either because the accruals had already been settled or were of such an age that the need to settle the liability was considered remote.

2.29 The AW report made a high priority recommendation that "*The Trust should introduce robust arrangements to regularly review the Charitable Funds automated creditor accruals to ensure that a continued liability exists at year end*".

2.30 Trust Management accepted the recommendation in full and the Trust confirmed "*A full review of the automated accruals has been undertaken as part of the audit exercise. Procurement have been contacted to close the orders that are no longer required. Measures are now in place to review the automated accruals on a quarterly basis and to clear down any accruals that are no longer valid*".

Timeliness of invoice payment

2.31 Whilst outside the scope of this review, we note that for three of the transactions selected, the Trust had received final demands for payment. We have not raised a matter arising for these as we were informed that the Trust monitors and reports on the timeliness for payment of invoices. However, we suggest the Trust identifies the underlying reason for these delays. Two of these final demands were from Cardiff University.

Conclusion:

2.32 We identified one medium priority matter arising relating to retrospective approvals and one low priority finding relating to appropriate evidence for, and timely submission of, expense claims. Noting this, we have provided **reasonable** assurance over this audit objective.

Audit objective 6: Follow-up on the medium priority recommendations from our 2018/19 Charitable Funds report.

2.33 The Trust's audit tracker includes all open recommendations. Closed recommendations are removed from the tracker when they are deemed as being implemented. We reviewed the most recent audit tracker as of January 2022. This confirmed that it did not include any of the previous Charitable Funds internal audit report recommendations. This suggests that the Audit Committee has been informed that the recommendations were fully implemented.

2.34 A summary of progress against the medium priority recommendations from the 2018-19 internal audit is detailed in the table below. Full details of our findings and updated recommendations are included in Appendix B.

Prior finding – current position	Previous rating	Direction of travel	Current rating
1. Moondance Programme Board - Attendance	Medium	⇧	**Closed**
We were informed that from January 2020 the 'Moondance Programme Board' has been replaced with the Advancing Radiotherapy Fund (ARF) Board. The previous audit reported that the Medical Director had not attended any of the meetings. We reviewed the updated Terms of Reference (ToR) for the ARF Board, confirming that the Trust has removed the Medical Director as a member of this Board. However, we note that the ToR has not been formally approved. We reviewed the minutes for the ARF Board to confirm attendance at the meetings since our previous review, i.e., April 2018. We noted that, of the twelve meetings scheduled between April 2018 and March 2022, good attendance from all members was evidenced in the minutes and only two meetings (August 2018 and September 2019) were not quorate. Between March 2020 and March 2022, three scheduled meetings have been cancelled. However, this is considered reasonable due to the Covid-19 pandemic. The original recommendation is **closed**. However, a new recommendation relating to the approval of the ToR is included in Appendix A (**see MA7**).			
2. Procedure for the Management of Fundraising Events is out of date	Medium	⇧	**Closed**
The Trust's Procedure for the Management of Fundraising Events (CFC005) was reviewed and approved by the Charitable Funds Committee in November 2018. However, we note that the revised procedure was due for review in September 2021 but was outstanding at the time of our audit (due to a decision that the policy/procedure update was not considered business critical in light of the pandemic). The original recommendation is **closed**. However, a new recommendation around policy/procedure updates is included under audit objective 1 in Appendix A.			

Prior finding – current position	Previous rating	Direction of travel	Current rating
3. Desktop Procedure – Monies Received	Medium		Medium
We were informed that the desktop procedure had been drawn up and circulated. However, the Trust confirmed they were unable to locate or provide a copy of the procedure. In the absence of audit evidence to support the statement made the recommendation remains **open** at **medium priority**. We have provided updated recommendations in Appendix B.			
4. Trust Guidance for Donations	Medium		Medium
We were informed that the desktop procedure had been drawn up and circulated. However, the Trust confirmed they were unable to locate or provide a copy of the procedure. In the absence of audit evidence to support the statement made the recommendation remains **open** at **medium priority**. We have provided updated recommendations in Appendix B.			

Conclusion:

2.35 Two of the previous recommendations have been fully implemented, whilst two remain open due to a lack of evidence to support implementation. Noting this, we have provided **reasonable** assurance over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Charitable Funds Policies (Design)	Impact
We reviewed the policies pertaining to Velindre Charitable Funds. The following policies were found to be past their review date of September 2021:	Potential risk of: • non-compliance with operational policies as well as legislation and The Charity Commission guidelines.

Ref	Policy/Procedure:	Last Review	Approval Date	Review due
No reference	Trust Procedure for the Management of Fundraising events	June 2018	November 2018	September 2021
CFC 001	Procedure for the Scheme of Delegation and Stages for the Purchasing and Authorisation of Goods and Services	June 2018	November 2018	September 2021
CFC 002	Travel and Expenses Reimbursement Policy	June 2018	November 2018	September 2021
CFC 003	Credit Card Policy and Procedures	June 2018	November 2018	September 2021

We acknowledge that there has been no change to the policy or procedures and that updating such document was not considered business critical during the pandemic. We understand the Trust intends to review the documents as the pandemic eases.

Recommendations	Priority
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

Management response	Target Date	Responsible Officer
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.	July 2022	Charitable Funds Finance Manager

Matter arising 2: Retrospective Purchase Orders (Operation)	Impact
Velindre '*NHS Charitable Funds Procedure for the Scheme of Delegation and Stages for the Purchasing and Authorisation of Goods and Services*' provides guidance and procedures for the payment and authorisation of goods and services paid through Velindre NHS Trust Charitable Funds. s8.1.2 of the procedure details that "*All requests made through charitable funds must be placed on the oracle system prior to any purchase being made. It is not acceptable to place an order once the goods or services have been received*". Our review of 25 expenditure transactions identified three instances where the invoice date preceded the approval date indicating that the approval had been sought retrospectively as follows:	Potential risk of: • charitable funds expenditure may be inappropriate, excessive or be incorrectly recorded and not in line with the principles of the policy.

Purchase Order (PO) Number	Amount	PO Approval date	Invoice date
712140407	£1,158.75	06/09/21 and 07/09/21	02/09/21
712142423	£229.50	14/10/21	23/08/21
712143070	£2,520.00	29/10/21	23/09/21

Recommendations	Priority
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

Management response	Target Date	Responsible Officer
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.	May 2022	Charitable Funds Finance Manager

Matter arising 3: Appropriate evidence for, and timely claiming of, expenses (Operation)	Impact
We reviewed a sample of 25 expenditure transactions and noted one instance where there was reimbursement of expenses over a year after they had been incurred and the related supporting documentation was inadequate. The expenditure (£728.53) related to South Wales Sierra Leone Cancer Care Link for March 2020. The 'Velindre NHS Trust (VUNHST) Consultant Medical and General staff study leave and charitable funds authorisation form' had been completed and authorised by an appropriate individual. However, the supporting documentation was a receipt from 'Wellbodi Partnership' which detailed 1 x return flight from Birmingham to Freetown £628.53 and 1 x single entry visa £80. Evidence of the visa was provided, however, evidence for the flight was not attached to the authorisation form. Additionally, the expenditure was incurred in March 2020 but not submitted for payment until May 2021. We were informed the delay in claiming these expenses was due to the Covid-19 pandemic.	Potential risk of: • inaccurate financial monitoring and reporting; • the Trust re-imburses expenditure that has not been incurred; and • expenditure is not posted to the correct financial year.

Recommendations	Priority
3.1 Management should: a. communicate to relevant individuals and authorisers the requirement for timely submission of expense claims supported by appropriate evidence; and 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

Management response	Target Date	Responsible Officer
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.	Complete - consultant has already been contacted.	Charitable Funds Finance Manager
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	Complete – consultant has already been contacted	Charitable Funds Finance Manger

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.

Matter arising 4: Acknowledgement letters (Operation)	Impact
Review of the income procedure 'Database Donation Entry instructions' details how to send out an acknowledgement letter. For 13/25 of the donations in our sample, acknowledgement letters had not been sent or were not provided during the audit. We were informed by key staff that acknowledgement letters are not issued for all income received. However, we note that the Trust's procedures do not set out when this is appropriate and whether another form of acknowledgement (e.g., a receipt) is required. The 13 donations where acknowledgement letters were not sent/provided were relate to the following Receipt IDs: *130151 - £1,145* | *130402 - £10,000* | *133240 - £1,400* | *134784 - £3,211* | *134780 - £150,000* | *136263 - £1,659* *137493 - £2,600* | *137892 - £47,500* | *129882 - £5,250* | *132474 – £2,210* | *136166 - £2,301* | *136600 - £2,610* *137726 - £3,000* It is unclear whether these were not provided because they were not issued or that the Trust was unable to locate copies of the letter. Due to the lack of Trust guidance, we could not identify whether it is appropriate or not that acknowledgement letters were not sent in relation to these receipts.	Potential risk of: • donor not acknowledged for fundraising effort and will not have evidence of the charitable donation for their own tax purposes; and • may negatively impact the donors' future plans for fundraising for the charity.

Recommendations	Priority
4.1 Management should update the 'Database Donation Entry instructions' document to detail when acknowledgment letters are not issued. 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

Management response	Target Date	Responsible Officer
4.1 Accepted – the manual will be updated	April 2022	Charity Director
4.2 Accepted – review is being undertaken	April 2022	Charity Director

Matter arising 5: Allocation of funds (Operation)	Impact
We understand that the donations database is used to generate fundraising reports. As such it is important that donation information is accurately recorded on the database. For our sample, the majority of funds received were posted to 6000 'Hospital General Purposes Fund'. However, 4/25 had been posted to specific funds and it was not clear from the supporting documentation provided why these had not been posted to the 'Hospital General Purpose Fund'. These relate to the following Receipt IDs: **Receipt ID 134780 - £150,000** related to money left to the Trust in a will. The donation database details that the amount has been posted to 6317 'Radiotherapy Department'. The letter from the executor did not specifically request that the donation be made to the Radiotherapy Department. **Receipt ID 132474 – £2,210** the donation database details that the donation was to 6312 'Brain'. No supporting documentation was available for the donation. As such we are unable to confirm why the donation was not posted to 6000 'Hospital General Purposes Fund'. **Receipt ID 135813 - £3,542** the donation database details that the donation was to 6304 'Urology / Prostate'. However, the letter from the donor does not specifically request that the donation is for Urology / Prostate. **Receipt ID 137726 - £3,000** the donation database details that the donation was to 6307 'Research Gynaecological (Aphrodite Appeal)'. The only evidence available for the donation was the pink slip receipt. As such, we are unable to confirm why the donation was not posted to 6000 'Hospital General Purpose Fund'. We were informed that there were no restricted funds received since 1 April 2021.	Potential risk of: • inaccurate fundraising reports from the donation database; and • charitable funds expenditure may not be in line with donor's wishes.

Recommendations	Priority
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; b. confirm that the four above receipts have been posted to the correct fund number code and update the donation database as necessary; and c. consider whether a review of the accuracy of the information in the database is required.	Low

	Management response	Target Date	Responsible Officer
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.	June 2022	Charity Director
	b. Accepted – All donations have been reviewed and confirmed that they are in the correct place.	Complete	Charity Director
	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	June 2022	Charity Director

Matter arising 6: Incorrect fundraising event noted (Operation)	Impact
We understand that the donations database is used to generate fundraising reports. As such it is important that donation information is accurately recorded on the database. The fundraising event that the donation relates to is recorded in 'Notes' on the donation database. We identified 4 instances where the fundraising event noted was incorrect or we were unable to confirm was correct based on the audit evidence provided. These were: **Receipt ID 130402 - £10,000** the donation database detailed that this related to match funding for 'Mile a Day 2021'. However, the Trust were unable to provide any supporting documentation or evidence in support of this. **Receipt ID 136169 - £15,000** related to a legacy in memory of donation. The note column of the donation database details 'Legacy21'. The majority in memory donations are posted to 'IMO21' on the database. **Receipt ID 137892 - £47,500** related to Jiffy50Cancer bike ride which was a joint fundraising event with Swansea Bay UHB. The note column on the donation database details 'SuppEvent21' instead of 'Jiffy50cancer'. **Receipt ID 133693 - £11,024** the donation database includes 'Majorca22' in the note column. However, there was no reference to 'Majorca22' on the audit evidence provided.	Potential risk of: • inaccurate fundraising reports from the donation database.

Recommendations	Priority
7.1 Management should: a. remind staff of the need for accurate recording of fundraising events in the donation database; b. confirm that the four above receipts have been allocated to the correct fundraiser and update the donation database as necessary; and c. consider whether a review of the accuracy of the information in the database is required (see also MA5).	Low

Management response	Target Date	Responsible Officer
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.	Complete	Charity Director

Management response (continued)	Target Date	Responsible Officer
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.	May 2022	Charity Director
c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	June 2022	Charity Director

Matter arising 7: Advancing Radiotherapy Fund Board Terms of Reference (Operation)	Impact
In our follow-up of previous recommendations (see prior year finding 1 in Appendix B), we identified that the ARF Board ToR had been updated since our previous review but had not been approved.	Potential risk of: • ToR does not appropriately cover ARF Board responsibilities; and • non-compliance with legislation and Charity Commission guidelines

Recommendations	Priority
8.1 Management should ensure the ARF Board ToR is formally approved and kept under review.	Low

Management response	Target Date	Responsible Officer
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.	April 2022	Moondance Programme Manager

Appendix B: Progress on 2018/19 Charitable Funds recommendations

Previous Matter arising 1: Moondance Programme Board – Attendance (Operating effectiveness)	
Original recommendation and management response	Original priority
Management should remind members of requirement to attend the meeting and review the attendance requirements of the Programme Board and update the terms of reference if required. **Management response:** Management note that the Medical Director has not attended since July 2017. The Terms of Reference (ToRs) of the Moondance programme board are currently being reviewed, but it should be noted that the Director of Finance is the vice chair and as a Trustee will deputise for the Medical Director in their absence. As part of the ToRs no decision can be made without two Trustees being in attendance. All members of the revised ToR will be reminded of the need to attend. *Jenny Stock – Moondance Programme Manager - 30.01.2019 (next MPB meeting date).*	Medium
Current findings	**Residual risk**
We were informed that from January 2020 the 'Moondance Programme Board' has been replaced with the Advancing Radiotherapy Fund (ARF) Board. The previous audit reported that the Medical Director had not attended any of the meetings. We reviewed the updated Terms of Reference (ToR) for the ARF Board, confirming that the Trust has removed the Medical Director as a member of this Board. However, we note that the ToR has not been formally approved. We reviewed the minutes for the ARF Board to confirm attendance at the meetings since our previous review, i.e., April 2018. We noted that, of the twelve meetings scheduled between April 2018 and March 2022, good attendance from all members was evidenced in the minutes and only two meetings (August 2018 and September 2019) were not quorate. Between March 2020 and March 2022, three scheduled meetings have been cancelled. However, this is considered reasonable due to the Covid-19 pandemic.	N/a – recommendation closed

Current findings (continued)

Conclusion:

The Medical Director is no longer a member of the ARF Board and there has been good attendance at the meeting since our last review. However, the Terms of Reference are still in draft and have not been finalised. Consequently, the original recommendation is considered **fully implemented** and **closed**. However, a new recommendation relating to the approval of the ToR is included in Appendix A (see matter arising 7).

Previous matter arising 2: Procedure for the Management of Fundraising Events is out of date (Control design)	
Original recommendation and management response	Original priority
Management should ensure that the procedure is reviewed and submitted to the Charitable Funds Committee for approval as soon as practicable. **Management response:** Whilst management recognise that the procedure is out of date by a few months, it is still relevant and we are not expecting any major changes. The procedure has been through the Exec team, and Divisional SMT teams, but due to the time it has taken to go through this process it missed the last committee meeting. *Andrew Morris – Fundraising Manager – 28/11/2018*	Medium
Current findings	**Residual risk**
The Trust's Procedure for the Management of Fundraising Events (CFC005) was reviewed and approved by the Charitable Funds Committee in November 2018. However, we note that the revised policy was due for review in September 2021 but was outstanding at the time of our audit. **Conclusion:** The original recommendation is considered **fully implemented** and **closed**. However, a new recommendation has been raised in Appendix A about the current status of the Charitable Funds policies and procedures, (see matter arising 1).	N/A – recommendation closed.

Previous matter arising 3: Desktop Procedure - Monies Received (Control design)	
Original recommendation and management response	Original priority
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. **Management response:** Fundraising Desktop procedure to be drawn up. *Andrew Morris – Fundraising Manager – 28/11/2018*	Medium
Current findings	**Residual risk**
We were informed that the desktop procedure had been drawn up and circulated. However, the Trust confirmed they were unable to locate or provide a copy of the procedure. **Conclusion:** In the absence of audit evidence to support the statement made the recommendation remains **open** at **medium priority**.	Charitable funds income may be incorrectly recorded and / or accounted for.

Recommendations	**Priority**
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. 3.2 Management should ensure that the original recommendation is reinstated on the Trust's audit tracker.	Medium

Management response	**Target Date**	**Responsible Officer**
3.1 Accepted – a new procedure will be developed	June 2022	Charity Director
3.2 Accepted – original recommendation will be reinstated	June 2022	Charity Director

Previous matter arising 4: Trust Guidance for Donations (Control design)	
Original recommendation and management response	Original priority
Management should draw up guidance as soon as possible that details the process to be followed for any donations or enquiries received directly by departments within the Trust. **Management response:** Communication has previously gone out to staff members advising them what to do, however management recognise that guidance can be drawn up and recirculated to all staff. *Andrew Morris – Fundraising Manager – 28/11/2018*	Medium
Current findings	**Residual risk**
We were informed that the guidance had been drawn up and circulated. However, the Trust confirmed they were unable to locate or provide a copy of the guidance. **Conclusion:** In the absence of audit evidence to support the statement made the recommendation remains **open** at **medium priority**.	Charitable Funds income is not maximised.

Recommendations	**Priority**
4.1 Management should draw up guidance as soon as possible that details the process to be followed for any donations or enquiries received directly by departments within the Trust. 4.2 Management should ensure that the original recommendation is reinstated on the Trust's audit tracker.	Medium

Management response	**Target Date**	**Responsible Officer**
4.1 Accepted – communication has previously gone out to staff members advising them what to do. However, management recognise that guidance can be drawn up and recirculated to all staff. A new communication highlighting the process for donations has been sent via the Trust's weekly staff newsletter.	Complete	Charity Director
4.2 N/a – updated recommendation addressed, therefore no need to reinstate on the tracker.	N/a	N/a

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.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

Client Organisation	Velindre University NHS Trust
Audit title	Charitable Funds
Audit reference	VT-2122-08
Final Report Date	21st April 2021
Auditor(s)	Johanna Butt

I would be very grateful if you would please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	Yes	No	Partially	n/a	Any further comments
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial e.g. providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Thank you very much for taking time to complete this questionnaire. Please return by email: **simon.cookson@wales.nhs.uk**.

AUDIT COMMITTEE

2021/22 INITIAL DRAFT INTERNAL AUDIT OPINION

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Simon Cookson, Acting Head of Internal Audit
PRESENTED BY	Simon Cookson, Acting Head of Internal Audit
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR OF CORPORATE GOVERNANCE

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board (Integrated Annual Board Effectiveness Assessment)	26/04/2022	IN SUPPORT

ACRONYMS	
-	-

1. SITUATION/BACKGROUND

Internal Audit has developed the 2021/22 Initial Draft Internal Audit Opinion (the Initial Draft Opinion) to support the Board's Integrated Annual Board Effectiveness Assessment process and the development of the Trust's Annual Governance Statement.

We present the Initial Draft Opinion to the Audit Committee for noting.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Initial Draft 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.

In developing the Initial Draft Opinion, we have taken into account the current status of our 2021/22 Internal Audit work (as of 19th April 2022) as follows:

- twelve assurance reports and one advisory review report issued as final;
- two assurance reports in draft report stage;
- two assurance reviews in late fieldwork stage (i.e., where sufficient fieldwork has been undertaken for an opinion to be determined); and
- six assurance reviews undertaken at other bodies:
  - NHS Wales Shared Services Partnership – one assurance report issued as final, and one assurance report issued as draft; and
  - Digital Health and Care Wales – four assurance reports issued as final.

Our 2021/22 Internal Audit work continues, with fieldwork ongoing on four assurance reviews (including the two noted above) and one advisory review. The Initial Draft Opinion will be updated as our work is completed in advance of final approval in June 2022.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The 21/22 Internal Audit work covered aspects of Quality and Safety, as outlined in section 2.4.2 of the Initial Draft Opinion
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	The Initial Draft Opinion covers multiple Healthcare Standards.
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

The Audit Committee is invited to **NOTE** the content of the 2021/22 Initial Draft Internal Audit Opinion.

Draft Head of Internal Audit Opinion & Annual Report 2021/22

April 2022

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

Report status: Initial Draft
Draft report issued: 19th April 2022
Final report issued: TBC
Author: Simon Cookson, Director of Audit & Assurance
Executive Clearance: Lauren Fear, Director of Corporate Governance
Audit Committee: May 2022

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Velindre University NHS Trust's (the Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

As a result of the continued impact of COVID-19 our audit programme has been subject to change during the year. In this report we have set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion.

1.2 Head of Internal Audit Opinion 2021-22

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2021/22 is that:

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.

1.3 Delivery of the Audit Plan

Due to the considerable impact of COVID-19 on the Trust, the internal audit plan has needed to be agile and responsive to ensure that key developing risks are covered. As a result of this approach, and with the support of officers and independent members across the Trust, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee (the

Committee). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2021/22 year was initially presented to the Committee in March 2021. Changes to the plan have been made during the course of the year and these changes have been reported to the Audit Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP and DHCW that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors (in 2018), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2021/22. For this year, as in 2020/21, our QAIP has considered specifically the impact that COVID-19 has had on our audit approach and programmes. We are able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have identified high priority matters arising, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, and in part reflecting the impact of COVID-19, we also undertook a number of advisory and non-opinion reviews to support our

overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2021/22

Substantial Assurance	Reasonable Assurance
• New Velindre Cancer Centre (nVCC) Mutual Investment Model (MIM) Governance • nVCC Financial Reporting (fieldwork)	• Infection Prevention & Control • Digital Health & Care Record for Cancer (CaNISC Replacement) • Divisional Review – Incident Management • Divisional Review – Risk Management • Board Committee Effectiveness • Trust Assurance Framework • Financial Systems • Scrutiny of Expenditure above £100,000 • Estates Assurance – Waste Management • Disclosure Barring Service Checks • Charitable Funds (draft report) • Follow-up of prior year recommendations (draft report) • nVCC Contract Management • nVCC MIM Procurement (fieldwork)
Limited Assurance	**Advisory/Non-Opinion**
N/A	• Use of Technology – Fit for the Future • Wellbeing of Future Generations Act (fieldwork)
No Assurance	
N/A	

Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's

objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Trust's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of

Velindre University NHS Trust which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

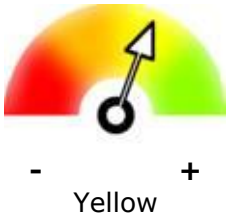
The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the

results using the eight areas that were used to frame the audit planning at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

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.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any significant recommendations made.

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2021/22 and reported to the Audit Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.

- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, two were allocated Substantial Assurance and 14 were allocated Reasonable Assurance. No reports were allocated a 'limited' or 'no assurance' opinion. In addition, two advisory or non-opinion reports were also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken three reviews in this area, all of which received **reasonable assurance** opinions.

Regarding the **Trust Assurance Framework** (TAF), significant matters arising included timely completion of the development of the TAF, completion of the refinement of operational risk reporting through the Trust Risk Register and ensuring key decisions and supporting justifications are

clearly demonstrated in Board and Committee papers / minutes. We also noted that there was no formal risk reporting to Board level during the period under review (September 2020 to September 2021).

We reviewed **Board Committee Effectiveness** in light of the September 2020 restructuring of the Trust's committees, noting the Trust had plans in place or was already acting to address many of the matters we identified throughout the review. We highlighted further actions to ensure robustness in the process and support the Trust in maximising efficiency and effectiveness, including clearer alignment of the committee cycles of business and agendas with the Trust's objectives and risks and ensuring a robust benefits realisation is undertaken on the restructuring.

No significant matters arising were identified in our audit of the Trust's new process for **Scrutiny of Expenditure above the Chief Executive's Limit**.

During the year, we were asked to undertake an advisory review on the Trust's Ways of Working, to look at whether governance arrangements in place are sufficient to deliver the strategic transformation plans. However, this review was cancelled due to the impact of the Covid-19 pandemic.

Strategic Planning, Performance Management & Reporting

We have undertaken one review in this area, an **advisory review** on the **Wellbeing of Future Generations Act**. The review was in late fieldwork stage at the time of drafting this report and aims to provide support and guidance on embedding the Sustainable Development Principle and Five Ways of Working throughout the Trust's operations.

Financial Governance and Management

The two reviews undertaken in this area – **Financial Systems** and **Charitable Funds (draft report)** – received **reasonable assurance** opinions. No significant matters were identified for reporting in either audit, although we note that management action regarding our prior year debt management findings was ongoing at the time of the Financial Systems review.

The audits of the payment systems provided by NWSSP, which we audit each year, concluded with positive assurance. The audits of Payroll (draft report) and Accounts Payable both received reasonable assurance opinion ratings.

Quality & Safety

We have provided **reasonable assurance** opinions on the two reviews undertaken in this area.

Infection Prevention & Control (IPC) has been an area of enhanced focus for the Trust and the positive assurance outcome (with no significant matters to report) is a result of this focus and the work undertaken by the Trust's IPC team and leads.

Our audit of **Disclosure Barring Service (DBS) Checks** was requested during the year to provide assurance the Trust has appropriate arrangements in place. We did not identify any significant matters for reporting.

The audit of the Trust's Quality and Safety Framework was deferred for inclusion in the internal audit plan for 2022/23 to a time when the Framework is sufficiently advanced to enable audit scrutiny. This also ensured our work did not overlap with the Audit Wales Quality Governance review which has taken place throughout 2021/22.

Information Governance & Security

We undertook two reviews in this area.

We provided a **reasonable assurance** opinion over our audit of the **Digital Health & Care Record for Cancer (CaNISC Replacement)**. Due to delays in implementation of the project, we could not complete a full review of the project. Key findings from the work we undertook were the need to ensure functionality is delivered so the ways of working can be finalised and that the delivery of full functionality was reliant upon further phases of development being approved nationally. We intend to revisit this area as part of our 2022/23 Internal Audit Plan.

Our **Use of Technology – Fit for the Future** report was an **advisory review** providing an assessment of the Trust's position and preparedness for the current and future provision of services using digital technology. Overall, the report concluded the Trust is well positioned to take forward the use of technologies whilst noting key barriers to progress in the lack of a Digital Strategy or Transformation Programme, a lack of visibility and leadership on digital at a Board level and a lack of security on the digital funding position.

Operational Service and Functional Management

We have undertaken two reviews in this area, being **divisional deep dives into risk and incident management**.

Whilst both reviews received **reasonable assurance opinions**, we noted a lack of consistency between the divisions in the approach to these areas, both in terms of our findings and the management responses received.

Our planned review of Private and Overseas Patients was deferred because the Trust commissioned a separate comprehensive independent review of Private Patients and developed an action plan in response. Our planned

review would have duplicated this work. We intend to revisit this area early in our 2023/24 Internal Audit Plan to follow-up on action taken in response to the independent report.

Workforce Management

We did not undertake any reviews under this domain, although note that our audit of DBS Checks (covered under the Quality & Safety domain) covers some aspects of workforce management.

Capital & Estates Management

We have undertaken five reviews in this area.

The audit of **Estates Assurance – Waste Management** received a **reasonable assurance** opinion.

Two positive reports were issued regarding the Integrated Audit and Assurance Plan (IAAP) for the new Velindre Cancer Centre (nVCC) development. The audit of the **Mutual Investment Model (MIM) Governance** received a **substantial assurance** opinion and the audit of **nVCC Contract Management** received a **reasonable assurance** opinion.

Additionally, two nVCC IAAP reviews were in late fieldwork stage at the time of drafting this report. We are expecting to provide a **substantial assurance** rating over **Financial Reporting** and **reasonable assurance** over **MIM Procurement**.

The nVCC IAAP audits of Design and Change Management and Enabling Works were in early fieldwork stage at the time of drafting this report.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports. In particular, as the only 2020/21 limited assurance report issued to the Trust was followed up during 2020/21, we considered progress made on a risk-based sample of findings in reports where we were able to give Reasonable Assurance, focusing mainly on high and medium priority findings. We also undertook some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

For the second year in a row, due to the impact of COVID-19, we are aware that it has been more difficult than usual for NHS organisations to implement recommendations to the timescales they had originally agreed.

In addition, we also recognise that for new recommendations it may be more difficult to be precise on when exactly actions can be implemented by. However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

Going forward, given that it is very likely that the number of outstanding recommendations will have grown during the course of the pandemic, audit committees will need to reflect on how best they will seek to address this position.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Trust's recommendation tracking process continued during 2021/22, but the pandemic affected the ability of management to take forward recommendations in some areas. Our follow-up of prior year findings took this into account in our assessment of the implementation of the recommendations.

Whilst we were able to provide a **reasonable assurance** opinion in our **follow-up of prior year recommendations** report, we identified areas for improvement in the Trust's audit recommendation tracker process. This included the need for clearer accountability and ownership in the process to ensure recommendations are appropriately implemented on a timely basis.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and

cyclical coverage on key control systems. In addition, the impact of COVID-19 on this year's (and to an extent last year's) programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Trust, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2021/22 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Trust's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2021/22.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The

work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit & Risk Committee that it has conducted its audit at Trust in conformance with the Public Sector Internal Audit Standards for 2021/22.

Our conformance statement for 2021/22 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2021/22 which will be reported formally in the Summer of 2022; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2021/22 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE TRUST

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership; and
- Digital Health & Care Wales.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Trust. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

Audit	Opinion	Comments
Accounts Payable	Reasonable	-
Payroll	Reasonable	Draft report

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Trust. These audits derived the following opinion ratings:

Audit	Opinion	Comments
Welsh Radiology Information System	Reasonable	-
Data Centre Transition	Substantial	-
Data Analytics (Information)	Reasonable	-
System Development	Reasonable	-

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre University NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2022/23 operational audit plan.

The audit plan approved by the Committee in March 2021 contained 15 planned reviews (excluding the separately agreed Integrated Audit and Assurance Plan for the new Velindre Cancer Centre). Changes have been made to the plan with two audits added and three deferred/cancelled. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 13 reviews, with a further advisory review in the fieldwork stage at the time of drafting this report. Additionally, we have delivered two reviews relating to the nVCC Integrated Audit and Assurance Plan and a further four were in the fieldwork stage at the time of drafting this report.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Trust. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	March 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2020/21	G	100%	100%	v>20%	10%<v<20%	v<10%

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	50%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 18 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

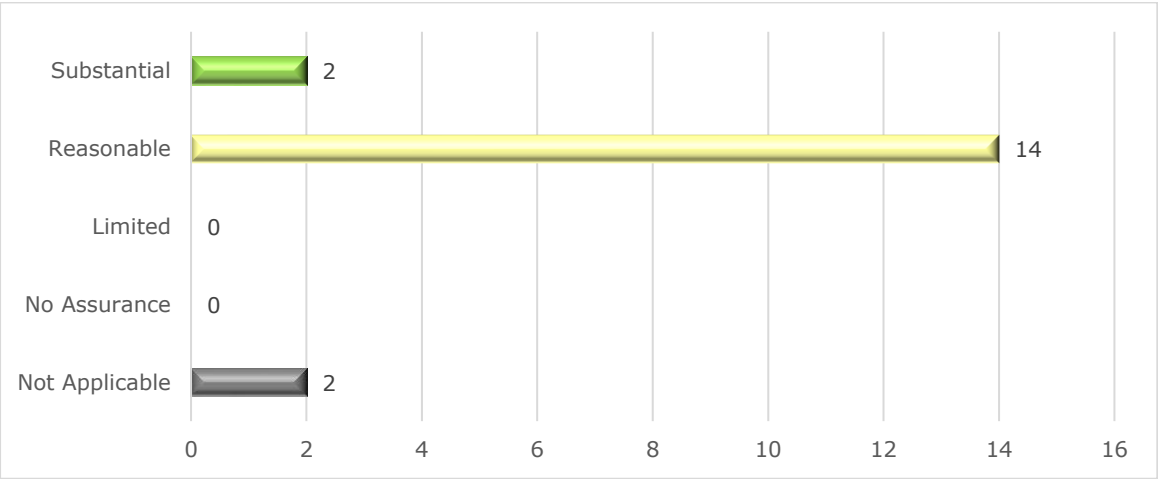


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP and DHCW.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of COVID-19 was the reason for the deferral or cancellation and in other cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
nVCC Mutual Investment Model (MIM) Governance	The audit was undertaken to determine whether governance arrangements were in place at the nVCC project as it enters the competitive dialogue phase of the Project Master Plan.
nVCC Financial Reporting (fieldwork)	To determine whether appropriate financial reporting / management is in place at the nVCC project as it enters the next stages of the Project Master Plan.

5.3 Reasonable Assurance (Yellow)

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Infection Prevention & Control (IPC)	We assessed adherence to: • the Trust's IPC policies; and • the Health and Care Standards. We focused on IPC activities within the Trust's divisions.
Digital Health & Care Record for Cancer (Canisc Replacement)	To provide assurance to the Trust that arrangements are in place for appropriate management of the Canisc replacement enabling the successful implementation of the system.
Divisional Review – Incident Management	To provide the Trust with assurance that: • its divisions and directorates / operational service groups are compliant with Trust incident management policies and procedures; and • incidents are being effectively managed at a divisional and directorate / operational service group level.
Divisional Review – Risk Management	To provide the Trust with assurance that: • its divisions, directorates and departments are compliant with Trust risk management policies and procedures; and • risks are being effectively managed at a divisional, directorate and departmental level.
Board Committee Effectiveness	To provide the Trust with assurance over the: • effectiveness of the new Board Committee structure; and • the adequacy and effectiveness of controls in operation.
Trust Assurance Framework (TAF)	To provide assurance that the TAF is robust, and that the Trust is managing its principal risks.
Financial Systems	To provide the Trust with assurance that core financial systems are operating effectively. We considered the key controls over the following areas:

Review Title	Objective
	• non-pay expenditure; and • fixed assets. We also followed up on our three 2020/21 high and medium priority matters arising, all of which related to debt management.
Scrutiny of Expenditure above £100,000	To provide the Trust with assurance that the newly implemented scrutiny process for expenditure over the Chief Executive's limit is operating effectively.
Estates Assurance – Waste Management	The audit was undertaken to assess the Trust's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.
Disclosure Barring Service (DBS) Checks	To ensure the Trust has appropriate arrangements in place in relation to DBS checks and that national DBS standards / requirements are complied with.
Charitable Funds (draft report)	To review whether the operational procedure is compliant with policies of the Trust as trustee.
Follow-up of previous recommendations (draft report)	To provide assurance that recommendations are implemented appropriately and in a timely manner.
nVCC Contract Management	The audit was undertaken to determine whether appropriate contractual arrangements are in place at the nVCC project, for technical and professional advisory services, as it enters the next stages of the Project Master Plan including competitive dialogue.
MIM Procurement (fieldwork)	To determine the adequacy of the procurement process undertaken by the Trust in receiving Pre-Qualification Questionnaires to participate in competitive dialogue for the Design & Build contract at the nVCC.

5.4 Limited Assurance (Amber)

No reviews were assigned a 'limited assurance' opinion.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Use of Technology – Fit for the Future	To provide an assessment of the Trust's position and preparedness for the current and future provision of services using digital technology. To evaluate and determine the ability of the Trust to move to a digitally enabled organisation and ensure that it drives value from investment in new technology.
Wellbeing of Future Generations Act (fieldwork stage)	To support the Trust in its development of the Sustainability Strategy and supporting implementation plan. Regarding the content and development of the Sustainability Strategy, we are identifying: • what the Trust is doing well; and • areas for development and improvement.

Review Title	Objective
	We are also providing an independent review of the sustainability gap analysis undertaken by the Trust on its Transforming Cancer Services Strategy.

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Objective / Reason for Deferral
Quality & Safety Framework	To review key aspects of the Trust Quality and Safety Framework to ensure it is operating effectively in practice. Deferred for inclusion in the internal audit plan for 2022/23 to a time when the Framework is sufficiently advanced to enable audit scrutiny. This also ensured our work did not overlap with the Audit Wales Quality Governance review which has taken place throughout 2021/22.
Private & Overseas Patients	To review processes and controls in relation to Private and/or overseas Patients. Deferred because the Trust commissioned a separate comprehensive independent review of Private Patients and developed an action plan in response. Our planned review would have duplicated this work. We intend to revisit this area early in our 2023/24 Internal Audit Plan to follow-up on action taken in response to the independent report.
Ways of Working (Advisory)	To look at whether governance arrangements in place are sufficient to deliver the strategic transformation plans. Cancelled due to the Covid-19 pandemic.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2021/22 plan.

Simon Cookson

Gyfarwyddwr Archwilio a Sicrwydd / Director of Audit & Assurance Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

April 2022

Appendix A – Conformance with Internal Audit Standards

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee.

	Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

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.

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

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

PROPOSED 2022/23 ANNUAL INTERNAL AUDIT PLAN

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Simon Cookson, Director of Audit & Assurance
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR OF CORPORATE GOVERNANCE

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Team	27/04/22	PROPOSED TO BE ENDORSED FOR APPROVAL

ACRONYMS	
-	-

1. SITUATION/BACKGROUND

Audit & Assurance Services has developed its Proposed 2022/23 Internal Audit Plan (the Plan) and presents the Plan to the Audit Committee for approval.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Plan development

The Plan was developed by Audit & Assurance Services through discussions with the Trust's Executive Directors, namely, the Chief Executive, Director of Corporate Governance and Director of Finance. We also considered:

- the Trust's key risks, as articulated in the Trust Assurance Framework and Trust Risk Register; and
- our knowledge of the organisation from attendance at various meetings, including meetings of the Board and Quality, Safety and Performance Committee, and meetings with Executive Directors and Trust senior management throughout the course of the year.

The Plan is proposed to be endorsed for approved by the Executive Team on 27th April 2022.

Plan content

Our proposed 2022/23 reviews are set out in Appendix A of the Plan. This includes:

- 13 assurance reviews; and
- one advisory / no opinion review on Staff Wellbeing.

Additionally, assurance reviews within the Integrated Audit and Assurance Plan for the development of the new Velindre Cancer Centre and Enabling Works are being separately agreed.

All assurance reviews in the Plan are full scope audits, unless specifically identified within the outline scope in Appendix A. In particular, we draw the Audit Committee's attention to the following reviews:

- Financial and Service Sustainability: with a view to providing assurance over the sustainability of services, particularly in relation to the Transforming Cancer Services and Velindre Futures transformation programmes, this will be a key area of focus in our Annual Internal Audit Plans over the coming years. We will determine the specific area(s) of focus through discussions with the Trust when we plan this review; and
- Divisional Deep Dive: as in 2021/22, we will undertake a deep dive across both divisions on a specific risk area to be agreed with the Trust to provide assurance

over divisional operations and support the Trust's goal to work as a joined-up organisation.

We will also develop a programme of assurance for the non-capital elements of the Transforming Cancer Services and Velindre Futures transformation programmes, similar to work we have undertaken on the Aneurin Bevan University Health Board Clinical Futures programme.

Other risk areas

Several areas were identified during the annual planning process as being potential replacement reviews should we need to revise the 2022/23 Plan. These were:

- Information Governance / Records Management; and
- Job Planning.

Should audit work in these areas not take place during 2022/23, we will ensure priority inclusion in the 2023/24 Plan.

Additionally, Private Patients remains a key area of focus for us. To allow the Trust time to implement the actions identified from the independent review of Private Patients, we intend to undertake a follow-up review against these actions early in the 2023/24 Plan.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Quality and Safety is covered in the 22-23 Plan, specifically through our audits of the Quality & Safety Framework, Clinical Audit and Patient & Donor Safety
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	The IA Plan covers multiple Healthcare Standards dependent upon the area under review. We will identify the specific standards addressed in our audit briefs.
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

The Audit Committee is asked to:

- **APPROVE** the Proposed 2022/23 Internal Audit Plan;
- **APPROVE** the Internal Audit Charter (Appendix C);
- **NOTE** the associated Internal Audit resource requirements (section 5) and Key Performance Indicators (Appendix B);
- **NOTE** the potential 2022/23 replacement reviews; and
- **NOTE** the intention to follow-up on the implementation of actions identified in the independent review of Private Patients in 2023/24.

Annual Internal Audit Plan: Draft Internal Audit Charter

April 2022

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

1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Trust Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19 and the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Trust Assurance Framework (TAF), Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Trust Assurance Framework and the Trust Risk Register (TRR) together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Trust, namely Public Health Wales (PHW), Health Education and Improvement Wales (HEIW), NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC).

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Trust's governance and assurance arrangements and the contents of the Trust Assurance Framework and Trust Risk Register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Safety and Performance Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head

of Internal Audit has met and spoken with a number of Trust Executive Directors and Independent Members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Trust's Executive team, the Chair of the Audit Committee and the Chair of the Board.

The draft Plan has been provided to the Trust's Executive Management Team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Trust Assurance Framework and Trust Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the Trust Assurance Framework and/or Trust Risk Register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by the Trust in its business case submission.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Simon Cookson

Director of Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2022/2023

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Director of Corporate Governance	Q4
Financial and Service Sustainability	01	TAF 01, 03, 08 TRR 2249, 2200	To review the arrangements in place (including demand and capacity planning) to ensure sustainability of services, including the longer-term planning for the Transforming Cancer Services and Velindre Futures transformation programmes. Specific areas of focus to be determined in discussion with the Trust.	Director of Finance / Chief Operating Officer / Director of Strategic Transformation, Planning & Digital	Q1
Cyber Security	02	TRR various	Specific focus to be agreed in discussion with the Trust and the cyber resilience unit. Work being undertaken nationally across NHS Wales.	Director of Strategic Transformation, Planning & Digital	Q3
Digital Health Record	03	TAF 07	To provide assurance that the Trust is prepared for the November 2022 'go live' date.	Chief Operating Officer / Director of Strategic Transformation, Planning & Digital	Q2/3
Staff Wellbeing (Advisory)	04	N/A	To review staff wellbeing support and initiatives utilised by the Trust, including throughout the Covid-19 pandemic. To determine if improvements can be made through benchmarking.	Director of Workforce & Organisational Development	Q2

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Divisional Review (Deep Dive)	05	TBC when focus agreed	Deep dive on a specific risk area across both divisions. Specific focus to be agreed in discussion with the Trust.	Chief Operating Officer	Q2
Research & Development	06	TAF 02, 09, 10	To provide assurance that there are effective systems, processes and governance in place around the research and development function, including partnership working.	Medical Director	Q2
Strategic Transformation Assurance	07	TAF 01, 02, 03, 05, 09	Programme of assurance for non-capital elements of the Transforming Cancer Services and Velindre Futures transformation programmes. To be agreed in discussion with the Trust.	Chief Executive / Chief Operating Officer / Director of Corporate Governance / Director of Strategic Transformation, Planning & Digital	Q4
Performance Management Framework	08	TAF 10	To provide assurance over phases 1 and 2 of the Trust's performance management framework development.	Director of Strategic Transformation, Planning & Digital	Q3
Quality & Safety Framework	09	TAF 06, 10	To review key aspects of the Trust Quality and Safety Framework to ensure it is appropriately designed and operating effectively in practice.	Director of Nursing, AHPs & Medical Scientists	Q3
Clinical Audit	10	TAF 06	To provide assurance that there are effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services.	Medical Director / Director of Nursing, AHPs & Medical Scientists	Q1
Patient & Donor Experience	11	TAF 06	To review the processes for capturing patient and donor reported experience measures and how data is used to effectively inform service improvement.	Director of Nursing, AHPs & Medical Scientists	Q3

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Capital provision	12	TBC when focus agreed	Focus on discretionary capital and / or major projects / programmes. Specific areas of coverage to be risk assessed and agreed with the Trust during 2022/23. Areas of coverage may include: • Compliance with Trust Capital Systems / Procedures; • Capital Planning; • Equipment; and • Project Audits (not progressed via Integrated Audit and Assurance Plans).	Director of Strategic Transformation, Planning & Digital	Q2/3
Estates Assurance - Decarbonisation	13		To determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy, and to provide assurance on decarbonisation capital allocations provided by Welsh Government to address decarbonisation issues across the estate during 2021/22.	Director of Strategic Transformation, Planning & Digital	Q2
Follow Up	14	N/A	Follow-up will be considered towards the end of the financial year if required.	Director of Corporate Governance / Director of Finance / Executive Team	Q4

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales, Welsh Health Specialised Services Committee and Emergency Ambulance Services Committee.	Director of Corporate Governance	Q4
Integrated Audit and Assurance Plans					
New Velindre Cancer Centre (nVCC) development and Enabling Works (nVCC)	N/A	N/A	2022/23 audits under this Integrated Audit & Assurance Plan to be agreed and charged for separately.	Director of Strategic Transformation, Planning & Digital	Per plans

Please note: The relevant national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed by 30 April (Audit Committee 3 May 2022)	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Velindre University NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Velindre University NHS Trust. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Velindre University NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
April 2022

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

VELINDRE UNIVERSITY NHS TRUST

Audit Committee 3rd May 2022

Counter Fraud Progress Report for the period 1st January 2022 to 31st March 2022

Nigel Price
Counter Fraud
Cardiff & Vale University Health Board

VELINDRE UNIVERSITY NHS TRUST

AUDIT COMMITTEE 3rd May 2022

COUNTER FRAUD PROGRESS REPORT

Mission Statement
To provide the Trust with a high-quality NHS Counter Fraud Service, which ensures that any report of fraud is investigated in accordance with NHS Secretary of State Directions and all such investigations are carried out in a professional, transparent and cost-effective manner.

1. INTRODUCTION

1.1 In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report details the Counter Fraud and Corruption work carried out, by the Trust's Local Counter Fraud Specialists, for the period 1st January 2022 to 31st March 2022.

The report's style has been agreed, in consultation with the Trust's Director of Finance, with the objective of informing, the Audit Committee of referrals of suspected fraud, investigations and any operational issues.

The Annual Work-Plan has 110 days allocated to the Trust for counter fraud work. At 31st March 2021, all 110 days have been completed and reported in Appendix 1. The days have been used in conducting investigations into allegations of fraud; interviewing witnesses and suspects; completing the Government's National Fraud Initiative; reviewing policies; preparing, and delivering fraud awareness sessions and analysing the feedback on those presentations; preparing reports for and attending national and audit committee meetings and completing national exercises set by the Counter Fraud Authority.

Any significant changes in the progress of the work, since the last report are outlined in point 2 below. An index of all referrals that have been or are still being investigated during this period is attached at Appendix 2.

2. CURRENT CASE UPDATE

During this reporting period no investigations have been closed, two investigations remain open; which are listed in Appendix 2.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

Face-to-face presentations have been severely reduced due to the COVID-19 restrictions. During this reporting period no presentations have been delivered. However, feedback from all the presentations this year shows that 100% "strongly agreed" that,

after the presentation, they are more comfortable discussing their concerns that a fraud may be happening.

3.2 Counter Fraud Resources Update

A new counter fraud specialist was appointed and started in January 2022 and a new manager has been appointed and started on the 1st April 2022. The department is now at fully resourced.

3.3 Employment Agency Risk Assessment Exercise

A health board recruited a new member of staff who had been provided by a recruiting agency. It was later discovered that their stated qualifications and experiences were false. An investigation by the Local Counter Fraud Services (LCFS) revealed a weakness in the recruiting process.

Following that incident, a risk assessment exercise has been conducted across several organisations to confirm that agencies apply robust checks on the claims made by potential employees. Agencies contracted to supply staff to the NHS must comply with requirements to complete pre-employment checks as set out in the NHS Employment Check Standards 2016.

The risks of employing unqualified and untrained staff in an organisation can have a considerable negative impact on;

1. Patient Safety,
2. Staff Safety
3. Health and safety within the workplace.
4. Financial Management.
5. the professional reputation of the organisation.

At the time of reporting it has not been possible to complete this exercise for the Trust due to difficulties in obtaining a full list of agencies which were used during the 2020/21 financial year. In the other exercises a total of 17 different agencies have been checked. Details of 103 agency workers out of the total 384 provided by these agencies have been assessed. Across all of the agencies whose practices were reviewed, only one agency was found not have completed satisfactory checks. It was established that there was a misunderstanding between the organisation and the agency. The agency staff believed

the organisation was conducting the relevant checks regarding experience and the organisation believed them to have been completed by the agency.
Although not yet specifically conducted for Velindre, it is likely that the agencies used will overlap with those already checked. It is believed that the results of any future checks would result in similar findings.
The following recommendations have been made by the LCSF to mitigate any future risks:

1. When requesting staff from a recruiting agency, include a note that highlights that it is the agencies' responsibility to complete pre-employment checks.

2. Conduct 'mini local audits' at regular intervals. At periodic intervals randomly select a worker who is being supplied, request the agency to provide all of the pre-employment/due diligence check information. This will ensure regular random checks are completed to ensure standards are kept high.

3. Include in the requisition document any information regarding restrictions on working hours/visas. The agencies hold this information and should not allow working over these restrictions but it is important to know this as the end 'employer' to avoid any inadvertent breaches to these restrictions.

4. When recruiting for a role that requires specific qualifications or registration ensure that it is clearly set out in the requisition that they are required and that it is expected that the agency will ensure that these are held by the worker prior to their commencing work.

5. In relation to agency suppliers, they should be informing the organisation of any changes to agency workers situation or who are no longer working for them in order to provide a more effective service. This could be a quarterly or bi-annual process in order to keep the Trust's records current and to reduce the risk of financial loss to the organisation.

A Velindre-specific exercise can be completed when the required information is available, however, in the absence of this the above recommendations are believed to be necessary at this time.

This exercise has shown that the agencies supplying staff have completed the majority of the required checks effectively and accurately, one shortcoming was identified which gave rise to potential risks to that organisation. However, the above recommendations will mitigate this risk in the future.

Recruiting staff through agencies and relying on an agency to complete thorough checks will always carry some level of risk. However, this risk can be reduced by setting out clearly and precisely what is required and expected from the agencies and conducting regular checks that it is being completed, as detailed above in the recommendations.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2020/21

AREA OF WORK	Velindre Planned Days	Days to Date
General Requirements		
Production of Quarterly Reports to Audit Committee	5	7
Attendance at Audit Committees	5	5
Planning/Preparation of Annual Report and Work Programme	5	7
Annual Activity		
Creating an Anti Fraud Culture	8	5
Presentations, Briefings, Newsletters etc.	16	14
Other work to ensure that opportunities to deter fraud are utilised	4	4
Prevention		
The reduction of opportunities for Fraud and Corruption to occur	6	6
Detection		
Pro-Active Exercises (e.g. Procurement)	6	6
National Fraud Initiative 2020/21	10	10
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	25	28
Ensure that Sanctions are applied to cases as appropriate	2	1
Seek redress, where fraud has been proven to have taken place	3	2
Pooled days to be used on “as and when” basis	15	15
TOTAL VELINDRE UNIVERSITY NHS TRUST	**110**	**110**

APPENDIX 2

COUNTER FRAUD ASSIGNMENT SCHEDULE 2021/22

Case Ref	Allegation	information	Current Situation
INV/21/00012	Providing false information to obtain a bursary	The allegation is that a student nurse withheld information to obtain more bursary funding than they were entitled.	**Opened 09/04/2021** Subject interviewed under caution twice. Witnesses have been interviewed and given statements. A 3rd interview of the suspect took place in April. Inquiries are continuing.
INV/21/00319	Abuse of position	The allegation in this case is that a senior manager gave preferential treatment to people not entitled to receive it.	**Opened 21/10/2021** The subject has been interviewed under caution and witness have been also been interviewed and given statements. This investigation is now on hold until the completion of the Trust's disciplinary process has been completed. **Update April 2022** a case conference was held to review the evidence and the information provided by witnesses. The decision was made that all the available evidence was not enough to support a criminal trial. The case will be dealt with by an internal discipline process but will remain open until that has been completed.

APPENDIX 3
Counter Fraud Newsletter January 2022

Counter Fraud Newsletter

January 2022

CAVUHB | Velindre | HEIW | PHW | NWSSP | DHCW

Local Counter Fraud Specialists (LCFS)

Welcome to the January 2022 edition of the Counter Fraud Newsletter

As the NHS came under unprecedented pressure from the COVID-19 pandemic, fraud was probably not at the top of most people's minds. Unfortunately, the same cannot be said for the criminals who target the NHS for financial gain. Fraudsters are always on the lookout for ways to make money from their victims, and their actions are a growing threat to individuals and organisations alike. Fraud in the NHS, on any scale, diverts crucial resources away from patient care, salaries and services.

Your LCFS team aims to raise awareness of fraud, offer advice and investigate fraud within the NHS. In more complex cases the LCFS team are supported by the Counter Fraud Service (CFS) Wales. Our end goal being to reduce fraud, identify persons responsible and recoup losses through Civil or Criminal Prosecution.

Below is a recent example of a fraud that your LCFS Team assisted in investigating:

A report was received that a nurse had been working on the bank whilst on sick leave from their full time employment.

An investigation as undertaken which showed the allegation to be true. However, prior to any formal action the subject resigned their position.

NOTE: Although people may not immediately see the impact this has on the NHS and its significance. It is key to remember that whilst on sick leave the NHS is paying sick pay (up to a full wage dependant on the situation), also paying to cover that persons 'normal' role and then in addition paying that same person bank pay.

Case Example: Recent investigation found a staff member left the NHS and continued to receive payments totalling over £3,800. The money has been recovered through civil proceedings.

Did you know?

Failure to disclose an overpayment could result in a criminal investigation.

An overpayment could be made in a number of ways; normal salary payment, maternity/paternity pay, continued pay after leaving the organisation. This could be a small amount or thousands of pounds.

It is your responsibility to check your payslips and disclose any over payments. If you don't do this you may be committing a criminal offence.

Mistakes happen, it may not be your fault that you received an over payment but it is wrong to know about it and keep it. If you are unsure then ASK, don't just wait. Cases can be resolved by a mutual agreement to pay back the money in a fair and reasonable timescale, as long as you are honest and upfront.

However, if you do not disclose the payments the matter may be referred to the Counter Fraud department for further investigation.

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

NHS Counter Fraud Service (Wales) recent case:

Following an investigation by NHS Counter Fraud Service (Wales), a doctor who abused his position to defraud both the NHS and fellow medics was sentenced at Cardiff Crown Court on 09 March 2021 to two years' imprisonment, suspended for two years. Dr Aled Meirion Jones pleaded guilty to two counts of Fraud by Abuse of Position (contrary to Section 4 of the Fraud Act 2006). He was also ordered to complete 200 hours of unpaid work within 12 months. A mitigating factor in sentencing was his gambling addiction, which was designated as a medical condition.

Dr Jones was reported via the NHS Counter Fraud Authority's Fraud & Corruption Reporting Line. The allegation being he diverted cheques to his own bank account that had been legitimately earned by other doctors for their work to certify the cause of death before a person's body is released for cremation.

In March 2019, Dr Jones was arrested by South Wales Police. Following his arrest, Dr Jones was interviewed under caution by specialist investigators for NHS CFS (Wales). He made full admissions to the theft of the cheques but denied any other wrongdoing. However, further enquiries revealed that between 2017 and 2019, Jones had stolen and altered numerous cheques worth £33,235.40; and submitted false claims for exaggerated hours and Locum shifts he did not work to a number of health boards in South Wales, totalling £34,184.86.

NHS Counter Fraud Service Wales Financial Investigators have now used their powers under the Proceeds of Crime Act 2002 and recovered the money.

Full details of this press release can be found here: £66,000 NHS money recovered from fraudster by NHS CFS Wales | NHS Counter Fraud Authority | NHSCFA

MANDATE FRAUD

Mandate fraud is where a fraudulent request is made to change the bank account details held for a genuine NHS supplier. This could then result in funds being transferred directly into a fraudsters bank account.

Fraudsters have used the COVID-19 pandemic to their advantage with this type of fraud. Making seemingly genuine requests with urgent timescales blaming the pandemic, meaning people are more likely to believe them.

Always be vigilant, especially when someone is requesting changes of bank details. If you are unsure do not rush anything, make further checks (through existing confirmed contacts) and follow internal procedures. You can also contact your LCFS Team for further help and support.

More information on mandate fraud and how to mitigate the risk can be found here: Mandate fraud risks | COVID-19 guidance| NHS Counter Fraud Authority (cfa.nhs.uk)

Local Counter Fraud Team

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

They are always happy to help and will treat what you have to say in confidence.

Nigel Price	Emily Thompson	Henry Bales
Tel: 02921 836 481	Tel: 02921 836 262	Tel: 02921 836 265
Email: Nigel.Price@wales.nhs.uk	Email: Emily.Thompson@wales.nhs.uk	Email: Henry.Bales@wales.nhs.uk
Local counter Fraud Specialist	Local counter Fraud Specialist	Local counter Fraud Specialist

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

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

NHS WALES
Velindre University
NHS Trust

COUNTER FRAUD PLAN
2022/2023

Gareth Lavington
Manager Counter Fraud
Cardiff and Vale UHB

This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Manager on behalf of VU NHS Trust in order 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 Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Gareth Lavington

Workplan agreed by:

Executive Director of Finance – Matthew Bunce

Date: 20/04/2022

WORKPLAN 2022-2023

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 (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 31/05/2023. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. They will provide a grading of compliance in relation to all areas of the functional standards. (Green, Amber or Red)

In order to achieve the standards set by the NHSCFA, Velindre University NHS Trust follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and buys in provision from Cardiff and Vale University Health Board for access to a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS). To ensure that the Health Board'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 Velindre University NHS Trust for 2022-2023. The tasks outlined will be considered and reviewed dynamically throughout the year as the need arises. 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 for the first time will directly mirror GovS:13 Standard (Counter Fraud) in order to bring the organisations provision into line 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 Local Counter fraud Specialist (LCFS).
The counter fraud work-plan should be tailor-made and specific to the NHS organisation, for example, carrying out local proactive exercises identified in the course of 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 local procedures adopted for such by the organisation, shared with the Internal Audit department and reported to DoF and Audit Committee. This aims to provide another level of assurance that the risk will be **owned** and managed. 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. Information received from external sources will be assessed and any risks locally identified will be targeted as a result.

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. This helps the LCFS when assessing the counter fraud arrangements at their own organisation. This provides direction in risk assessment work and provides a basis of measuring local risks using a dedicating risk matrix scoring system and template. Results of all local risk work carried out by the Counter Fraud Team will be reported through the quality

assurance process to NHS CFA, managed on the CLUE case management system and will be locally reported to the Audit Committee

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 External Auditors when planning Local Counter Fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which 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 Cardiff and Vale UHB Counter Fraud team, on behalf of VU NHS Trust will maintain a close working relationship with Wales Audit as required.

Resource Provision

Resource Provision for VU NHS Trust	Days Planned 22 / 23
Counter Fraud provision bought in from CAVUHB	110

Resource by Activity

Activity	Days Planned 22 / 23
Proactive	70
Reactive	40
Total	110

With the move to the GovS:13 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 breaking down resource time spent 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 as a result 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 this will be reported in progress reports to the DoF and the Audit and Assurance Committee. Any changes to the overall days provided or in regard to the areas planned for will be reported in the end of year report.

Work Plan Objectives

The 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	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 the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the	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. The DoF to act as the link between the Audit and Assurance Committee (AAC) and Risk Management Group to allow key risks to be identified, managed and mitigated. CFM to produce the VU NHS Trust 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 AAC and to present these quarterly at AAC.	Ongoing throughout the Year Ongoing throughout the year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
NHSCFA at the earliest opportunity and in accordance with the nominations process. N.B. 'Equivalent body' may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation 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.	Checks to be carried out by CFM that nominations to NHSCFA are correct, up to date and in order. Where necessary and appropriate Counter Fraud Manager (CFM) will seek to hold regular one to one meetings with the Audit Committee Chairperson, Counter Fraud Champion. In addition to this CFM to attend pre-audit committee meetings with non-executive Audit Committee and Board Members. Counter Fraud to remain a standing agenda item at AAC. Counter Fraud Manager to provide written and oral reports to this forum, annually and progressively throughout the year. CFM to report to DoF and AAC any matters arising from NHSCFA in relation to thematic assessment exercises, matters arising out of Fraud Prevention Notices and national exercises.	Q1 As required Ongoing throughout the year Throughout the year addressing matters arising as necessary

Gov s013 / NHS Requirement	Objective	Proposed Delivery
The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. 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 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 regularly with internal partners, such as Internal Audit, HR, Information Governance and Communication Department to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision. CFM to carry out annual reporting to NHSCFA in the form of the NHS CFA Functional Standard return and to subsequently address any issues rising from the results of this assessment.	Throughout the year (regular 1:1 meetings diarised in advance where possible) Q1

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 resource allocation are aligned to the objectives of the strategy and locally identified risks. **(The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)**	CFM to verify that the organisational Counter Fraud Bribery and Corruption Policy is in place and review to check that in date and fit for purpose. CFM to ascertain whether the local policy is properly aligned to the current NHS CFA Strategy. CFM to ensure that work planned for in the Annual Counter Fraud Plan and that work carried out is 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 & Q2 Q1 Continual Monitoring
3: Fraud bribery and corruption risk assessment	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. Locally identified risk	

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 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	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 AAC by way of counter fraud progress reporting. CF Team to develop a fraud risk profile upon the CLUE case management system in order to effectively evaluate, evidence and measure the effectiveness of counter fraud risk assessment work with a view to reducing fraud to an absolute minimum. Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year as a result of local identification or if 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.	Dynamic – throughout the year as the need arises

Gov s013 / NHS Requirement	Objective	Proposed Delivery
risks within any associated sub company of the NHS organisation.	CF manager to explore with Corporate Governance the preferred method of reporting and recording risk, including the maintenance of a register review. (To compliment the recording upon CLUE) Where resource implications are present priority to be given to those areas identified as higher risk.	Q1& Q2
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. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF Manager to establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. Counter Fraud team to promote awareness of the policy at presentations 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 Throughout the Year Q3 & Q4

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 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 complete annual CF fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed action time period. CF Manager to ensure the plan is agreed by DoF, ratified by AAC and is informed by national and local risk and is aligned to organisational objectives and CFA Strategy. CF Manager to ensure that the provision of the CF function is written in to the overall organisation plan. CF manager to provide quarterly reports to AAC. CF manager to provide quarterly statistics to Counter Fraud Service Wales. CF manager to provide annual report measuring the effectiveness of the plan.	Q4 (Due to change of manager 22/23 plan provided Q1 as agreed by AAC) Q1 Throughout the Year Q4
6: Outcome-based metrics	A new contact, enquiry and reporting method is being developed by the CF team. This will benefit from the	

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 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.	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. Where necessary regular review will be used to inform change. Data will be collected in relation to the amount of fraud awareness work is carried out. In turn the effectiveness of these actions will be measured by how many enquiries are generated on a newly developed internal interactive Counter Fraud Enquiry Form. A new local incident/referral reporting form is to be created in order that all enquiries made to the team are recorded an have an audit trail not just those that are logged on the CLUE system. The development of a generic email account (hosted by CAVUHB) will take place in order to assist in the process of this.	Development and Implementation Q1 Data collection throughout the year Development and Implementation Q1

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	Interactive feedback forms will be developed to measure the effectiveness of the service supplied by the CF team throughout the year.	Throughout the Year
	Locally and nationally informed risk assessments will be recorded according to local policy and using the CLUE case management system and will and a suitable review date added to check upon progress of recommended remedial action. These items will also be shared automatically with the Internal audit department and reported to the AAC.	Throughout the Year
	All investigations will be recorded and Managed on the CLUE case management system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Throughout the Year
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 corruption are recorded on the approved NHS fraud case management system.	CF team is undertaking a project of assessing the current infrastructure in place for the reporting of concerns and making of general enquiries from all groups. (As indicated at point 6 above) This will involve infrastructure development to include the creation a dedicated Counter Fraud Enquiry email address, the development of interactive referral/awareness request forms available internally to provide a dedicated route of reporting and enquiry to staff (incorporating an anonymised version to provide assurance to the reporter), and liaison with the Communications Department in order to ensure	Q1 & Q2 Implementation Q1 & Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	that this process and route is promoted in the most effective way in order to give the CF Fraud team have a brand identity and presence. CF team to liaise with Communications Department to explore the possibility of a dedicated Counter Fraud page on the organisations Intranet. Ongoing review of the effectiveness of the work undertaken and where necessary remedial action to take place dynamically throughout the year. Continuance of promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA. Ongoing events throughout the year such as half-day events at key premises promoting the reporting methods available to all groups. E.g. Velindre HQ	 Q1 Throughout the Year Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 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 team to make full use of the CLUE case management system for recording and managing Investigations, System Weakness reporting, and Local Proactive exercise reporting. CF Manager to ensure that all members of CF team are suitably trained and qualified to access the CLUE case management system. H Bales to be added upon accreditation as ACFS. CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated CF manager to oversee live investigations on CLUE. CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting.	Ongoing throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF manager to provide direction to IO concerning case management where necessary. CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and reported to DoF and AAC at progress updates and at year end in Annual report.	Ongoing throughout the Year
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 organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest	The organisation currently employs/has access to provision from, three fully accredited, nominated and qualified LCFS. The team has a further member who is currently undertaking ACFS training course. Target date for accreditation July 2022. Nomination to CFA to follow accreditation and to be actioned by CF manager. 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	Throughout the year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of 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.	will keep abreast of changes and updates to legislation and undertake training as necessary. All staff will continue to develop professionally, attending appropriate training sessions provided by 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 staff to maintain full compliance with mandatory training/e learning as measured on the ESR system. 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	Throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	relevant IT systems, data systems and access to NHS Wales) CF team to continue to have access to secure office accommodation accessible only by them. 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.	Throughout the Year
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	CF team to assess the work already completed in relation to the Thematic Assessment exercise published by the NHS CFA in 2020. Any work left incomplete to be carried out in period stated.	Q1 & Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 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 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 Health Boards and Special Health Authorities. CF team will undertake Local Proactive exercises in response to locally identified risk with a view to identifying if fraud has occurred. Remedial action will be reported as appropriate and any necessary investigative action undertaken. CF Manager to interact with key managers and stakeholder groups such as NWSSP Payroll Services, Corporate Finance, Information Governance, Communications Department and HR to foster relationships improve awareness of CF department and function.	Throughout the Year Throughout the Year Throughout the year (with the aim of scheduling regular quarterly catch ups.)

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF Manager to agree to a joint working protocol with Internal Audit and to meet with Head of IA on a quarterly basis to discuss ongoing areas of mutual concern.	Quarterly and as required
	CF team will engage with investigators from other organisations and agencies where necessary (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies, complying with relevant legislation and organisational policies when countering fraud bribery and corruption.	Throughout the Year
	CF team to make use of NFI database to assist in countering fraud, bribery and corruption within NHS and other organisations.	As required

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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 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 assess whether Fraud Awareness training is mandatory and a standing item of agenda at all corporate inductions. CF manager to liaise with workforce / education and development directorates accordingly and if this is not the case in order to drive forward. CF team to maintain an up to date e-learning module for staff to undertake. 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	Q1 Q1 & Q2 Development and implementation to take place Q1 Delivery throughout the Year

Gov s013 / NHS Requirement	Objective	Proposed Delivery
	• 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 in order to provide face to face contact with staff and public promoting the work of the team and its function (Liaison with Comms Dept to discuss) 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 general public. CF team to fully participate in National Counter Fraud Week initiative.	Q3
12: Policies and registers for gifts and hospitality and COI.	CF manager to assess whether a conflicts of interest/business conduct policy is in place and is in date.	Q1 & Q2

Gov s013 / NHS Requirement	Objective	Proposed Delivery
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	CF team to assess whether a register for conflicts of interest, gifts and hospitality is in place and in date and being utilised effectively. CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters. CF team to consider use of a local proactive exercise in order to identify if the policy is being followed. CF manager to provide a presence and input into relevant policy review, and to record and document changes highlighted through Counter Fraud review.	Q1 & Q2 Throughout the Year As required

AUDIT COMMITTEE

AUDIT COMMITTEE EFFECTIVENESS SURVEY FINDINGS 2021

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Claire Bowden, Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In accordance with the Trust Standing Orders, the Audit Committee is required to undertake an annual self-assessment of effectiveness.

1.2 The 2021 survey was issued on 30th November 2021, with reminders being issued on 13th December 2021 and 17th December 2021 (the original deadline). The low number of responses was reported to the Audit Committee meeting on 11th January 2022, and a further, final, request for completion was issued on 13th January 2022. To enable as much time as possible for final responses, the survey was left open until information was downloaded and collated on 13th February 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 A summary of responses is attached in appendix one to this paper.

2.2 An analysis of results and suggested actions is attached in appendix two to this paper.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The review of the Committee's effectiveness supports good governance & accountability within the organisation.
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	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:

4.1.1 note appendix 1 which outlines the questions and anonymised responses included in the survey;

4.1.2 review appendix 2 which outlines key findings and some suggested actions;

4.1.3 discuss and agree actions at the meeting which they would like taken forward, and / or suggest alternative or additional actions to be progressed.

Audit Committee Effectiveness Survey 2021

Appendix 1

Question number		Number of Responses				Comments
		Member	**Attendee**			
1	Please indicate if you are a member ie Independent Member or an Attendee of the Committee	2	8			
		Agree	**Disagree**	**Undecided**		
2	There are clear Terms of Reference, with clarity as to the role of the Committee and the relationship between the Committee and the Trust Board.	10	0	0		
		Yes	**No**	**Don't Know**		
3	Has the Committee established a cycle of business to be dealt with during the year?	10	0	0		
		Agree	**Disagree**	**Undecided**		
4	The number and length of meetings is sufficient to allow the Committee to fully discharge its duties.	10	0	0		But sometimes there is a lot of work to get through.
		Always	**Sometimes**	**Never**	**Undecided**	
5	Are Committee meetings scheduled prior to important decisions being made?	5	2	0	3	a) I do think the gap between the January Audit Committee 2022 and the next meeting in May is too large b) The timings of the Committee are set out in advance as is the cycle of business for all trust meetings. I feel this approach is rational and allows, as far as practicable, for decisions and tasks to be aligned to the cycle. There will always be occasions where decisions fall outside of this arrangement.
		Yes	**No**	**Undecided**		
6	Has the Committee been provided with sufficient authority and resources to fulfil its role effectively?	10	0	0		Unable to comment on whether there are sufficient resources
		Always	**Sometimes**	**Never**	**Undecided**	
7	Is the behaviour of all members / attendees at Committee meetings courteous and professional?	9	1	0	0	Collegiate
		Agree	**Disagree**	**Undecided**		
8	The Committee Chair has a positive impact on the performance of the Committee.	10	0	0		

9	Committee meetings are chaired effectively with clarity of purpose and outcome.	10	0	0		
		Always	**Sometimes**	**Never**		
10	Is each agenda item closed off with clarity on the decision / outcome of discussion?	8	2	0		
		Agree	**Disagree**	**Undecided**		
11	The Committee Chair allows debate to flow freely and does not assert their own views too strongly.	9	0	1		
		Always	**Sometimes**	**Never**	**Undecided**	
12	Is the atmosphere at Committee meetings conducive to open and productive debate?	9	0	0	1	I don't attend enough to comment on this
13	Is sufficient time allowed for questions, discussion and debate at Committee meetings?	8	2	0	0	
		Agree	**Disagree**	**Undecided**		
14	The papers received by the Audit Committee are concie and relevant	10	0	0		
		Always	**Sometimes**	**Never**	**Undecided**	
15	Committee papers are received sufficiently far in advance of meetings	6	4	0		Occasionally we have late papers, but on the whole they are timely
		Agree	**Disagree**	**Undecided**		
16	The Governance and Executive Support Function provide Secretariat for the Committee. I am satisfied with the support provided.	8	0	2		
17	I feel the Committee receives sufficient detail, at the right level, to allow me to focus on asking the right questions.	9	0	1		Sometimes updates are missing from items (eg the recommendations tracker)
18	The Committee actively contributes to discussions on the Trust's key strategic risks and offers insights into areas of future risk and challenge (including horizon scanning), to support the Executive and Senior Management Team.	8	1	1		a) limited discussion on strategic risks b) perhaps the balance of the business of the Committee could be more towards horizon scanning
19	The Committee has effective escalation arrangements in place to alert relevant individuals, Committees, Board of any urgent / critical matters that may affect the operation and / or reputation of the Trust.	9	0	1		
		Always	**Sometimes**	**Never**	**Undecided**	
20	Do you consider that where Private (Part B) meetings are held, that these have been used appropriately for items that should not be discussed in the public domain, ie commercially sensitive or identifiable?	7	1	0	2	a) I haven't attended Part B enough to comment on this b) I wonder if the reason for items not being discussed in public is always fully articulated

Appendix 2

Audit Committee Effectiveness Survey 2021

Analysis of Results

Invitation and Response Rate

An invitation to participate in the survey was issued electronically to 18 individuals (members and attendees). The invitation was sent by email on 30th November 2021, with reminders being issued on 13th and 17th December 2021 (the original deadline), and an extension given to the original deadline, due to a low number of initial responses. The survey was eventually closed on 13th February 2022.

The survey contained 20 questions with the 1st question asking the responder to indicate whether they were an Independent Member (which received 2 responses) or an Attendee (which received 8 responses). The analysis in this paper will therefore relate to the remaining 19 questions. The questions this year remained the same as the previous year.

In total, 10 people responded to the survey, giving a response rate of 55%. This is a 23% increase on last year's response rate when 8 people (33%) responded.

Analysis of Responses and Suggested Actions for Discussion

Of the 19 questions asked, 16 received either a fully positive response, or a predominantly positive response with no more than 2 responders choosing 'don't know', 'undecided' or 'sometimes'. These are shown in appendix 1 but not given further attention in this paper.

Responses to the remaining 3 questions, and suggested actions where appropriate, are shown below.

Question / Statement 5 – Are Committee meetings scheduled prior to important decisions being made?

5 people responded to say they always were, while 2 people responded to say this only happened sometimes, and 3 people were undecided.

Suggested Action:

- The Committee discuss whether they feel the meetings are scheduled adequately ahead of key decisions and / or could be improved.

Question / Statement 15 – Committee papers are received sufficiently far in advance of meetings.

6 people agreed this was the case, while 4 people said it happened sometimes.

Suggested Action:

- A discussion to take place in May Audit Committee so that the Committee can reflect on what this feedback means for the finalising of the 2022-23 cycle of business – which will then be brought to be July Committee, following informal feedback from members.

Question / Statement 20 – Do you consider that where Private (Part B) meetings are held, that these have been used appropriately for items that should not be discussed in the public domain, ie commercially sensitive or identifiable?

7 people agreed this was always the case, with 1 stating it was sometimes, and 2 undecided (although 1 person commented that they hadn't attended Part B meetings enough to comment). Another comment suggested that the reason for items not being discussed in public is not always fully articulated.

Suggested Action:

- The refreshed paper template will be more directive in gives further rationale for why a paper not able to be presented in Part A of the meeting.
- Members to continue to provide clear feedback on any instances they do not think are appropriate during Part B meetings.

AUDIT COMMITTEE

CHARITY ANNUAL ACCOUNTS 2020/21 LESSONS LEARNED

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steven Coliandris, Financial Planning and Reporting Manager Chris Moreton, Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		Choose an item.

ACRONYMS	
CFC	Charitable Funds Committee
ISA	International Standard on Auditing

1. SITUATION/BACKGROUND

1.1 The 2020/21 Annual Accounts were expected to be unconditionally signed off by the Charitable Funds Committee at an extraordinary meeting on 22 December 2021, where Audit Wales presented the ISA 260 report for Velindre University NHS Trust Charitable Funds. The ISA 260 report included an assessment of the impact of Covid-19 on the audit timelines, which had resulted in a later timetable than previous years.

1.2 The update provided by Audit Wales to CFC in December 2021 confirmed that although the audit had been substantially completed, an immaterial error had been identified. This did not affect the unqualified opinion of the accounts, however, auditing standards required Audit Wales to undertake further testing after the extraordinary meeting thereby delaying the submission of the annual accounts.

1.3 The Charity's 2020/21 annual accounts were submitted on the 31st January 2022 the statutory deadline, following the satisfactory completion of further testing in line with the conditional approval granted by the extraordinary meeting of the CFC in December 2021.

1.4 Professor Donna Mead OBE, Chair, Velindre University NHS Trust suggested that a lessons learned exercise should be conducted in order to help facilitate timely completion for 2021/22 accounts.

1.5 The process improvements identified from the lessons learned exercise are presented in section 2.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 There were several challenges which affected the audit of the 2020-21 acounts, such as the audit starting on the 8th November, whereas in previous years the audit would begin in September. During the audit a member of the audit team caught Covid which resulted in the work being delayed by a week. In addition, the team were unable to access key information due to a member of the fundraising team being off on long term sick, which delayed the ability to provide required evidence. A further unexpected challenge was the outsourcing of the Annual Report which significantly impacted the ability to make changes to the report, with each amendment having to be sent externally to be corrected.

2.2 Audit Wales and Velindre Finance jointly undertook a lessons learned exercise as a result of the situation outlined in section 1.

2.3 As a result of this exercise, the key areas for process improvement are as follows:

2.3.1 Make earlier preparations for audit start, building on the good relationship in place with Audit Wales. Ensure that resilience is built into the process for a potential later start date of the audit, which will include earlier drafting and review of the annual report narrative before the audit, and aligning the date for sign off by the Charitable funds Committee.

2.3.2 Improve oversight of the annual accounts process through allocation of more senior experienced support on production of the accounts.

2.3.3 Increase provision of quality assurance, building on improvements to the preparation of the accounts from the previous year.

2.3.4 Improve automated accruals review process.

2.3.5 Improve the process of recording income in fund raising team.

2.3.6 Improve the Analytical Review process by ensuring internal review and sign-off by Trust and Audit prior to any outsourcing to publishing suppliers of financial statement for review.

2.3.7 Evaluate how information sharing can be improved due to size of Analytical Review and issues experienced.

2.4 In order to deliver the recommendations, the Finance team will reallocate roles and responsibilities within the team to segregate duties, reduce risk and improve performance in the delivery of the Charity annual accounts production as follows:

2.4.1 The Financial Operations team will be responsible for producing the Charity annual accounts in addition to the Trust's annual accounts. Oversight will be provided by the Head of Financial Operations.

2.4.2 The Charity Finance Business Partner will focus on the provision of day-to-day operational finance support to the Charity. E.g. Delivering the systems and processes required for recording income and the provision of timely financial information to support the delivery of the Charity's strategy and plans. Oversight will be provided by the Financial Planning and Reporting Manager.

2.5 It is expected that these changes will improve resilience for the production of the Charity's 2021/22 annual accounts and reduce the risk of having a single point of failure.

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	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	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Audit Committee is asked to **DISCUSS & REVIEW** the lessons learned and the proposed Finance Function improvements that will help facilitate timely completion for 2021/22 and future accounts.

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ann Marie Stockdale, Head of Out-Patient, Medical Records and Private Patient Services
PRESENTED BY	Ann Marie Stockdale, Head of Out-Patient, Medical Records and Private Patient Services
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR APPROVAL

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

1.5 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.

1.6 The 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 Private Patient Team has focused on aged debt dating back to 2016 resulting in a significant reduction in the overall position.

2.2 The aged debt position has been shared with the Committee with the last up-date provided January 2022.

2.3 The Private Patient Team have completed a cross reference against the Unapplied and Unallocated Income Reports. Private Patient income has been identified as a result of this work and will be included in the income reported in the 2021/2022 accounts. This activity is now up-to-date and forms part of the routine/monthly tasks undertaken by the Team.

2.4 A template has been developed to support the reporting process going forward. The template has been split by patient profile/categorisation to provide a comprehensive overview, including movement between months to aid and support monitoring of the overall debt position.

2.5 The template has been populated as to the position 31/01/22 and 28/02/22 in readiness for the Committee Meeting, please refer to Appendix 1.

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 are asked to REVIEW and APPROVE the template for reporting purposes going forward.

4.2 Following approval of the proposed reporting template, and up-dated report as to the position on 31/03/2022 and 30/04/2022 will be circulated to Committee members.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1

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

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
Within maturity (0-30 day	194,349	108,522	0	0	0	0	0	0
31-60 days	44,949	151,954	0	0	0	0	0	0
61-90 days	40,168	43,327	0	0	0	0	0	0
91-180 days	107,874	121,265	0	0	0	0	0	0
181-365 days	62,635	82,974	0	0	0	0	0	0
1 year +	128,476	128,824	0	0	0	0	0	0
Total	**578,452**	**636,867**	**0**	**0**	**0**	**0**	**0**	**0**
Self payer								
Within maturity (0-30 day	0	0						
31-60 days	380	0						
61-90 days	150	210						
91-180 days	260	410						
181-365 days	0	170						
1 year +	1,098	1,098						
Total	1,888	1,888	0	0	0	0	0	0
Top Up								
Within maturity (0-30 day	0	5,531						
31-60 days	338	0						
61-90 days	0	338						
91-180 days	6,894	4,632						
181-365 days	156	156						
1 year +	15,453	15,453						
Total	22,841	26,110	0	0	0	0	0	0
Insured								
Within maturity (0-30 day	191,500	102,991						
31-60 days	43,477	151,397						
61-90 days	40,018	42,025						
91-180 days	100,720	116,223						
181-365 days	62,479	82,648						
1 year +	111,925	112,273						
Total	550,120	607,558	0	0	0	0	0	0
Overseas								
Within maturity (0-30 day	2,849	0						
31-60 days	754	557						
61-90 days	0	754						
91-180 days	0	0						
181-365 days	0	0						
1 year +	0	0						
Total	3,603	1,311	0	0	0	0	0	0

Movement between Months (brackets indicate increase in debts)

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
Within maturity (0-30 days)	85,827	0	0	0	0	0	0	0
31-60 days	(107,005)	0	0	0	0	0	0	0
61-90 days	(3,159)	0	0	0	0	0	0	0
91-180 days	(13,390)	0	0	0	0	0	0	0
181-365 days	(20,339)	0	0	0	0	0	0	0
1 year +	(348)	0	0	0	0	0	0	0
Total	**(58,415)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Self payer								
Within maturity (0-30 days)	0	0	0	0	0	0	0	0
31-60 days	380	0	0	0	0	0	0	0
61-90 days	(60)	0	0	0	0	0	0	0
91-180 days	(150)	0	0	0	0	0	0	0
181-365 days	(170)	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0
Top Up								
Within maturity (0-30 days)	(5,531)	0	0	0	0	0	0	0
31-60 days	338	0	0	0	0	0	0	0
61-90 days	(338)	0	0	0	0	0	0	0
91-180 days	2,262	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0
Total	(3,269)	0	0	0	0	0	0	0
Insured								
Within maturity (0-30 days)	88,509	0	0	0	0	0	0	0
31-60 days	(107,920)	0	0	0	0	0	0	0
61-90 days	(2,007)	0	0	0	0	0	0	0
91-180 days	(15,502)	0	0	0	0	0	0	0
181-365 days	(20,169)	0	0	0	0	0	0	0
1 year +	(348)	0	0	0	0	0	0	0
Total	(57,437)	0	0	0	0	0	0	0
Overseas								
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0
31-60 days	197	0	0	0	0	0	0	0
61-90 days	(754)	0	0	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0
Total	2,292	0	0	0	0	0	0	0

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Velindre University NHS Trust

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Velindre Cancer Centre

PRIVATE PATIENT UNDERTAKING TO PAY FORM

This document is an agreement to pay for any and all hospital charges and is legally binding. You should read and understand the Terms of Business (which are part of this agreement) on the reverse side of this form including those sections on the sharing of your personal information with the Private Health Information network before filling it in.

PERSONAL DETAILS

Surname……..…… Mr/Mrs/Miss/Other……

Forenames…… Date of Birth……

House and/or street…… Tel. no. *(Home)*……

Town…… Tel. no. (*Mobile)*……

County/Country…… Email Address..……..

Post code…… Admission / Appointment date……..

To be completed by / on behalf of insured patients:

I authorise Velindre Cancer Centre, Velindre University NHS Trust, to contact my insurer to confirm the extent of my health insurance policy.

Insurance Company…… Insurance Policy No……

Extent of cover…… Insurance authorisation No……

Insurance authorisation expiry date……..

I agree to assign to Velindre Cancer Centre any of my rights to be paid hospital charges by my insurer in respect of treatment provided. Should there be any shortfall in payment by the insurer I accept liability for the shortfall. I accept liability for any hospital charges related to my treatment that are not settled by my insurer within 90 days of my treatment date. I authorise disclosure of any medical notes including the provision of copies thereof to my insurer as part of their claim and payment processing requirements.

Initial ☐

To be completed by / on behalf of all private patients (insured and self-pay patients):

PATIENT/GUARANTOR DECLARATION

I agree to pay those private patient charges associated with my treatment. All charges are subject to the provisions of section 65(3) of the National Health Service Act 1977 as subsequently amended and section 14 of the NHS and Community Care Act 1990. I understand that the account will be referred to the Velindre University NHS Trust recovery agents if not paid in accordance with the Velindre University NHS Trust Terms of Business and that all the above details will be made available to the said recovery agents. This authority is unconditional and irrevocable. I further understand that such charges unless specifically stated do not include professional fees for the services of a medical or dental practitioner under whom I am admitted and to whom I have arranged to pay separate fees.

Signature…….. Print name……

Date……

TERMS OF BUSINESS

1. Charges

1.1 VELINDRE CANCER CENTRE, VELINDRE UNIVERSITY NHS TRUST ("Velindre") is required under the provisions of section 65(3) of the National Health Service Act 1977 as amended by section 14 of the NHS and Community Care Act 1990 and other later statutes and NHS regulations to make charges in respect of private patient (pp) services.

1.2 VELINDRE CANCER CENTRE accommodation charges are calculated based on your presence at 12 pm except for the day of admission which is counted as a day no matter what time you are admitted. Discharges that occur after 12 pm will incur an accommodation charge for that day.

1.3 Normally, VELINDRE CANCER CENTRE will only levy charges in respect of hospital fees which will include the cost of reporting on any X-Rays or pathology tests. Professional fees due to your Consultant and (if appropriate) the Anaesthetist are usually not included in VELINDRE CANCER CENTRE charges. The clinicians concerned will charge you separately for their professional fees.

2. Insured patients

2.1 VELINDRE CANCER CENTRE has made arrangements with certain insurance companies through which the insurer can make direct payments to VELINDRE CANCER CENTRE. If you intend to pay for your treatment in this way then please let VELINDRE CANCER CENTRE know at the earliest opportunity. However, such arrangements do not mitigate your liability as an individual to pay for any and all treatment given by VELINDRE CANCER CENTRE should your insurer, for whatever reason, not reimburse VELINDRE CANCER CENTRE in respect of any and all charges levied by VELINDRE CANCER CENTRE for your care.

2.2 You should check with your insurer prior to your admission or being seen by a Consultant to make sure that the insurance policy you hold covers you for the treatment that you need. You should also be clear that sometimes insurers will only reimburse VELINDRE CANCER CENTRE for part of those costs associated with your care.

2.3 VELINDRE CANCER CENTRE will expect that you pay any and all charges not covered by your insurance policy and/or which your insurer refuses to pay within 28 days of the date of VELINDRE CANCER CENTRE 's invoice. Please however note that it does not always become apparent that your insurer will not pay for certain items until your claim has been fully assessed (potentially some weeks after discharge). Accordingly, if your insurer, at a later date, is unwilling to cover any charges, VELINDRE CANCER CENTRE will issue you with a supplementary invoice which has to be paid by you within 28 days of the issue date**.**

2.4 VELINDRE CANCER CENTRE assist by seeking pre-authorisation from your insurance company. The fact that this pre-authorisation has taken place, however, will not mitigate your liability to any charges levied by VELINDRE CANCER CENTRE but not paid by the insurer and does not change the substance of the terms above.

2.5 You will be liable for any charges related to your treatment that are not settled by your insurer within 90 days of your treatment date.

3. Non-insured patients

3.1 If you elect to pay for your own treatment VELINDRE CANCER CENTRE may ask you to pay a deposit in advance. Alternatively, at VELINDRE CANCER CENTRE 's sole discretion, arrangements can be made for you to pay after your treatment with payment expected within 7 days of the date of the invoice normally issued to you within a week or so of your discharge from hospital.

3.2 VELINDRE CANCER CENTRE reserves the right to instruct an appropriate agency to undertake debt recovery on its behalf. VELINDRE CANCER CENTRE may also seek to verify your address or other details (after you have approved it so to do by signing an Undertaking to Pay Form) where either you have elected to pay for treatment yourself and not provided a deposit or other form of payment guarantee in advance. Such an enquiry will be recorded on the agency's file and may be shared with other users.

4. Method of payment

4.1 Accounts may be settled by debit or credit card. All forms of major debit and credit cards are accepted, except American Express.

4.2 If paying in advance of your stay or attendance at the hospital, please contact for details on how to make your payment.

4.3 If a third party is paying for your treatment whether this be a member of your family, a friend, or a company, VELINDRE CANCER CENTRE reserves the same rights as relates that individual as if you yourself were paying for your treatment. You should also note that VELINDRE CANCER CENTRE, once guarantor arrangements are in hand, will not interfere or mediate between you and your guarantor or sponsor. Once the said guarantor or sponsor undertaken liability on your behalf they become, from the VELINDRE CANCER CENTRE viewpoint, the individual or company liable for any and all costs associated with your care.

5. Late payments

If you have difficulty paying VELINDRE CANCER CENTRE invoices, please contact the Private Patient Credit Controller. You should do this at the earliest opportunity. Where necessary special arrangements can be made to help you. If you have not indicated that you have difficulties settling your invoice(s), after two reminders, your account will be passed on to VELINDRE CANCER CENTRE debt recovery agents. All costs associated with recovery of amounts due will be charged to you and the outstanding will be subject to interest charges equivalent to 8% per annum from the date of invoice.

6. Queries

If you are in any doubt regarding any charges to be made or that have been made for pp services at VELINDRE CANCER CENTRE, please do contact the Private Patient Administration team at the address and telephone number listed overleaf.

7. Patient confidentiality: how we use your information

7.1 Your personal information is treated with high standards of confidentiality in accordance with data protection laws. VELINDRE CANCER CENTRE will store information about you and will use your information to ensure that staff caring for you have up to date and accurate information to help them deliver the best possible care and treatment for you. The sharing of your information may also be required when providing and administering your care. Additionally, there may be circumstances where VELINDRE CANCER CENTRE has a statutory duty to share your information. Further detail is contained on the Trust's Privacy Policy, on the Trust's website (www.velindre.nhs.wales)

7.2 As part of a UK-wide programme to improve the public's access to information on the quality and outcome of private healthcare, we share some of your data, in an anonymised form, with The Private Healthcare Information Network (PHIN). PHIN subsequently sends this data to the relevant national information authority (for example NHS Digital in England) which links it to national hospital data and mortality data. The linked information, with your personal data removed, is then provided to PHIN to measure quality of care, and to check for adverse events after discharge from this hospital, such as unplanned readmissions to hospital, emergency transfers between hospitals, or deaths following treatment. The records we send to PHIN will include your postcode to enable statistical processing. Any information that is published will always be in anonymised statistical form and will not identify you. This information will not be shared or analysed for any purpose other than those stated above. Further detail is contained in PHIN's Privacy Notice, on PHIN's website (www.phin.org.uk).

3.3	For British citizens who live overseas, or patients who are not of British nationality, VELINDRE CANCER CENTRE reserves the right, directly or through its recovery agents, to contact British Government missions or Embassies abroad to confirm and/or verifying the data provided by you, regarding yourself, next of kin, guarantor, and/or sponsor for visa purposes.	

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Velindre Cancer Centre

Dear ,

Please find enclosed agreement for Top Up undertaking to pay forms.

I ask that you read this document prior to signing to understand the Velindre University NHS Trust Privacy Statement prior to signing.

Enclosed are two copies, one for your personal record and one to sign and send back to the Private Patient team in the pre-paid envelope enclosed.

If you would like to discuss this further please contact me on 029 2061588 ext 6841 or via email at Louise.Blackmore@wales.nhs.uk.

Kind regards,

Louise Blackmore
Private Patient Manager

Private Patient Service: TOP UP PATIENT CHECKLIST

This form MUST be completed for all patients choosing to receive a top-up treatment package alongside their NHS Treatment.

The patient has the right to proceed to the top-up process without having first accessed IPFR, therefore point 5 and 6 will not be applicable, however the disclaimed at the foot of the form will need to be completed.

Patient Information			
Patient's Name:			
DOB:		Velindre Hospital Number:	
Address:			
Town:	City:	Postcode:	
Contact Telephone Number (s):			
Email Address:			

Top Up Provider
NHS Provider: Velindre University NHS Trust (Velindre Cancer Centre)
Top Up Provider:

		Consultant	Patient
1.	The patient (or their representative) has received written information about the proposed treatment in addition to a face to face consultation		
2.	The patient (or their representative) has been given full information about the potential benefits, risks, burdens and side effects of the treatment		
3.	This information has been recorded on the consent form for the patient's treatment. Informed consent has been obtained in line with GMC guidance and Hospital protocol.		
4.	The patient has received a second clinical opinion		
5.	Funding options with the NHS for the proposed treatment have been explored and are exhausted		
6.	The proposed treatment has been considered by an Individual Funding Request Panel		
7.	The outcomes of this treatment with be contributed to relevant national monitoring programmes		
8.	The outcomes of this treatment will be discussed at multi-disciplinary clinical meetings		

9.	The patient understands that the additional medicines and any associated costs (e.g. extra tests, monitoring, days in hospital etc) are not being funded by the NHS		
10.	The patients (or their representative) has received written information about the proposed treatment costs and payment plan		
11.	The patient understands that if they become unable to fund their top up package the treatment will stop and that the NHS are not able to provide the top-up treatment.		
12.	The patient has signed and returned the Agreement to Pay – PP1//A Form		
13.	The patient understands that if the NHS decides to fund this treatment at a future date, including as a result of an IPFR application, the NHS will not refund the cost of treatment already given as part of a top-up treatment		

	Signed:	Print Name:	
Patient or representative:			Date:
Consultant:			Date:
Representative of private Patient Service			Date:

VELINDRE UNIVERSITY NHS TRUST PRIVACY STATEMENT

Confidentiality: The confidentiality of patient information is of paramount concern to the Trust. To this end, the Trust complies with applicable data protection law and clinical confidentiality guidelines. Details of processing undertaken are provided in the Trusts Privacy Policy which can be found at http://www.velindre-tr.wales.nhs.uk/privacy-policy

Clinical Information: Clinical information will be kept confidential and secure. It will only be disclosed to, and received from, those involved with your treatment or care or to their agents and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents (e.g. where payment is being met by NHS, Insurers etc.).

Research: The Trust participates in national audits and initiatives to help ensure that patients are getting the best possible outcomes from their treatment and care. The Trust will use your personal data in order to monitor the outcome of your treatment by us and any treatment associated with your care, including any NHS treatment. The highest standards of confidentiality will be applied to your personal data in accordance with data protection law and confidentiality. Any publishing of this data will be in anonymised statistical form. Anonymous or aggregated data may be used by the Trust, or disclosed to others, for research or statistical purposes and registered with such bodies.

Access to Non-Clinical Information: Access to non-clinical information may be granted by the Trust to others on a strictly confidential basis in the course of, and for the purpose of, the efficient administration of the Trust (for example, in connection with audit, systems development, managing or improving our services).

Support Services: In the usual course of our business, we may use third party organisations to support the essential delivery of our IT services. Some IT service providers may host data in servers located outside of the EEA, when using cloud-based solutions. Where this is the case we have implemented appropriate security to protect the personal information disclosed to us from loss, misuse, unauthorised access, disclosure, alteration and destruction.

By signing this agreement you accept the terms of the Trusts Privacy Statement.