Bundle Public Audit Committee - Velindre University NHS Trust 4 October 2022

1.0.0 STANDARD BUSINESS
Led by Gareth Jones, Chair of the Audit Committee

1.2.0 In Attendance
Led by Gareth Jones, Chair of the Audit Committee

1.3.0 Declarations of Interest
Led by Gareth Jones, Chair of the Audit Committee

1.4.0 Action Log
Led by Gareth Jones, Chair of the Audit Committee
1.4.0 Audit Committee Action Log updates for October 2022 Meeting.pdf

2.0.0 CONSENT AGENDA
Led by Gareth Jones, Chair of the Audit Committee

2.1.0 FOR APPROVAL
Led by Gareth Jones, Chair of the Audit Committee

2.1.1 Draft Minutes from the Public Part A Audit Committee meeting held on 03 May 2022
Led by Gareth Jones, Chair of the Audit Committee
2.1.1 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 03 May 2022 - Final.docx

2.1.2 Draft Minutes from the Public Part A Audit Committee meeting held on 19 July 2022
Led by Gareth Jones, Chair of the Audit Committee
2.1.2 MB DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 19 JULY 2022-LFAmended2 (002).pdf

2.2.0 FOR NOTING
Led by Gareth Jones, Chair of the Audit Committee

2.2.1 Procurement Compliance Report
Led by Matthew Bunce, Executive Director of Finance
Audit Report Oct 22 Proc Final 27.09.22.pdf

2.2.2 Declarations of Interests, Gifts, Sponsorship, Hospitality & Honoria
Led by Lauren Fear, Director of Corporate Governance & Chief of Staff
2.2.2 DOI Gifts, Sponsorship, Hospitality and Honoria.pdf

3.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

3.1.0 Trust Risk Register
Led by Lauren Fear, Director of Corporate Governance & Chief of Staff
3.1.0 Audit Committee- Trust Risk Register Paper.pdf

3.2.0 Full Audit Action Tracker Review of from Internal & External Audit
Led by Matthew Bunce, Executive Director of Finance
3.2.0a MB Review clean Cover Paper - Audit Action Tracker October Audit Committee 2022.pdf
3.2.0b Audit Action Tracker - October 2022 Audit Committee.pdf

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

4.1.0 Audit Position Update
Led by Katrina Febry and Steve Wyndham (Audit Wales)
4.1.0 VUNHST Audit Position Statement 2022 10 Oct.pdf

4.2.0 Public Sector Readiness for Net Zero Carbon by 2030
Led by Katrina Febry (Audit Wales)
4.2.0 Public_Sector_Readiness_for_Net_Zero_Carbon_by_2030.pdf

4.2.1 Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report
Led by Katrina Febry (Audit Wales)
4.2.1 Public_Sector_Readiness_for_Net_Zero_Carbon_by_2030_Evidence_Report_English.pdf

5.0.0 INTERNAL AUDIT

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

5.1.0 2022/23 Internal Audit Progress Update Report

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

5.1.0a VUNHST Audit Committee Progress Update Cover Paper - Oct-22.pdf

5.1.0b VUNHST Audit Committee Progress Update - Oct-22 AC.pdf

5.2.0 Staff Wellbeing (Advisory)

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

5.2.0 VT 2223-04 - Final Advisory Review Report - Staff Wellbeing - Trust issue.pdf

5.3.0 Financial & Service Sustainability

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

5.3.0 VT 2223-01 - Final Internal Audit Report - Financial Sustainability - Trust issue.pdf

5.4.0 Research & Development

Led by Rhian Gard, Principal Auditor (NWSSP - Audit and Assurance Services)

5.4.0 VT 2223-06 Research and Development Final Internal Audit Report.pdf

5.5.0 Enabling Works Integrated Audit Plan 2021/22

Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services)
• nVCC Enabling Works – Final Report

5.5.0 VUT_2122_nVCC Enabling Works_Final Report.pdf

6.0.0 COUNTER FRAUD

6.1.0 Counter Fraud Progress Report Quarter 2

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

6.1.0 4. VELINDRE Period 2 2022 Progress Report.pdf

7.0.0 FINANCE

7.1.0 Private Patient Service Debt Position

Led by Ann Marie Stockdale, Head of Medical Records and Cancer Services Management and Lisa Miller, Director of Operations

7.1.0a Audit Committee - Aged Debt Private Patient Service Sept 22.pdf

7.1.0b Appendix 1 Audit Committee - Aged Debt Private Patient Service Sept 22.pdf

7.2.0 Losses and Special Payments Report (Verbal Update)

Led by Claire Bowden, Head of Financial Operations

8.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

9.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

10.0.0 ANY OTHER BUSINESS

By prior approval of the Chair of the Committee

11.0.0 DATE AND TIME OF THE NEXT MEETING

Thursday 12 January 2022, 10:00-12:30

12.0.0 CLOSE

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 03 May 2022 Meeting			
05/2022 6.6.0	**Internal Audit Report: DBS Checks** In relation to Management response 2.1.a. (i) DBS Policy target date of September 2022 is too far away. ****ACTION: Matthew Bunce to feedback to Sarah Morley that the Trust should develop it's DBS Local Policy as a matter of priority and consider the points raised in the recommendations/findings.**	**ACTION: Sarah Morley**	**Update SEPTEMBER 2022:** The draft DBS procedure is currently with Trade Union colleagues for comment as all documents are developed in Partnership. Comments requested back by 7th October. Two responses received so far. Once this has been collated and amendments made this will be progressed to SLT/SMT for comment and then to EMB for approval. **OPEN** **Update JULY 2022:** DBS Policy is on track to be developed by September 2022. The policy has to go through its internal consultation phase and be signed off. It is not possible to do this within any shorter timeframe. The Trust currently has a clear procedure for the use of	**SM**

			DBS Checks which is being followed for all appointments.	
05/2022 8.1.0	**Audit Committee Effectiveness Survey** **ACTION: Lauren Fear, Claire Bowden can discuss with Emma Stephens in terms of this general point could look at an extra meeting for next year. Need to make sure schedule better to not have papers that have already been to Board as can't evidence the scrutiny when it's already been someone else to another meeting and the process in which Committee Papers could be shared longer in advance of the meetings.**	**ACTION: Lauren Fear, Emma Stephens and Claire Bowden**	**Update SEPTEMBER 2022: CLOSED.** Feedback will be incorporated into 2022/23 Committee schedule. **Update JULY 2022:** Approach to 2023/24 schedule to be agreed in principle with Audit Committee Chair. This will be completed in readiness for the September 2022 Board Committee Schedule Planning Arrangements.	**CB / LF / ES**
	Actions from 19 July 2022 Meeting			
07/2022 2.2.1	**Procurement Compliance Report** Andy Butler (AB) has provided MB with an update that a protocol is being developed by NWSSP to give the Trust Audit Committee, through the Director of Finance, early sight of any risk of legal challenges from bidders participating in All Wales Contract tenders**.** **ACTION: Draft protocol to provide Trust Audit Committee with early sight of any risk of legal challenge from bidders participating in All Wales Contract tenders to be included in October 2022 Audit Committee.**	**ACTION: Andy Butler and Matthew Bunce**	**Update SEPTEMBER 2022: PROPOSE TO CLOSE** NWSSP Director of Procurement has shared draft protocol for consideration by the Trust. Meeting arranged 28 September 2022, between Trust DOF, NWSSP DOF and NWSSP Director of Procurement. The draft protocol was shared outside of Committee with MV and GJ for review.	**AB / MB**

07/2022 2.2.1	**Procurement Compliance Report** Initial assessment by the new Head of Procurement is that there are a high volume of Single Tender Actions (STAs) and Single Quotation Actions (SQAs) for which potentially alternative complaint procurement routes may be available. Procurement will commence work to review all available procurement framework agreements to establish whether they can be accessed as an alternative route to market, negating the need for SQA/STA. ****ACTION: Head of Procurement to provide an update and circulate an update ahead of next Audit Committee.**	**ACTION: Helen James**	**OPEN** **Update SEPTEMBER 2022:** Included in the Procurement Compliance Report on agenda. The process to review alternative procurement routes has commenced, but this will take approximately 6 months to complete.	**HJ**
07/2022 2.2.1	The new Head of Procurement has recognised there are repeat SQA/STA requests for the same service/providers and has agreed that future procurement reports will contain information in relation to the total value of expenditure to date **ACTION: Head of Procurement to include information in relation to the total value of expenditure to date for repeat SQA/STA**	**ACTION: Helen James**	**Update SEPTEMBER 2022: CLOSED.** Appendix 1.1 – Summary Information of Compliant Arrangements has been updated to include a filed identifying if the STA/SQA is a “First Submission” or “Repeat” and where “Repeat” the total contract value to date if included.	**HJ**
07/2022 4.0.0	**Governance of Internal and External Audit Recommendations and Management Actions Tracking** **ACTION: Emma Rees noted an ongoing piece of work of where Digital Health & Care Wales are looking to develop their system using Power BI and agreed to bring a verbal update to the October 2022 Audit Committee.**	**ACTION: Emma Rees**	**UPDATE AUGUST 2022: CLOSED.** Verbal update will be provided 04 October 2022 Audit Committee.	**ER**

07/2022 5.1.0	**ACTION: Following Committee discussions Emma Stephens will action Committee queries as below:** • **To share the documents related to the Policy.** • **To clarify to the Committee the viability of the mitigation of actions and controls and how that is viewed within Datix.** • **Emma Stephens to speak to Lauren Fear to discuss the possibility of incorporating some training in the Board Development Sessions, with specific sessions for Independent Members, specific to their respective Committees.** • **To confirm if there is a corporate risk register as this is not described in the policy.**	**ACTION: Emma Stephens**	**OPEN** **UPDATE SEPTEMBER 2022:** Velindre University NHS Trust Risk Management Procedure has been shared with Audit Committee members. This will be clarified via the Board Development Session on Risk in early November 2022. This will also be incorporated into the November 2022 Board Development Session on Risk Management. There is no standalone Corporate Risk Register, there is one single Trust Wide Risk Register which is received by Audit Committee.	**ES / LF**
07/2022 5.2.0	**Trust Assurance Framework** **ACTION: Emma Stephens to discuss with Lauren Fear our requirements for Power BI to support further future development of TAF and share with Steve Wyndham to assess feasibility of what support might be available from Audit Wales Data Analytics Team to take forward as a project.**	**ACTION: Emma Stephens**	**OPEN** **UPDATE SEPTEMBER 2022:** Scope of BI support requirements currently being assessed in conjunction with Trust Digital Services to assess possible support to be requested from Audit Wales. This will be confirmed before end October 2022.	**ES**

07/2022 6.1.0	**Audit Position Update** **ACTION: Martin Veale questioned the term 'will be undertaken' in relation to the Charitable Funds Audit and requested that a more specific date be clarified.**	**ACTION: Steve Wyndham**	**UPDATE SEPTEMBER 2022: CLOSED** Aiming to start the audit of the 21-22 Charitable Funds in November 2022 with completion planned prior to Christmas.	**SW**
07/2022 8.2.0	**Counter Fraud Progress Report Quarter 1** **ACTION: Gareth Lavington agreed to circulate the Appendices included in the document following the meeting.**	**ACTION: Gareth Lavington**	**UPDATE SEPTEMBER 2022: CLOSED.** The Counter Fraud Progress Report Quarter 1 appendices were circulated to the Audit Committee members 06 September 2022.	**GL**
07/2022 10.1.0	**Agreement of Committee Cycle of Business** **ACTION: The Committee to review the Cycle of Business and flag anything they think should be changed or added. Martin Veale asked if the Cycle of Business can be checked back to the Terms of reference for completeness.**		**UPDATE SEPTEMBER 2022: CLOSED.** No requests for changes have been received for the Cycle of Business. The Cycle of Business has been checked back to the Terms of Reference.	**ALL**

MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS

TUESDAY 03 MAY 2022 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
Lauren Fear	Director of Corporate Governance
Claire Bowden	Head of Financial Operations
Lisa Miller	Director of Operations
Chris Moreton	Deputy Director of Finance
Jacinta Abraham	Executive Medical Director
Simon Cookson	Director of Audit & Assurance, 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)
Katrina Febry	Audit Wales
Clare James	Audit Wales
Steve Wyndham	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
Nigel Price	Local Counter Fraud Specialist
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 Ham, CEO	
1.2.0	**In Attendance** Led by Martin Veale, Chair, and Independent Member Martin Veale welcomed Chris Moreton, to his first Audit Committee since recently being appointed as the new Deputy Director of Finance. Martin Veale also welcomed attendees from Audit Wales and Internal Audit Services to the Audit Committee Meeting.	
1.3.0	**Declarations of Interest** Led by Martin Veale, Chair, and Independent Member Jacinta Abraham declared to the Committee her position in terms of the Private Patient discussions, as she has some private patients.	
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 – Lauren Fear gave an update to the Committee on the three remaining framework items, which are due to be completed by end June 2022: • Policy – This has been drafted and is with Divisions and Risk Leads for review.	

	• Training - Task and Finish sessions have taken place. This will be finalised in line with the policy. • WBS migration to Datix 14 – Plan to fully migrate by end June 2022. **07/2021 3.1.0 Legislative & Regulatory Compliance Register** The Committee noted a report will be received at the July 2022 Audit Committee. **10/2021 4.5.0 Update on review of Private Patients debts (Verbal Update)** The Committee noted that all Private Patient actions would be addressed on today's Agenda. The Committee proposed to hopefully get an ongoing review of the Aged Debts. Pending meeting outcome can CLOSE this action. The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions.	
	Felicity Quance left the meeting 10:23am following items 6.2.0 and 6.3.0 being discussed early on the agenda with the prior agreement of the Chair.	
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 Public Audit Committee meeting held on 11 January 2022** Led by Martin Veale, Chair, and Independent Member Gareth Jones queried some items in the minutes that don't appear in action log. Item 2.2.2 page 5 'Emma Stephens agreed for future meeting a clean copy and a copy with track changes noted will be available.' Lauren Fear gave assurance that the specific was captured and actioned but is not recorded as an action due to the ongoing nature. The AUDIT Committee **AGREED** the minutes of the meeting held on the 11 January 2022.	
2.1.2	**Draft Minutes from the Private Audit Committee meeting held on 14 October 2021** Led by Martin Veale, Chair, and Independent Member The AUDIT Committee **AGREED** the minutes of the meeting held on the 14 October 2021.	
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 Matthew Bunce gave the Committee an overview of the storage of records emergency measures: • The update on the storage of records – Regent emergency measure and the reasons for the allocation of the Single Tender Action for Harwells of £20,000. • Maltings Contract £90,000 (including non-recurrent element £20,000) finalised, and STA signed off, value of contract for 12 month holding position and then will start the tender process over the next 4 to 6 months . • Notified ICO and notified Welsh Government in their early warning system. • The governance perspective around the management of this and reporting into Gold Command. Ensured that Comms is part of the incident response. • Paper is going to the next Private Quality, Safety & Performance Committee. Vicky Morris highlighted the significant number of Single Tender actions and the significant variants included in Appendix 1.1 and the need for narrative to provide oversight of the process to give assurance from a standard financial instruction. Matthew Bunce agreed to pick this up with Helen James, Head of Procurement . Matthew Bunce highlighted that his signature is only added to the Single Tender when the Procurement section is signed with an explanation as to why they support.	

	Martin Veale fully endorsed the comments made by the Committee and expressed the importance on grouping items and adding narrative. ****ACTION: Matthew Bunce to confirm with Helen James, Head of Procurement to raise the importance of grouping items and adding narrative to provide oversight of the process within the Procurement Compliance Report.** Gareth Jones noted that at the last Audit Committee it was agreed where there is an extension of an existing contract, we would be given the details of the aggregate value of the contract as extended. Matthew Bunce responded this can be difficult to provide. With regards to drug companies, these are often the sole supplier of an essential product so can't go to market and tender and can't always predict what's required and volumes used. Vicky Morris noted in Appendix 1.2 Further Matters; there are quite a few delays outlined as regrettable in terms of the tendering process due to capacity. Matthew Bunce responded to note to the Committee that Procurement Services are now up to full capacity with new Head of Procurement. This report was **NOTED** by the AUDIT Committee.	**MB**
2.2.2	**Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Martin Veale asked how we decide what aspects of external activity are worthy of giving Consultant's time off. Jacinta Abraham replied that this is considered on an individual basis. There is a process by which Clinical Director considers sign off, within set parameters. This report was **NOTED** by the Audit Committee.	
2.2.3	**Audit Committee – ISO Paper** Led by Rhiannon Freshney, Environmental Development Officer The AUDIT Committee received this report to note that this has been accredited and commented this was a positive report. The AUDIT Committee **NOTED** the recertification audit of the ISO14001:2015 audit.	
2.2.4	**Losses and Special Payments Report** Led by Claire Bowden, Head of Financial Operations Matthew Bunce noted the process included in the Standing orders and SFIs and the scheme of delegation in terms of limits. Claire Bowden confirmed the scheme of delegation for Executive limits: • Up to the value of £10,000 - Executive Director of Finance • Up to £50,000 - Chief Executive. Claire Bowden noted to the Committee the report totalling an amount of £92,000 which consists of several individuals' debts, none exceeding £10,000 each. The AUDIT Committee **REVIEWED** and **NOTED** the report.	
3.0.0	**PRIVATE PATIENT SERVICE REVIEW** Led by Matthew Bunce, Executive Director of Finance	
	Matthew Bunce noted to the Committee that he has reviewed the report and is in the process of seeking additional procurement support to help with actions and is also seeking provider support for the implementation of the recommendations. Matthew Bunce reassured the Committee he is confident we are in process of delivering actions by deadlines. Jacinta Abraham provided assurance to Vicky Morris and the Committee in terms of Clinical Governance and organisation oversight of Private Patients that there are processes in place	

	to give the facility to group together all the DATIX and complaints that are specific to Private Patient services. Following questions on the governance of the action plan, Lisa Miller confirmed her understanding was that Cath O'Brien would be the owner of the action plan as the Chief Operating Officer and that it would be reported into the Senior Leadership Team and into EMB given the interest and the work needed going forward. The AUDIT Committee **NOTED**: • The Final Report from TPW (**Appendix 1 – circulated out of committee as commercially sensitive**) • The Action Plan (**Appendix 2**) • The procurement of external expert management, training and development expertise to support the VCC Private Patient Team ****ACTION : Private Patient Service Review to be a standing item on the agenda with a process for each element of the report and how they are going to be reported governance wise in Audit. Audit Committee only to look at finance governance sections. Decide on agenda items going forward and to consider the need for agenda items going forward to make sure this is engaged in a committee.** ****ACTION: Paper to be received in the July 2022 Audit Committee to articulate the oversight arrangements of the process going forward.**	**MB / LM** **MB / LM**
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 Lauren Fear reminded the committee that the paper had already been to Trust Board, and the overall framework and development in terms of the policy, training, and migration of Welsh Blood Service were noted previously in the Audit Committee. The updated register was considered by EMB last week and the papers for QSP that will be published this week will contain the updated register. The Audit Committee noted that progress against the management of the risks has moved on considerably, which will be reported through the next Cycle of Governance. Gareth Jones questioned how the risks from Trust Board are going to be reflected in the Audit Committee to ensure this Committee is doing its job adequately. ****ACTION: Lauren Fear to look at how the risks taken from Trust Board can be represented clearly in the Audit Committee report cover paper.** The AUDIT Committee **NOTED**: • The risks level 20 and 16 reported in the Trust Risk Register and highlighted in this cover paper. • The on-going developments of the trust's risk framework.	**LF**
4.2.0	**Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Martin Veale highlighted in Appendix 2, there is still work to do and populate around demand and capacity, and resource and assurance. Vicky Morris raised the variants in terminology and stressed the need to be clear in papers about which strategic objectives referring to and the risks against that strategic objective and highlighted this will need to be in the papers that go to QSP as have to be able to ensure our business is supporting the delivery of those strategic objectives.	

	Gareth Jones highlighted that in paragraph 3.7.3 in the cover paper refers to a discussion in Strategic Development Committee about reverse stress testing and questioned the timing of this as it was requested this exercise be completed promptly? ****ACTION: Lauren Fear will work through the reverse stress testing element with Emma Stephens to see how this can be brought forward.** The Committee agreed the Assurance Framework will be brought to AUDIT Committee frequently, but once in place and content we can operationalise and revert to an annual review. ****ACTION: To receive further updated version of the Trust Assurance Framework at the July 2022 AUDIT Committee.** The AUDIT Committee **NOTED** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1***, and the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework.	**LF** **LF**
4.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** Led by Matthew Bunce, Executive Director of Finance Martin Veale expressed concerns that the Audit Action Tracker Cover Paper was sparce and the list of individual recommendations is remains significant, with 41 overdue recommendations marked as red. Matthew Bunce highlighted to the Committee the need to make sure Executive ownership is taken of each audit and action within those audits and responses for individuals within their teams and stressed the importance of this and the possibility to invite people to come to AUDIT Committee to explain individual actions if responses weren't received. ****ACTION: Martin Veale requested the Audit Action Tracker be at the forefront of the Highlight Report to the next Board to make sure all Executives are sighted on this, and the Committee agreed with this.** The AUDIT Committee **NOTED** 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. The AUDIT Committee **APPROVED** the actions closed in this period. The AUDIT Committee **AGREED**: • All extensions requested within the Audit Action Tracker. • Target date end June 2022 for actions that didn't have extensions listed or silent.	**AH**
5.0.0	**EXTERNAL AUDIT** Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales	
5.1.0	**Audit Plan 2022** Led by Clare James (Audit Wales) Steve Wyndham and Katrina Febry took the AUDIT Committee through the Audit Pan 2022. • Financial Audit aspects of the plan, including key areas of attention, such as, Management override risk, Inventory – Stock issues, Pension Tax liabilities and Break-even Duty. • Performance Audit aspect, including the structured assessment focusing on governance and leadership, financial management and strategic planning and use of resources. • A. further piece of work on workforce planning, looking at medium- and longer-term workforce needs. Steve Wyndham confirmed in relation to the 3.7% fee, the vast majority of larger audits all experiencing increase in fee rate. Gareth Jones raised the question on Paragraph 23 'changes would be discussed with the Director of Finance' should say 'changes would be agreed with Director of Finance' Steve Wyndham was content for the wording to remain the same and noted to the Committee at times the cost of the audit would exceed the audit fee, but this would be discussed and agreed with Director of Finance.	

	Clair Bowden confirmed to the Committee following raised questions provision is included. Martin Veale requested that the July 2022 final audit report has narrative included to state the reason why there is a different route Clinicians Scheme Pays to be taken in Wales as opposed to England. ****ACTION: Steve Wyndham to include the reason why there is a different route to be taken in Wales as opposed to England in the July 2022 final audit report.** The AUDIT Committee **NOTED** the report.	**SW**
5.2.0	**Audit Position Update** Led by Katrina Febry and Steve Wyndham (Audit Wales) Steve Wyndham took the AUDIT through the Financial Audit Update. • S1 and S2 Forms been audited, with submission to Welsh Government. • Received the Trust accounts and audit work picking up huge momentum. Aim to report back to Audit Committee mid-June 2022. Katrina Febry took the AUDIT Committee through the Performance Audit 2020 plan. • Quality Governance piece of work initially stood down due to pandemic. • Structured assessments 2021 completed. • Unidentified piece of work – Local Study used the budget for that and added to the 2020 Quality Governance work. • 2022 audit plan started work for structured assessment now. • Workforce planning element will commence Autumn into Winter 2022. The AUDIT Committee **NOTED** the report.	
5.3.0	**Taking Care of the Carers** Led by Katrina Febry (Audit Wales) Katrina Febry noted to the Committee that the report is based on how NHS bodies across Wales supported staff welling being during pandemic. Providing an opportunity to re-focus on staff wellbeing and take forward the learning. It was highlighted to the Committee that the paper has been to EMB and has been flagged to the team in terms of communications. The AUDIT Committee **NOTED** the Management Response to the Taking Care of the Carers audit.	
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) Simon Cookson informed the Committee of the good position of the core audit plan with a majority of reports been finalised. Emma Rees noted to the Committee KPI of management responses has fallen below target, sitting at 50%. Matthew Bunce, Lauren Fear and Emma Stephens have a meeting arranged Thursday to address this issue. Emma Rees highlighted to the Committee that ability to get all work done and the pathway is an issue in terms of initial management response to closing the action, ensuring prioritisation and ownership. The AUDIT Committee **NOTED** progress and change to plan.	
6.2.0	**Internal Audit Report: nVCC MIM Governance** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services) (Discussed at the start of AUDIT Committee at 10:08am)	

	Felicity Quance noted to the Committee the report provides substantial assurance and 2 new raised recommendations, regarding timelines of decision making and completeness of information being provided. Felicity Quance noted the level of good governance. Felicity Quance confirmed in relation to the timeline and responses being 2 months following the draft report meeting was in account of a meeting taking place today that was cancelled on 4 occasions previously, due to non-availability of staff, causing delay for report to be issued as final. Matthew Bunce highlighted to the Committee that Internal Audit Reports were discussed at EMB and will have a further discussion in terms of management responses again at EMB to stress the importance. Martin Veale highlighted the language in the recommendations and the action plan page 10, in the 2 agreed management actions, should read 'will ensure'. Felicity Quance confirmed that would ordinarily expect to be 'will ensure' but confirmed that at the latest project board through attendance could see that the recommendation has been taken with the intention which is required. The Audit Committee **NOTED** the report.	
6.3.0	**Internal Audit Report: nVCC Contract Management** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services) (Discussed at the start of AUDIT Committee at 10:16am) Felicity Quance noted to the Committee the report provided reasonable assurance; • Weaknesses in process timeliness in contract documentation signing. • Contract sum didn't reconcile to that what was reported to project board. • Evaluation dates when tenders come through for review. • Finalisation of some procurement exercises, timeliness needs to improve. • Reporting on key performance indicators. The Audit Committee **NOTED** the report.	
6.4.0	**Internal Audit Report: Financial Systems** Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees took the Audit Committee through the Internal Audit Report: Financial Systems report noting reasonable and followed up on the 3 high and medium priority matters arising from last year's report around debt management. Key points identified: • Late payment of invoices and in one case late payment fees were being incurred. • Private patient Debt key when ensuring a handle on unallocated and unidentified receipts. The AUDIT Committee **NOTED** the report.	
6.5.0	**Internal Audit Report: Scrutiny of Expenditure** Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees noted to the Committee the report provided reasonable assurance with 2 medium priority findings. Recommendations: • About strengthening and enhancing that process to make sure sits implemented and embedded properly. Mainly in terms of assuring the quality of proposal documentation. • Ensuring the quality of minutes to evidence the scrutiny that has taken place. Making sure it reflects level of scrutiny. The AUDIT Committee **NOTED** the report.	
6.6.0	**Internal Audit Report: DBS Checks**	

	Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees noted to the Committee the report provided reasonable assurance with 2 medium and 2 low priority recommendations: • Ensuring job descriptions are accurate. • Trust to have its own policy and procedure around recruitment and DBS checks, wasn't completed at the time of audit. Request to put on risk register hadn't been complete. The Audit Committee felt in relation to Management response 2.1.a. (i) DBS Policy target date of September 2022 is too far away as this is a priority so needs completion sooner. ****ACTION: Matthew Bunce to feedback to Sarah Morley that the Trust should develop it's DBS Local Policy as a matter of priority and consider the points raised in the recommendations/findings.** Vicky Morris highlighted the triangulation of Committees and the need to be clear on job description in recruitment and make sure clear and timescales for requirements. The AUDIT Committee **NOTED** the report.	**MB**
6.7.0	**Internal Audit Report: Charitable Funds** Led by Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees noted the report provided reasonable assurance with 3 medium priority finding and 6 low priority findings . 2 mediums related to prior findings. • Assuring PO raised at the appropriate time. • Findings around different procedures, with no evidence provided. The AUDIT Committee **NOTED** the report.	
6.8.0	**Draft 2021/22 Internal Audit Opinion** Led by Simon Cookson, Director of Audit & Assurance (NWSSP - Audit and Assurance Services) Simon Cookson noted the reports provided strong reasonable assurance, vast majority reasonable and some advisory pieces. Positive report. The AUDIT Committee **NOTED** the report.	
6.9.0	**Draft 2022/23 Internal Audit Plan** Led by Simon Cookson, Director of Audit & Assurance (NWSSP - Audit and Assurance Services) Simon Cookson explained to the Committee this is a formal document requiring approval of committee for the plan, agreement of the audit charter and KPIs included within the plan covering service continuity. Simon Cookson noted reviews around VCC will be added separate and will be brought back to the Committee for formal sign off. The AUDIT Committee formally **APPROVED** the report.	
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 Gareth Lavington took the Audit Committee through the Counter Fraud Progress Report and highlighted those 2 investigations remain open: • Providing false information to obtain a bursary – Been changed now to a Shared Services Partnership investigation and is going to Crown prosecution service decision. • Abuse of Position – Decided didn't reach the threshold and remains at disciplinary level.	

	Gavin Lavington informed the Committee that the Counter Fraud Team is now at full capacity, with the addition of Henry Bales, new Investigator, and now consists of three Investigators and a Counter Fraud Manager. Provided the 110 days provision. Gareth Jones requested following a discussion at the previous Audit Committee that where possible could a value be attributed to cases. Gareth Lavington confirmed One case didn't proceed, as investigate cases £0-15,000 then should go to Counter Fraud Service. Martin Veale requested tat some comparators for scale should be provided in future. The Committee **RECEIVED** and **DISCUSSED** the Counter Fraud Progress Report for the period for the period 1st January 2022 to 31st March 2022.	
7.2.0	**Counter Fraud Approval of Annual Plan** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington explained that the Counter Fraud Plan has been aligned to the new functional standards that the NHS CFA plan reflects and aims to adopt a more methodical work in risk assessment. The plan will work to identify fraud risk as opposed to other risk and improve infrastructure reporting lines. It has been agreed to adopt Counter Fraud as an Awareness Session at Corporate Induction. Gareth Lavington confirmed that the end of year report is finished and is waiting for someone from Cardiff and Vale to input correct figures into the report. Planning to bring to July 2022 Audit Committee The AUDIT Committee **RECEIVED** and **DISCUSSED** the Plan.	
8.0.0	**ADMINISTRATION**	
8.1.0	**Audit Committee Effectiveness Survey** Led by Claire Bowden, Head of Financial Operations Claire Bowden went through the outcome if the Audit Committee Effectiveness Survey which was overall positive, but highlighted the following: • **Committee meetings and the need to schedule prior to important issues being raised and timed adequately for key decisions.** The Committee discussed whether Audit Committee meetings are scheduled adequately in key decisions and felt that 4 and one to sign off annual accounts feels reasonable and aligns with other bodies, but did recognise that another meeting could help align with Board business. • **Private Committees/meetings questioned are they used appropriately?** The Committee agreed the need to take a view if papers need to go to a Part B meeting and whether a Part B meeting is needed. ****ACTION: Claire Bowden and Lauren Fear can discuss with Emma Stephens in terms of this general point could look at an extra meeting for next year. Need to make sure schedule better to not have papers that have already been to Board as can't evidence the scrutiny when it's already been someone else to another meeting and the process in which Committee Papers could be shared longer in advance of the meetings.** The AUDIT Committee: • **NOTED** appendix 1 which outlines the questions and anonymised responses included in the survey; • **REVIEWED** appendix 2 which outlines key findings and some suggested actions; • **DISCUSSED** and **AGREED** actions at the meeting which they would like taken forward, and / or suggest alternative or additional actions to be progressed.	**CB/ LF/ ES**
9.0.0	**FINANCE**	
9.1.0	**Charity Annual Accounts 2020/21 Lessons Learned** Led by Matthew Bunce, Executive Director of Finance	

	Matthew Bunce explained to the Committee that the paper was produced following a request from the Chair of Charitable Funds Committee following the position of the Charity Annual accounts at the extraordinary meeting in December 2021. This paper will now be taken to the May 2022 Charitable Funds Committee for noting. The Committee **DISCUSSED** and **REVIEWED** the lessons learned and the proposed Finance Function improvements that will help facilitate timely completion for 2021/22 and future accounts.	
9.2.0	**Private Patients Debt Position** Led by Ann Marie Stockdale, Head of Medical Records and Cancer Services Management Martin Veale was content with the development of document, but highlighted it is missing a general oversight of policy in terms of overseas patients and questioned the assurance of insurance company making payment before costs are incurred. ****ACTION: Lisa Miller responded that they could include a summary around how seek authorisation pre-payment and preapproval up front for each of the categories.** Matthew highlighted that the process information attached in the appendix should be included in the overall report. Gareth Jones stressed the need for a realistic assessment for the recoverability of figures, in relation to insurance. ****ACTION: Matthew Bunce and Gareth Jones to have a conversation outside of the meeting regarding process and possible improvements.** The AUDIT Committee **REVIEWED** and **APPROVED** the template for reporting purposes going forward. 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.	**LM** **GJ / MB**
10.0.0	**HIGHLIGHT REPORT TO THE TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting 26 May 2022.	
11.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	None.	
12.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
13.0.0	**DATE AND TIME OF NEXT MEETING**	
	Confirmed Final Accounts – Audit Committee -13 June 2022, 10:30–11:30 via Microsoft Teams. Public Audit Committee – 19 July 2022, 10:00–12:30 via Microsoft Teams.	
14.0.0	**CLOSE**	
	The meeting closed at 1:40pm	

MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
TUESDAY 19 JULY 2022 AT 11:00AM

PRESENT:	
Martin Veale	Chair and Independent Member
Gareth Jones	Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Claire Bowden	Head of Financial Operations
Lisa Miller	Director of Operations
Emma Stephens	Head of Corporate Governance
Chris Moreton	Deputy Director of Finance
Felicity Quance	Senior Audit Manager, NWSSP (Audit and Assurance Services)
Emma Rees	Audit Manager, NWSSP (Audit and Assurance Services)
Katrina Febry	Audit Wales
Steve Wyndham	Audit Wales
Darren Griffiths	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
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 • Lauren Fear, Director of Corporate Governance & Chief of Staff • Jacinta Abraham, Executive Medical Director • Nigel Price, Local Counter Fraud Specialist • Steve Ham, Executive Chief Officer • Simon Cookson, Director of Audit & Assurance	
1.2.0	**In Attendance** Led by Martin Veale, Chair, and Independent Member Martin Veale welcomed attendees from Audit Wales and Internal Audit Services 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 The AUDIT Committee: • **NOTED** the updated actions. • **AGREED** and **NOTED** all the **CLOSED** actions.	
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 Public Audit Committee meeting held on 03 May 2022** Led by Martin Veale, Chair, and Independent Member The AUDIT Committee **AGREED** the notes from the meeting held on the 03 May 2022 would be brought to the October 2022 Audit Committee meeting.	

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 Matthew Bunce took the Committee through the changes to the paper: • Regulations and section of SFIs for procurement that must be followed have been included in the Situation/Background section of the report • Where there are contracts of over £1m, a standard statement is included in the SFIs for Boards and Trusts that states WG approval should be sought before entering. The SFIs need to be amended to state that the Trust needs to notify WG when entering contracts >£1m but does not need to seek approval. • Assessment section been updated to include more context and background regarding compliance assurance already in place and proposed further work. Matthew Bunce noted to the Committee: Andy Butler (AB) has provided MB with an update that a protocol is being developed by NWSSP to give the Trust Audit Committee, through the Director of Finance, early sight of any risk of legal challenges from bidders participating in All Wales Contract tenders**.** **ACTION: Draft protocol to provide Trust Audit Committee with early sight of any risk of legal challenge from bidders participating in All Wales Contract tenders to be included in October 2022 Audit Committee.** Initial assessment by Helen James, the new Head of Procurement is that there are a high volume of Single Tender Actions (STAs) and Single Quotation Actions (SQAs) for which potentially alternative complaint procurement routes may be available. Procurement will commence work to review all available procurement framework agreements to establish whether they can be accessed as an alternative route to market, negating the need for SQA/STA. ****ACTION: Head of Procurement to provide an update and circulate an update ahead of next Audit Committee.** The new Head of Procurement has recognised there are repeat SQA/STA requests for the same service/providers and has agreed that future procurement reports will contain information in relation to the total value of expenditure to date **ACTION: Head of Procurement to include information in relation to the total value of expenditure to date for repeat SQA/STA** This AUDIT Committee **NOTED** the report.	**AB/MB** **HJ** **HJ**
2.2.2	**Losses and Special Payments Report (Verbal Update)** Led by Claire Bowden, Head of Financial Operations Claire noted the write offs to the Committee: • Four debts written off this year to the value just under £40,000 for Cross Border patients aged debts going back to 2013. Had difficulty recovering as responsible commissioning organisations no longer exist in their current form and commissioning organisations also disputed which was responsible for the costs. Steve Ham approved the write-offs in line with SFIs. • Foreign exchange currency loss of £170 due to a US payment being made twice in error and recovery of over-payment resulted in exchange loss.	

	Matthew Bunce noted that the Trust has put in place a system that flags patients identified as NHS England responsibility to ensure authorisation from their responsible commissioner prior to treatment occurs to reduce the likelihood of future cross border patient bad debts. This AUDIT Committee **NOTED** the verbal update provided.	
2.2.3	**NHS Wales – Health Boards and NHS Trusts All Wales Chairs of Audit Committee Minutes** Led by Martin Veale, Chair of the Audit Committee The AUDIT Committee **NOTED** the information.	
3.0.0	**PRIVATE PATIENT SERVICE REVIEW** Led by Matthew Bunce, Executive Director of Finance	
3.1.0	**Private Patient External Review Oversight and Action Plan** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce noted that section 2.7 was added to the paper following the May 2022 Audit Committee, that shows the process of assurance around the private patient improvement action plan through the Strategic Development, Audit and QS&P Committees the approach agreed by the Trust Board. Revised target dates to the end of Quarter 3 and 4 have been identified by the VCC Senior Leadership team for a number of the strategic and commercial actions. A number of these actions require the procurement of further external specialist support from Liaison Financials the supplier procured to undertake the private patient income review. Enquiries will be made with Liaison as to whether they can provide the additional services required and timescales for that support. Matthew Bunce noted the agreement to establish a private patient improvement group with the Executive Director of Nursing, AHP's & Medical Scientists as SRO to oversee the implementation plan, the first meeting of the group is on 27 July '22 and monthly to the end of the year. Vicky Morris had concerns with generic quarter 3 and 4 deadlines as they were not specific enough and wanted further clarity on the delay to completing the strategic actions and agreeing the strategic direction. Matthew Bunce assured the committee he would communicate the concern to Nicola Williams as SRO to ensure the revised dates within the action plan are specific as well as discuss with Cath O'Brien regarding explicit timescales to agree the strategic direction for the services. Lisa Miller highlighted there has been a lot of work and progress on completing several the actions to improve the operational processes in response to the TPW Ltd external review report recommendations. Matthew Bunce noted that the additional external support is required to focus on review and update of prices and negotiation of the contracts with the three Insurers. Matthew Bunce highlighted that the Private Patient Service contributes at least £450,000 (income more than costs) to the cost of NHS services. Martin Veale summarised that the Committee's view was there is control of the issues identified by the TPW report through the improvement action plan and leadership of the SRO via the improvement group and that the private patient service is moving in the right direction. Audit Committee suggested the contract agreement for external specialist support to undertake a review of the private patient income base and the proposed procurement of further external support to support the shaping of the service strategic direction are progressed as soon as possible. There will be reporting to Trust Board across the whole suite of actions twice a year.	

	The AUDIT Committee **NOTED** the recommendations.	
4.0.0	**GOVERNANCE OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS AND MANAGEMENT ACTIONS TRACKING** Led by Matthew Bunce, Executive Director of Finance	
	Matthew Bunce took the Committee through the report and noted: • The review of the Audit Action Tracker should be undertaken as part of the risk management review process going forward as audit reports form part of the Trust Assurance Framework as one of the 3rd lines of defence to the management and mitigation of risks. • Need to make sure when monitoring audit actions in the Audit Committee that the Trust has identified the correct actions to respond to audit recommendations, that actions have been delivered and the risk identified by audit have been mitigated or removed. • EMB need to collectively have oversight and scrutiny of all audit actions to ensure progress to implement is on track prior to scrutiny by the Audit Committee. • EMB is working with Emma Rees of internal audit to improve Trust staff engagement in relation to audit recommendation responses. • Paper outlines a procedure for the management of internal and external audit recommendations, management response and actions, next steps, and recommendations. The Committee agreed the paper and its recommendations together with the new procedure for the management of internal and external audit recommendations, management response and actions was a significant step forward. The Committee didn't agree with the recommendation for Audit Committee to review the full tracker 4 times a year as it considered this would involve more of an executive function rather than oversight and assurance, but agreed twice a year would be sufficient for assurance purposes. The Committee agreed all actions should remain in the tracker to ensure an audit trail including previously completed actions which are currently removed from the tracker. These should be marked as closed (colour coded Blue). Matthew Bunce confirmed as part of the new procedure each divisional Senior Leadership Team/Senior Management Team will be required to review the Tracker regularly as will the Executive Management Board. Matthew Bunce noted that the Microsoft (MS) Excel format of the Audit Action Tracker may be changed to assist the production of the summary information of action progress and he also plans to explore other system options for tracking audit actions e.g. MS Power BI. **ACTION: Emma Rees noted an ongoing piece of work of where Digital Health & Care Wales are looking to develop their system using Power BI and agreed to bring a verbal update to the October 2022 Audit Committee.** The AUDIT Committee: • **NOTED** recommendation 4.1, 4.5, 4.6 and 4.7. • **DISCUSSED** and **REVIEWED** recommendation 4.2, 4.3 and 4.4 and APPROVED the procedure, changes to the action tracker and twice a year review of the action tracker.	**ER**
5.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
5.1.0	**Trust Risk Register** Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff	

	Emma Stephens noted to the Committee: • Risks to be scrutinised by each of the respective Committees. • Ongoing framework will be structured into the risk and assurance programme of work to which more detail will be added for the October 2022 Audit Committee. • Significant step forward on training. • Provides an overview of the framework and development. • WBS on track to migrate all data onto Datix 14 by the end of this month. • The Risk Management Policy co-created by a Risk Working Group made up of divisional representatives and risk subject matter experts. Management procedure developed to underpin this. • Way in which information is extracted from Datix in terms of action plans is being reviewed at pace, including core data quality. **ACTION: Following Committee discussions Emma Stephens will action Committee queries as below:** • **To share the documents related to the Policy.** • **To clarify to the Committee the viability of the mitigation of actions and controls and how that is viewed within Datix.** • **Emma Stephens to speak to Lauren Fear to discuss the possibility of incorporating some training in the Board Development Sessions, with specific sessions for Independent Members, specific to their respective Committees.** • **To confirm if there is a corporate risk register as this is not described in the policy.** The AUDIT Committee decided to postpone the decision on whether to endorse the Risk Management Policy until after the actions above, particularly sharing of related documents, was progressed. It was agreed to progress this outside of Committee to allow the opportunity of presenting the Policy to the September 2022 Trust Board Meeting for approval.	**ES / LF**
5.2.0	**Trust Assurance Framework** Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff Emma Stephens noted to the Committee: • The update to the key developments on the TAF, link to risk register, performance framework and the quality framework and how we bring those frameworks together. • Following the establishment and embedding of the new performance and quality management framework, the next steps will be to link the measures within those frameworks into the Trust Assurance Framework. • Linking of the risk framework and other frameworks the intention is the work is being developed through the Summer and will be taken to Strategic Development Committee and then Audit Committee in October 2022. • Reverse stress testing - there will be a workshop at next Board Development Session. • Review of the workforce planning risk, as the score and assurance mechanisms require update. • Mapping the Trust assurance framework to the Governance Cycle and the need to recognise the links to the Audit action Tracker and mitigation of removal of risks identified by audit. Going forward the TAF will be a key document, whilst strategic element is still a live document. **ACTION: Emma Stephens to discuss with Lauren Fear our requirements for Power BI to support further future development of TAF and share with Steve Wyndham to assess feasibility of what support might be available from Audit Wales Data Analytics Team to take forward as a project.** Matthew Bunce also expressed his interest with obtaining some information on the Power BI System for use as audit action tracker.	**ES**

	The Committee raised questions on the format and consistency. Gaps in the second- and third-line assurance and some concerns over completeness with missing information in some of the strategic risks and were particularly concerned on workforce strategic risk. Emma Stephens confirmed with regards to the Workforce risk there was an agreement to review in the last Executive Management Board and this had also been supported by Quality, Safety & Performance Committee so confirmed this has already been recognised as an important action. Emma Stephens noted the programme of regular meeting with Executive Leads and their teams and review around how we link TAF into cycle of business of the team. The AUDIT Committee **DISCUSSED** and **REVIEWED** the recommendations.	
5.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce noted to the Committee: • 6 new audits and 58 agreed actions added since the last Committee (May '22). • Reconciliation to show movement of outstanding actions from May audit Committee to July Committee; 84 to 130 actions. • The proposal to introduce blue status to always keep actions on the tracker to provide a clear audit trail of all actions back to the audit reports. • Summary tables of actions developed providing information on the audit year, implementation status by priority and Executive lead and highlighting the overdue actions (red status). • Summary tables for May to provide comparison and show changes to action status from the previous meeting. This comparison from the previous to current committee will be a key element of each report. • An additional column has been added to the tracker to identify the Executive Lead. Further development of the tracker is being considered, e.g., whether it's possible to provide detail on the no. months action dates have been extended by Martin Veale noted: • the improved status from 39 overdue red status actions in May'22 to 18 in July '22. • that 58 more actions in response to audit recommendations from 6 new audit reports is a significant increase since the previous reporting period. Emma Rees stated the volume of audit recommendations has been picked up as an issue by the internal audit service, following a review of the data across all organisations they audit. They are commencing discussion on what recommendations are being raised, why and are they adding value? Also questioning do low risk advisory points need to be added to audit reports? Martin Veale asked if additional information showing the priority timescale for action completion status (High, Medium, Low) could be added to the summary table (section 2.2.3) showing the movement in total audit actions between each committee . Gareth Jones noted it would be helpful to have a summary matrix in terms of when action implementations were due as agreed by Trust management and priority implementation timescale importance (High, Medium, Low) set by Internal Audit. Vicky Morris noted the discrepancy on the summary tables to the Estate 2015/16 audit and questioned whether the remaining action should this be closed. Matthew Bunce assured this would be reviewed following the Committee. Gareth Jones highlighted the need to add the missing dates of when the Audit reports were received at the Audit Committee on the individual sheets for each audit in the action tracker.	

	The Committee were encouraged by the progress made on the Audit Action Tracker and based on the improved performance in completing actions within the agreed timescales seen to date were not minded to request Executive Leads to attend the Audit Committee to provide assurance and agreed this would be a last resort. The AUDIT Committee: • **NOTED** recommendation 4.1. • **APROVED** recommendations 4.2 closure of 79 actions and 4.3 extension of 19 action implementation dates.	
5.4.0	**Legislative & Regulatory Compliance Register** Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff Emma Stephens highlighted the key changes since this had been updated: • Worked with the Digital Team and there may be some additions by the next Committee. • Included some specific details for areas that are red on the tracker, i.e., 3.1.2 Estates internal audit programme of work in relation to the construction, design, and management regulations. That was planned for August 2021 but has been deferred. • Finance team have undertaken a considerable piece of work in updating the register with new additions to reflect that. • Included procurement compliance in the report but want Head of Procurement more involved and to sign off final version of the register. • Few new additions to register in terms of Information Governance to reflect the requirements set out in the Information Governance toolkit. Vicky Morris noted this Register and cover paper being helpful in showing the value of being triangulated in terms of a cross Committee review. The AUDIT Committee **NOTED** the report.	
6.0.0	**EXTERNAL AUDIT** Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales	
6.1.0	**Audit Position Update** Led by Katrina Febry and Steve Wyndham (Audit Wales) Steve Wyndham outlined the latest position of work at Velindre and more widely across the wider spectrum of NHS and the Welsh Public Sector. Financial audit section Completed all work 21/22 except for the Charitable Funds Final Accounts Audit which will be undertaken later in the Autumn (date to be confirmed). **ACTION: Martin Veale questioned the term 'will be undertaken' in relation to the Charitable Funds Audit and requested that a more specific date be clarified.** Darren Griffiths noted that a draft report has been sent on Quality Governance Arrangements to the Trust, with a few weeks to review and consider. Will then be giving management additional time to prepare a management response, so the final report is due to be received at the October 2022 Committee for consideration. The commenced 2022 structured assessment work and an update will be brought to the October 2022 Audit Committee for consideration. The AUDIT Committee **NOTED** the report.	**SW**
6.2.0	**21-22 Accounts Memorandum Report** Led by Steve Wyndham (Audit Wales) Steve Wyndham noted the report contained minor issues that have been identified that can help improve the accounts audit going forward, noting 4 issues were identified and 4 recommendations that have been accepted by management. This report also included review of prior year recommendations of which one has been responded to and addressed	

	and another been picked up and repeated in this year's recommendations regarding returns to the Welsh Government. Steve Wyndham expressed his thanks for the Trust management for their support and assistance. The Committee noted that as its public document there is a need to avoid use of abbreviations. The AUDIT Committee **NOTED** the report.	
7.0.0	**INTERNAL AUDIT** Led by Simon Cookson, Director of Audit & Assurance and Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)	
7.1.0	**2022/23 Internal Audit Progress Update Report** Led by Emma Rees, Audit Manager, on behalf of Simon Cookson, Director of Audit & Assurance (NWSSP - Audit and Assurance Services) Emma Rees noted in terms of progress updates, the reporting now reflects the Trust's "alert, advise, assure" categorisation of assurance. Given this is the first update for 22-23, most of the work is in planning and field work stages. She has been liaising with the DoF around the engagement challenges from last year and will be attending Executive Management Board to discuss the learning and recommendations for improvement. The AUDIT Committee **NOTED** the report.	
7.2.0	**Final 2021/22 Internal Audit Reports from the 2021/22 Core Internal Audit Plan** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)	
7.2.1	**Wellbeing of Future Generations Act Advisory Review Report** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees noted the advisory review was aiming to support the Trust in the development of the sustainability strategy. In summary the review demonstrated good governance for accountability and ownership. Key areas for on-going development included looking at how to monitor and measure progress and making the most of opportunities to work in a joined-up manor. Emma Rees noted in general wouldn't expect advisory report to be put on the Audit Action Tracker. Matthew Bunce highlighted that advisory reports have been included in the action tracker for completeness, but the summary tables in the cover paper identify the actions separately. The AUDIT Committee **NOTED** the report.	
7.2.2	**Follow Up: Previous Recommendations** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees stated part of this report notes the issues and concerns around the Audit Action Tracker and recognised the improvements already made and draft procedure proposed for implementation. In relation to recommendations followed up during 2021/22 and included in other 2021/22 reports summarised in Appendix B, she noted that whilst the Trust action tracker status identified the recommendations as closed, t from audit perspective they didn't consider for some of the recommendations the original risk has been fully addressed or clarity of acceptance by the Trust of the residual risk. Therefore, these recommendations remain subject to further work. The AUDIT Committee **NOTED** the report.	

7.3.0	**nVCC Integrated Audit Plan 2021/22** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services)	
7.3.1	**Financial Reporting – Final Report** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services) Felicity Quance noted the 3 reports Aug 2021-March 2022. There were three recommendations and all recommendations had been addressed post field work. Martin Veale noted this to be positive report and suggested it may be helpful share with Welsh Government. The AUDIT Committee **NOTED** the report.	
7.3.2	**MIM Procurement – Final Report** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services) Felicity Quance noted this report as specifically looking at receipt and management of the Pre-Qualification Questionnaires, the Procurement Strategy, governance of the process, the evaluation of the Pre-Qualification Questionnaires and the declarations of interest. It was acknowledged that there have been some deviations in timetable programme. In summary the MIM procurement was well managed and didn't raise any recommendations. The AUDIT Committee **NOTED** the report.	
7.4.0	**Enabling Works Integrated Audit Plan 2022/23** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services)	
7.4.1	**Security Contract – Final Report** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services) Felicity Quance noted this as an advisory piece of work because the team wanted advice from audit on how well the contract was being managed and areas for improvement. The audit involved looking at cost in relation to that contract. Key findings included issues with contract changes, work being undertaken with no contract, poor financial control specific to those contract changes and inaccuracy on payments. The report raised 6 recommendations. The Committee considered this report shouldn't be included in the public domain as specific financial values were identified in relation to a commercial contract. The Committee agreed these recommendations be included in the Audit Action Tracker as looking to ensure contract variation and associated price increases above delegated financial limits is sighted at Board level. The AUDIT Committee **NOTED** the report.	
	Emma Stephens left the meeting at 2pm	
8.0.0	**COUNTER FRAUD**	
8.1.0	**Annual CF Report 2021-2022** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington highlighted information in relation to the report: • Written in alignment with the new NHS Counter Fraud authorities standards. • Measure compliance in colour coding as green amber and red. • Service last year was impacted by issues with staffing and covid. • Improvements can be made in the areas of risk assessment, outcome-based metrics and undertaking detection activities. • 110 days were provided last year to the organisation (excluding NWSSP) from the Counter Fraud Team. • Previous student bursary fraud had been reported through Velindre because they host Shared Services. In future this will be reported against HEIW so won't come to Trust Audit Committee.	

	The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	
8.2.0	**Counter Fraud Progress Report Quarter 1** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington provided an update to the Committee on the report noting that in the first quarter provided 24 days to organisation, around developing infrastructure, modernising, and improvement in several areas which are outlined in the report. Gareth Lavington noted that two investigations are currently open. **ACTION: Gareth Lavington agreed to circulate the Appendices included in the document following the meeting.** The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	**GL**
9.0.0	**FINANCE**	
9.1.0	**Private Patient Service Debt Position** Led by Ann Marie Stockdale, Head of Medical Records and Cancer Services Management and Lisa Miller, Director of Operations Matthew Bunce confirmed below information to the Committee: • There is now in place an upfront requirement for self-payers to pay via a bank transfer or other means. • Negotiation of contracts with insurance companies is a key priority. • KPIs included for sign off. • Need to add a further KPI of day sales outstanding, as important to see relationship between the income growth and the value of debts. Matthew Bunce suggested that the reason for the rise in the KPI percentage of debt in February and April 2022 relates to moving off the online system based on advice from the external consultants TPW Ltd, where invoices were raised automatically with Insurance companies to a manual invoicing process which has led to a delay and backlog of invoices due to staffing issues. Matthew Bunce confirmed he would seek assurance on this explanation from Lisa Miller and Ann Marie Stockdale and would then share with the Committee as part of this regular agenda item. The AUDIT Committee **NOTED** the report and **REVIEWED** and **APPROVED** the KPIs.	
10.0.0	**ADMINISTRATION**	
10.1.0	**Agreement of Committee Cycle of Business** Led by Martin Veale on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff **ACTION: The Committee to review the Cycle of Business and flag anything they think should be changed or added. Martin Veale asked if the Cycle of Business can be checked back to the Terms of reference for completeness.**	**ALL**
10.0.0	**HIGHLIGHT REPORT TO THE TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting September 2022.	
11.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	None.	
12.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
13.0.0	**DATE AND TIME OF NEXT MEETING**	
	04 October 2022, 14:00–17:00 via Microsoft Teams.	
14.0.0	**CLOSE**	
	The meeting CLOSED at 2:20pm	

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT
21st June 2022 – 9th September 2022
(Reporting Period)

DATE OF MEETING	04/10/2022

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 • SO's/SFI's – Standing Orders/Standing Financial Instructions

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 21st June 2022 – 9th September 2022 and whether in accordance with Standing Financial Instructions (SFIs) Chapter 11 Procurement and Contracting for Goods and Services, Procurement Manual, and the Contract Notification Arrangements, included as Schedule 1 of the SFIs.

1.2 Schedule 1 of the SFIs sets out the processes for LHBs and NHS Trusts Contract and Interests in Property Exceeding £0.5m Notification Arrangements:

LHBs and HEIW
Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts
Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Entering into contracts
Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group

The process which NHS Wales bodies entering into contracts must follow is:

- *All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract*;
- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- ***All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and***
- ***All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.***

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team: Robert.Eveleigh@gov.wales

1.3 Assurance is also provided regarding compliance with statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102', which are reflected in Section 11.5 of the SFIs and procurement procedures and schedule 2.1.2 Procurement and Contracts Code for Building and Engineering Works of the SFIs.

1.4 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	**Minimum competition[1]**	**Form of Contract**
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers

[2] in accordance with the requirements set out in SO 11.6, however Schedule 1 of the SFIs as set out in paragraph 1.2 above states "All eligible NHS Trust contracts >£1m in total to be submitted to the

Director General HSSG for notification prior to award" not for "Consent" i.e. Approval. The table above in SO 11.6 is incorrect for an NHS Trust as it refers to "Approval".

1.4 Advice from the Procurement Services must be sought for all requirements in excess of £5,000

1.5 Single Quotation Application or Single Tender Application (SFI section 11.13)

In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences);
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Trust Scheme of Delegation; and
- An "or equivalent" test has been considered proving the request is justified.

Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

As SQA/ STAs are only used in exceptional circumstances, the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Trust.

The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Trust to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training; or
- Take internal disciplinary action.

No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition is not possible.

For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA's/STA's not endorsed by Procurement or any exceptional matters.

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

SFI Reference	SFI Description	Description	Items
11.13	Single Quotation Application or Single Tender Application	Single Quotation Actions	5
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	4
11.13	Single Quotation Application or Single Tender Application	Single Tenders for consideration following a call for an OJEU Competition	1
11.17	Extending and Varying Contracts	Contract Extensions and Contract Change Note (CCN) or Variation of Terms)	0
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes)	3

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Compliance Assurance

Appendix 1.1 outlines the number and type of Single Quotation Action (SQA) and Single Tender Action (STA) requests that have been submitted to NWSSP Procurement Services for approval. The SFI Reference column identifies the process followed, i.e. SQA or STA, which are dependent upon value excluding VAT that, for clarity, are £5,000 to £25,000 and above £25,000, respectively. The Compliance Comment column confirms Procurement has scrutinized the request, assessed the Value for Money element and has endorsed this approach.

Repeat Submissions

As outlined in the July Audit Committee paper, previous costs for repeated submissions are now included to highlight the aggregated value of expenditure incurred for the same requirement. The end column 'First Submission or Repeat', now contains the total aggregated value of expenditure incurred to date, excluding the cost of the repeated requirement detailed in this paper.

Audit Committee is requested to note, for WBS-SQA-1013, it has emerged that the maintenance of this equipment has been managed by NWSSP's Maintenance Team and the associated SQA/STA Trust approval has been obtained, however they failed to notify the Velindre Procurement Team. As a consequence, this is a repeated request for SQA approval where there have been previous costs of £79,954 despite this being recorded as a First Submission. As this was not known at the time, the appropriate notification to Audit Committee was not undertaken. This has now been rectified and, as of now, all future requests will be processed and reported to Audit Committee.

Non-Compliance

Appendix 1.2 highlights three instances where service areas have engaged with providers to supply goods and/or services with a value in excess of £5,000 without following the process outlined in SO's/SFI's and without procurement involvement. Whilst it has been common practice for service areas to undertake competition, it is on the basis that the quotations procedure within SFI's is followed, which they have failed to undertake Competition not sought in accordance with SFI'S. As they are in breach of SO's/SFI's, File Notes are completed and a record maintained.

All Wales Contracts

Appendix 1.3 summarises the All-Wales Contracts that are in progress by NWSSP for information purposes only. The list of contracts has yet to be presented and approved by NWSSP's Audit Committee therefore, as their next meeting is not taking place until 14th October 2022., this information is not available.

In view of this, the All-Wales Contract information will be presented to the next Audit Committee.

Legislative Regulatory Compliance Register

The Trust Legislative Regulatory Compliance Register has been updated to include reference to procurement regulation and also that this report provides assurance through the Audit Committee.

NWSSP has confirmed that it doesn't currently have a register.

2.2 General Observations Update

SQA/STA Requests

As part of the strategy to reduce the number of SQA/STA requests, as and when applications are received for the maintenance/servicing of equipment, discussions have commenced with NWSSP's Maintenance Team to identify existing contractual arrangements that mirror the Trust's requirements, so that they can be amalgamated. Amalgamation will involve establishing whether there are 'closed protocol arrangements' in place, i.e., only the Original Equipment Manufacturer (OEM) are certified to provide the required maintenance/servicing, or whether other suppliers are able to provide a like-for-like service provision. This exercise is time consuming as there are several factors that must be taken into consideration, such as supplier equipment knowledge, expertise, capability, capacity, technical skills, etc. Where only the OEM can undertake the required maintenance, framework agreements that can be accessed will be reviewed with a view of awarding the contract via that route to underpin the necessary governance. Where no frameworks are available then there will be no alternative other than to proceed with the SQA/STA request, considering the potential to contract for longer-term arrangements, particularly where it will be more cost effective.

In addition to this exercise, for non-maintenance/servicing-related requirements, framework agreements are, again, being reviewed to engage with suppliers/providers appointed to the framework, to remove the necessity of the SQA/STA request. If there are no frameworks available and there is appropriate justification of a sole supplier status, the SQA/STA request will be processed, for example, Dwr Cymru STA ref VCC-STA-004 - nVCC MIM Site Connection of Water Supply and Sewerage Discharge, this is exempt from competition under the Public Procurement Regulations 2015 Regulations - Regulation 32(2)(B)(ii). Where there is no appropriate justification then a competitive quotation/tender process will be followed.

This is currently work in progress; however, it is anticipated that this will take some months to conclude with a target date set of 31st March 2023 to complete this piece of work.

Publication of Contract Awards

In accordance with the recommendation to publish all contracts awarded above £25,000, 3 contract award notices have been published. There is no guarantee that there will be no risk of challenge from market providers, regardless of the approach adopted from the Public Procurement Regulations 2015. There are however no associated, perceived or anticipated risks resulting from these award notices and no challenge have been made to date.

Procurement Activity Between £5,000 and £25,000

NWSSP Procurement Services has provided temporary funding of a Band 3 Buyer role to undertake the Trust's £5,000 to £25,000 procurement activity that is undertaken by Trust departments. Training is currently being provided to ensure the individual has the necessary skills required to fulfill the role and it is anticipated that this will be completed within the next few weeks. A formal communication will be issued to all service areas to inform them of the new arrangements and that formal quotations will be managed by the Procurement Department.

2.2 Other Matters of Interest

Trust Board Approvals Process

It is apparent that there is a general lack of understanding in respect of the procurement processes and ways of working that service areas must follow. In view of recent issues with obtaining the appropriate signatures for Board approvals in respect of forthcoming contract awards, resulting in a breach, a constructive meeting with the Chief Operating Officer and Deputy Director of Finance and Procurement colleagues was held. It was acknowledged that for the process for contract approvals, there was a lack of clarity in several areas, namely:

- what are the financial thresholds, i.e., Scheme of Delegation or Oracle hierarchy thresholds?
- who is the appropriate approval officer?
- what is the sequence for seeking approval?
- when should approval be sought?

It was noted that the overall Trust contract list wasn't visible however, were this to be made available, it would a) raise awareness of the contractual arrangements and their values that are associated with the service areas, b) detail the contracts that are due to expire and c) indicate when contract renewals will require the appropriate signatures and approvals.

It was also recognized that there have been many staff changes over recent years and it is probable that there is a lack of general understanding of procurement processes, phases of procurement activity, roles and responsibilities and SFI compliance. To address this, it was accepted that procurement training should be provided to raise procurement and SFI awareness in the coming months.

The meeting concluded with an agreement that a short-term Task and Finish Group should be established to explore and address the above issues, create a process map, identify roles and responsibilities within SFI's. The output of this Group, together with the delivery of procurement

training will increase staff's procurement awareness and understanding and should significantly reduce contract award approval delays and a breach of SFI's.

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 of Compliant Arrangements) and 1.2 (Further Matters / Non-Compliant Arrangements)

4 RECOMMENDATION

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – October 2022

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Rachel Hennessy	Velindre Cancer Centre	VCC-SQA-997	01/05/2022 to 30/04/2023	Single Quotation Action	Various radiation chemicals for use in Velindre cancer centre	GE Healthcare Ltd	£12,790	Sole OEM	Endorsed	Procurement to seek longer term agreement	Repeat Submission Last reported in July 2020. Total cost to date - £45,000
Rachel Hennessy	Velindre Cancer Centre	VCC-SQA-002	11/08/2022	Single Quotation Action	Urgent Engineer Breakdown Visit and parts	Xstrahl Ltd	£13,294	Sole OEM	Endorsed	No further actions.	First Submission
Rachel Hennessy	Velindre Cancer Centre	VCC-STA-005	01/09/2022 to 30/09/2022	Single Tender Action	Interim Maintenance and Support of Radiotherapy Synergy equipment	Elekta	£56,815	Sole OEM	Endorsed	Procurement to award new term contract for support until IRS replacement equipment is completed.	First Submission
Alan Posser	Welsh Blood Service	WBS-SQA-1013	01/07/2022 to 31/12/2022	Single Quotation Action	Maintenance BD Care Level 3 (Service and Cover) for FACSCanto II Cytometer 4/2 System IVD / V96100892 and Loader	Becton Dickinson	£6,981	Sole OEM	Endorsed	New Equipment replacement validation in stage, completion expected by end of life of agreement.	First Submission Total cost to date - £79,954 Please see final paragraph in section 2.1 Repeat Submissions.
Alan Prosser	Welsh Blood Service	WBS-SQA-1014	05/09/2022 to 30/06/2024	Single Quotation Action	MSc in Healthcare Leadership & Management for two candidates. The course runs for 2 years from 5th September 2022.	University of South Wales	£14,000	Only University to provide this MSc	Endorsed	No further actions	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – October 2022

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Alan Prosser	Welsh Blood Service	WBS-SQA-1008	08/08/2022 to 31/10/2022	Single Quotation Action	Clinical Service Review	Catherine Howell OBE	£15,750	Specialist expert	Endorsed	No further actions	First Submission
Alan Prosser	Welsh Blood Service	WBS-STA-987	01/01/2022 to 31/12/2022	Single Tender Action	Supply of Flow Cytometry Consumables & Reagents	Beckman Coulter UK Ltd	£56,000	Unable to maintain service without these consumables	Endorsed	Look to put Agreement in place to avoid repeat STAs	Repeat Submission - last reported January 2021 - Total cost to date - £113,533
David Powell	TCS	VCC-STA-004	31/08/2022 to 30/11/2022	Single Tender Action	nVCC MIM Site Connection of Water Supply and Sewerage Discharge	Dwr Cymru Welsh Water	£67,237	Only Water supplier in Wales that operate the Water and Sewerage network	Endorsed	No further actions.	First Submission
David Powell	TCS	VCC-STA-913	01/01/2022 to 31/03/2022	Single Tender Action	Work compromising of tree felling and clearance of mature trees over an area of approx. 2.5 Hectares	Walters UK Ltd	£374,323	Identified supplier after no bids in previous Tender exercise – Public Procurement Regulation 32(2)(a) exercised.	Endorsed	No further actions.	Repeat Submission - last reported April 2022 - Total cost to date £119,869

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – October 2022

Appendix 1.2 - Further Matters / Non-Compliant Arrangements

Executive / Director Responsible	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
Rachel Hennessy	Velindre Cancer Centre	VEL-FN-001	31/03/2022 to 30/03/2026	File Note	Maintenance of Revolution CT Scanner	NHS Supply Chain	£262,460	Delay in renewal quote submission. Further negotiation to achieve £6,396 per annum savings when beyond renewal date.	Extended without appropriate authorisation	Procurement Maintenance Team is to engage with service prior to expiry	First time submission
Rachel Hennessy	Velindre Cancer Centre	VEL-FN-003	01/04/2022 to 31/10/2022	File Note	Extended Supply of a Temporary marquee to provide comfort to patients during the COVID-19 Pandemic social distancing	County Marquees Ltd	£18.256	The breach of procedure was due to winter pressure Covid – 19, social distancing in line with Welsh Government Legislation and the requirement to provide suitable covered areas for patient safety waiting. Currently looking at a more substantial fixed modular unit which will reduce overall lease cost.	Competition not sought in accordance with SFI'S	Service is continuing to determine the longer-term requirement; in the meantime, a quotation exercise is progressing to cover from 01/11/2022 to 31/03/2022 in first instance.	Repeat submission - Last reported in January 2020. Total cost to date - £82,507
David Powell	TCS	VEL-FN-004	16th May 2022 to 15th May 2023	File Note	Provision of Escrow Services	Intertrust Escrow and Settlements B.V.	£15,200	Due to the complex situation of acquiring an Escrow account supplier that has agreement by both VUNHST and Asda, Velindre's contracted solicitor DLA Piper initially suggested 1 Escrow account supplier to Asda who agreed first time.	Competition not sought in accordance with SFI'S	No further actions.	First time submission

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Velindre University NHS Trust - Audit Committee Report – October 2022

Appendix 1.3 - All Wales Contracts in progress

No.	Contract Title	Doc Type	Total Value	Director of procurement Services (Jonathan Irvine) approval <£750K	Welsh Government approval >£500k	Managing Director (Neil Frow) approval £750k-£1M	Chair Approval (Tracy Myhill) approval £1M+
See 2.1 above. The list of contracts has yet to be presented and approved by NWSSP's Audit Committee therefore, as their next meeting is not taking place until 14th October 2022., this information is not available. **In view of this, the All-Wales Contract information will be presented to the next Trust Audit Committee.**							

AUDIT COMMITTEE

DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY & HONORARIA (01 MAY 2022 – 28 SEPTEMBER 2022)

DATE OF MEETING	04/10/2022

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 amendments and additional entries received for the period **01/05/2022 – 28/09/2022.**

- There has been **5** new entries on the Gifts, Hospitality and Sponsorship Register this period.
- There have been **15** 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: 01/05/2022 – 28/09/2022)

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
06/05/2022	Dr Simon Waters	Consultant	Velindre Cancer Service	Gilead Sciences Ltd	29/04/ 2022	Online Advisory on Breast Cancer. Initial Briefing and Several Questions and Debate points over next 12 months. Outside of working hours.	Advisory Board meeting	Honorarium - £2,200	Own Time	Tax and NI Declaration Form.	Eve Gallop-Evans, Clinical Director	06/05/22	Accepted
26/05/2022	Dr Kein Yim	Consultant	Velindre Cancer Service	Pharma	2605/2022	Chair talk on HCC Webinar	Webinar	Honorarium - £583	Own Time	Tax and NI Declaration Form.	Eve Gallop-Evans, Clinical Director	12/05/2022	Accepted
26/05/2022	Chloe George	Head of Component Development	Welsh Blood Service	Cerus	20/06/2022	Cerus pathogen reduction – 15th International Seminar on Blood Safety, Dublin-Ireland Attendance at conference, flights, flight transfers, hotel and all meals paid for by Cerus	Conference	Hospitality - £1,300	Trust Time	N/A	Alan Prosser, Director WBS	26/05/2022	Accepted
15/09/2022	Prof John Staffurth	Consultant	Velindre Cancer Service	Accord	22/09/2022	Advisory Board	Advisory Board meeting	Sponsorship - £1,250	Study Leave	N/A	Eve Gallop-Evans, Clinical Director	15/09/2022	Accepted
28/09/2022	Jonathan Hibbert	Pharmacy Technician Homecare	Velindre Cancer Service	Servier Laboratories	16/11/2022	Homecare review meeting	Speaker	Honorarium - £210	Own Time	Tax and NI Declaration Form.	Rachel Hennessey Interim Director VCC	15/09/2022	Accepted

Appendix 2 – Trust Declarations of Interest Register (Amendments / Additional Entries: 01/05/2022 – 28/09/2022)

Date Entry Received for Register	Name	Designation	Division	Details
04/05/2022	Nigel Downes	Interim Deputy Director of Nursing	Corporate	• Nil Interests Declared
25/05/2022	Alan Prosser	Director of Welsh Blood Service	Welsh Blood Service	• Nil Interests Declared. • Note: No longer Club Secretary and Team Captain of the Bridgend Squash Club. No longer seeks sponsorship for club activities, fundraising or handles cash of members in the Club. This was not a paid position when held previously.
25/05/2022	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: Departmental 21/22 – Roche Pharmaceutical providing grant for medical writer to develop journal article for submission on behalf of departmental member; Lily Pharma – departmental member undertakes honorarium work, payment for which is submitted to VCC
26/05/2022	Rachel Hennessey	Acting Director of Velindre Cancer Service	Velindre Cancer Service	• Nil Interests Declared
26/05/2022	David Mason Hawes	Head of Digital Delivery	Corporate	• Nil Interests Declared • Note: No longer requirement to use Matthew Tyson Design for graphic design services to support development of Digital Services branding who is an old friend of approx. 23 yrs. and is a fully qualified graphic designer, with over 20 years' experience.
27/05/2022	Stephen Harries	Vice Chair	Corporate	• Former Trustee of City Hospice until 5 September 2019. Remains a "member" of the Company, which is subject to the payment of a small annual subscription fee • Independent Member of the Welsh Government's Economy, Treasury and Constitution Group Audit and Risk Assurance Committee (ARAC). The role requires a maximum commitment of 6 days per annum.
27/05/2022	Lauren Fear	Director of Corporate Governance & Chief of Staff	Corporate	• Nil Interests Declared • Note: No longer Non-Executive Director & Trustee of Cardiff & Vale Citizens Advice - General Advice and contracted to run advice lines for the health/Social charities - e.g. Motor Neurone Disease and no longer married to a Solicitor in Legal & Risk - part of Hosted Organisation NWSSP.
27/05/2022	Sue Thomas	Deputy Director of Organisational Development & Workforce	Corporate	• Other Positions of Authority: Personal - Appointed as a Magistrate (JP) May 2022
31/05/2022	Dr. Jacinta Abraham	Executive Medical Director	Corporate	• Personal / Departmental Sponsorship: Attending a Medical Governance Advisory Board Committee for Sciensus, 2-3 times per year (11/02/22-10/02/23) - Honorarium will be received for hours of work which will be performed during annual leave. • As part of role as Lead Executive and budget holder for Research Development and Innovation (RD&I), receives, on behalf of the Trust a number of external grants from Commercial & Academic Partnerships which are for specific projects previously agreed within the RD&I Sub-Committee.
31/05/2022	Christine Thorne	Deputy Head of National Sourcing	NHS Wales Shared Services Partnership	• Nil Interests Declared

Date Entry Received for Register	Name	Designation	Division	Details
31/05/2022	Claire Lesley	Deputy Director of Procurement	NHS Wales Shared Services Partnership	• Nil Interests Declared
01/06/2022	Neil Frow	Managing Director and Accountable Officer	NHS Wales Shared Services Partnership	• NHS Wales Representative Board Member and Vice Chair on the Welsh Government Hosted National Procurement Service (NPS) - 5 Years - NPS Contracts for common and repetitive spend areas. • NHS Wales Representative on the Welsh Government Public Sector Procurement Board - 5 Years - Nil transactions or benefits in kind. • Spouse is employed Cym Taf Morgannwg University Local Health Board.
05/06/2022	Martin Veale	Independent Member	Corporate	• Sport Wales - Board Member and Chair of Audit and Risk Committee 2018– Remunerated • Hafod (Housing Association & Care Homes) - Member of Audit and Risk Committee 2020– Remunerated • Pen y Cymoedd Windfarm Community Fund (charity) - Director 2019– Daily Rate • Welsh Government Member of Audit and Risk Assurance Committee, Health and Social Services Directorate 2019– Daily Rate • Merthyr Tydfil County Borough Council - Lay Member of Standards Committee 2019– Daily Rate • Pembrokeshire County Council - Lay Member of Audit Committee 2017– Daily Rate • Blaenau Gwent County Borough Council - Lay Member of Audit Committee 2020– Daily Rate • HM Court and Tribunal Service Justice of the Peace, Mid Wales Bench 2016– Voluntary • Coleg Gwent - Governor and Chair of Audit Committee 2015– Voluntary • Hawthorn High School, Pontypridd - Governor 2019– Voluntary • South Wales Police – Member of Joint Audit Committee (joint committee reporting to Chief Constable and Police & Crime Commissioner) – 2021– Daily Rate • Mid and West Wales Fire Authority – Chair of Standards Committee – 2021– Daily Rate • Merthyr Tydfil County Borough Council Lay Member of Governance and Audit Committee – 2022– Daily rate • Brecon Beacons National Park Authority – Lay member of Standards Committee – 2021- Daily rate • Rhondda Cynon Taf CBC – Governor member of Children & Young People Committee – 2022- Daily rate • Monmouthshire County Council – Lay member of Governance and Audit Committee – 2022- Daily rate • New 3-16 school at Hawthorn, Pontypridd – Governor of temporary governing body – 2021- Voluntary

Date Entry Received for Register	Name	Designation	Division	Details
14/06/2022	Hilary Jones	Independent Member	Corporate	• Chief Executive of Bro Myrddin Housing Association – 10 years – Salary • Wrights Independent Food Ltd – 7 years – Entitlement to Dividends up to 05 April 2022 (no longer Shareholder) • Member of West Wales Regional Partnership Board – voluntary • Director of Wales Young Farmers Club – not a shareholder, no financial gain – voluntary • Spouse / Partner: • Company Secretary and Director of Wrights Independent Food Ltd – 7 years - Entitlement to Dividends – Salary
05/09/2022	Vicky Morris	Independent Member	Corporate	• Local Authority School Governor- St Mary's RC Primary School, Newtown, Powys - February 2022 to date. • Non-executive member role with Herefordshire and Worcestershire Integrated Care System as Chair of their Quality, Resource and Delivery Committee and member of their Audit committee, strategic Commissioning Committee and Remuneration Committee.

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

AUDIT COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	4.10.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and 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	01.09.2022	NOTED
Quality, Safety and Performance Committee	15.09.2022	DISCUSSED and NOTED
Trust Board	29.09.2022	APPROVED

Acronyms

VCC	Velindre Cancer Centre	SLT	Senior Leadership Team
WBS	Welsh Blood Service	SMT	Senior Management Team
TCS	Transforming Cancer Services	EMB	Executive Management Board

1. BACKGROUND

The purpose of this report is to

- Summarise the final phase in implementing the Risk Framework.
- Outline approach to risk appetite review for autumn 2022.
- Note the Trust Board approval of the new Trust Risk Management Policy.

2. ASSESSMENT OF MATTERS FOR CONSIDERATION

2.1 Key points for the Committee:

- The content of the risk register has been scrutinised by Quality, Safety and Performance Committee in September and by the Trust Board. There was a focused discussion on the Digital Health and Care Record risks in the Quality, Safety and Performance Committee particularly.
  The risk register is included in this paper for context only given the Committee's primary role in oversight of the risk framework.
- Following endorsement of the Risk Management Policy by the Audit Committee this was approved by the Trust Board on 29th September.

3. DEVELOPMENT OF RISK FRAMEWORK

3.1 Three key steps remain for the development of risk framework:

3.1.1 Approval of the Risk Management Policy:

- The Audit Committee in July considered the Risk Management Policy and asked to have a view of the other framework documents to provide a fuller context:
  - Trust Assurance Framework – as approved in Trust Board September 2021
  - Risk Appetite Strategy – due for renewal in November Trust Board (following the Board Development risk and assurance session in early November)
  - Risk Management Procedure – at Executive Management Board level for approval
- Following Members receiving these documents, the Audit Committee Chair confirmed the action as complete and therefore endorsed for Trust Board approval.
- Trust Board approved the Policy on 29th September.

3.1.2 Three levels of training to be delivered:

- All staff Level - training covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input form which all staff in organisation have access to in order to raise a risk. This training will be delivered via online learning on ESR. This training is in the later stages of the development process with Shared Service.
- Management level – covering the Policy and Corporate Management Level Procedure and second form of Datix 14, which requires scoring, articulation of controls, setting actions and assigning ownership. It is following this step that a risk is confirmed onto the risk register. The Manager level then has the on-going responsibility for the overall management of that risk. Level 2 training has been completed at the Welsh Blood Service, is currently underway for Corporate division, which will be completed by the end of September. Velindre Cancer Centre training will be delivered primarily via October away day but additional sessions will be run.
- Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. Training has been completed for Board members and Executive Management Board members, including Divisional leadership.

3.1.3 The transition to version 14 of Datix for The Welsh Blood Service is complete.

3.1.4 Oversight of the development of the risk framework is via the Audit Committee. This includes specific action tracking following Internal Audit's report on the Risk Framework at the end of 2021.

3.1.5 The review of risk appetite will be discussed with the Board in development session in early November.

4. TRUST RISK REGISTER

The risk register is provided as appendix for context only.

5. 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
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	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.

6. RECOMMENDATIONS

Audit Committee is asked to:

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

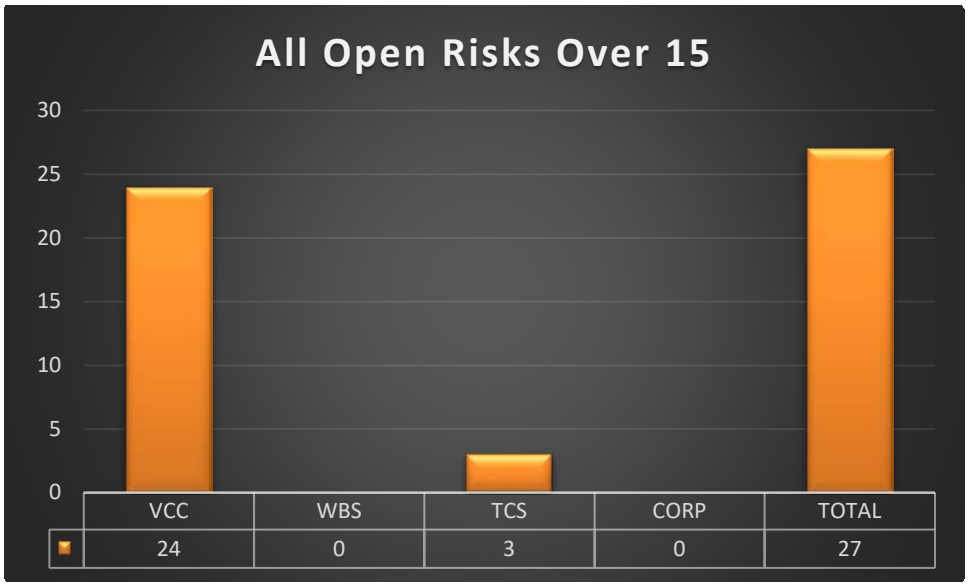
Appendix – Trust Risk Register

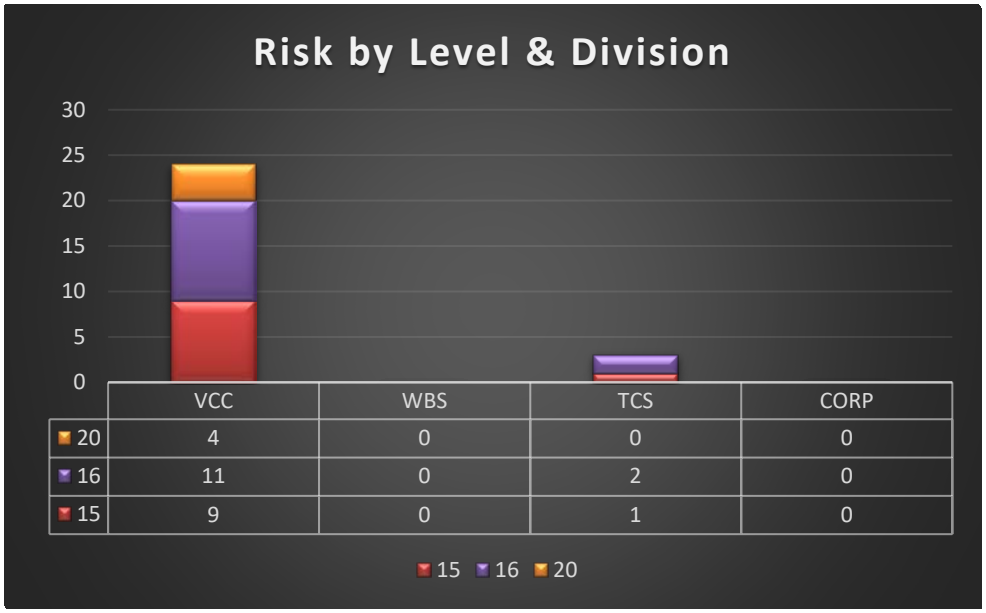
2.4.1 Total Risks

There are a total of 33 risks with a current risk level over 15 recorded on Datix 14.

2.4.2 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 include.





2.4.3 **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 (to note, the data extract is at end August)- and title of the risk.

Risks level 20

The table below provides a breakdown of level 20 risks**.**

ID	Title	Division	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Summary
2644	Digital Health & Care Record DH&CR080(R) - SACT Treatment Summary PDF displaying 'Authorised' status	Velindre Cancer Centre	An issue has been identified whereby the SACT Treatment Summary PDF is displaying an 'Authorised' status for a cycle where all the drugs within the cycle have been marked as Given or Not Given. The Chemocare application has inbuilt logic to derive the 'Completed' status when the cycle has been Authorised + drugs marked as Given/Not Given. The SACT TS PDF is misleading and could cause the reader to interpret that the treatment was not given to the patient.	20	1	30/09/2022	
2630	Digital Health & Care Record DHCR062(R) - Dual Running timeline - risk of patients in Canisc with not finished treatment	Velindre Cancer Centre	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. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirements, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	20	15	05/09/2022	

2579	Palliative Care Training posts	Velindre Cancer Centre	Wales been unsuccessful in appointing to any of the pall care registrar posts at the recent round of UK wide recruitment, this appears to be reflected across the UK with posts in all regions unfilled.In addition one of our trainees has been successful in gaining an Inter Deanery Transfer to Severn Deanery which will mean she will leave our training programme in October 2022 and return directly from maternity leave to Severn.2 new palliative care StR training posts have had their funding frozen - which means it isn't lost (this year at least), goes back to Welsh Government, but at present we are told that we cannot access the funding for these 2 posts to appoint locum replacement specialty or LAS doctors. Added to this a further trainee is likely going for an Intradeanery transfer to London, and if final approval is granted which is likely, will be there for Oct 2022. This leaves us with approximately 4 middle grade doctors on the 1:6 on call rota. There will need to be locum provision into these vacant on call spots, unless we are able to fill the vacant posts with specialty doctors.	20	4	30/09/2022	
2200	Radiotherapy Capacity	Velindre Cancer Centre	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 updateHazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ).This will be linked to Risk 22455/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.23/11/2021 - UpdateCurrently 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 service13/6/2022 - UpdateCurrently 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 service31/8/2022 -	20	6	31/10/2022	

			UPDATERisk reviewed and no change to risk rating due to no change in capacity or outsourcing possibilities.				

Risks level 16

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks.

ID	Title	Risk Type	Division	Risk (in brief)	Rating (current)	Rating (Target)	Review date
2650	Digital Health & Care Record DH&CR094(R) - Non-delivery of interface that pulls clinical annotations from WCP OMN to VCC DMS	Performance and Service Sustainability	Velindre Cancer Centre	A risk has been raised regarding the non-delivery of the interface that pulls clinical annotations from the WCP Outpatient Medical Note (OMN) to the VCC Document Management System (DMS). This is an existing interface that pulls clinical annotations recorded against the outpatient appointment in Canisc into DMS at the point of letter creation.	16	4	05/09/2022
2211	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Performance and Service Sustainability	Velindre Cancer Centre	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	12	05/09/2022

2221	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	Performance and Service Sustainability	Velindre Cancer Centre	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 eIRMER 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	12	05/09/2022

2326	Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	Performance and Service Sustainability	Velindre Cancer Centre	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	9	05/09/2022
2329	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	Performance and Service Sustainability	Velindre Cancer Centre	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	12/09/2022
2440	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	Performance and Service Sustainability	Velindre Cancer Centre	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 Minimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	16	6	05/09/2022

2499	Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin	Performance and Service Sustainability	Velindre Cancer Centre	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. DHCRO51(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.	16	8	05/09/2022
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	Velindre Cancer Centre	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	4	30/11/2022
2407	Risk of overlapping timeframes and interdependencies between RSC & IRS Projects	Performance and Service Sustainability	Transforming Cancer Services	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependencies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	16	4	20/10/2022
2513	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Performance and Service Sustainability	Velindre Cancer Centre	There is a risk that patient treatment is delayed as a result of a lack of medical work forward holding a prostate brachytherapy practitioners licence	16	10	31/07/2022
2428	There is a risk of increased infection transmission due to poor ventilation.	Compliance	Velindre Cancer Centre	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	9	02/09/2022

2554	There is a risk that Patients may not be informed in a timely manner	GDPR	Velindre Cancer Centre	There is a risk that Patients may not be informed in a timely manner as to the loss/damage to their Medical Records caused by the capacity of the Medical Records Department to identify and categorise lost/damaged records. The impact will be a material breach of the Data Protection Act 2018 in that patients who suffer a loss or damage to records may not be informed in line with the requirements of the Act	16	4	30/09/2022
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Performance and Service Sustainability	Transforming Cancer Services	There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met	16	6	30/06/2022

Risks level 15

Summary of level 15 risks are detailed in the table below.

ID	Title	Risk Type	Division	Risk (in brief)	Rating (current)	Rating (Target)	Review date
2187	Radiotherapy Physics Staffing	Safety	Velindre Cancer Centre	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. 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. 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	15	5	31/10/2022

				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.			
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce and OD	Velindre Cancer Centre	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	15	6	28/10/2022
2253	Availability of CANISC System	Performance and Service Sustainability	Velindre Cancer Centre	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	5	01/12/2022
2205	CANISC failure	Performance and Service Sustainability	Velindre Cancer Centre	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.	15	9	01/12/2022

				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. IRMER-lite form in WPAS will go live in November 2023			
2638	Digital Health & Care Record DH&CR065(R) - Provision of a DPIA - as WPAS is a national system for the WPAS System.	Compliance	Velindre Cancer Centre	The VCC IG Manager discussed with DHCW IG colleagues about providing a copy of the data protection impact assessment (DPIA - as WPAS is a national system) for the WPAS System. From a DHCW perspective WPAS predates current assurance processes and was introduced before GDPR and the requirement for Data Protection Impact. The NIIAS integration is documented but It is believe there is no formal DPIA for WPAS. The WPAS Applications Manager has stated that the WPAS system has a sophisticated role-based security model and further success controls. When WCP was implemented into VCC a DPIA was provided which provide assurance from an information governance perspective on access controls, role based structure and permission levels etc. The impact is on the DPIA being requested by VCC not being available in the same format as the WCP DPIA with access controls etc. being documented. Currently no IG Manager on post at VCC	15	4	05/09/2022
2649	Digital Health & Care Record DH&CR093(R) - Lack of Administrative Support and associated processing errors using WPAS	Performance and Service Sustainability	Velindre Cancer Centre	Specific Risk raised by Therapies Team regarding the lack of Administrative support for processing their planned and drop in clinics. At present there are 32 members of clinical staff and 0.4 wte of administrative support. The clinical staff process all of their clinics on Canisc themselves. The incoming process with the WPAS system is far more intricate and less forgiving - as it has strict booking and outcoming rules which require skilled and knowledgeable processing. The potential for error is increased - and for clinical staff to be responsible for this will further increase the potential for error. The assistants and Therapies Technician's will have to be removed from their clinical roles, to manage the administrative work.1) They will no longer be working at the top of their banding/liscence2) Patients may not be seen in a timely fashion by therapies teams, impacting their quality of care and potentially their outcomes.3) Increase potential errors by staff who are not employed to do the role they are doing.	15	4	05/09/2022
2512	Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation	Performance and Service Sustainability	Velindre Cancer Centre	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	15	12	05/09/2022

				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			
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Performance and Service Sustainability	Velindre Cancer Centre	"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	5	27/05/2022
2604	There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution.	Workforce and OD	Transforming Cancer Services	There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution.	15	4	30/09/2022
2609	There is a risk to safety as a result of hot weather leading to harm to staff in non clinical areas	Safety	Velindre Cancer Centre	The Met Office have issued an Amber Weather warning for the 17th, 18th and 19th July for extreme heat with temperatures potentially reaching in excess of 360C. It may possibly be hotter in the VCC buildings due to their age, construction, equipment and lack of mechanical ventilation. The Met Office identifies population wide adverse health effects are identified and substantial changes to working practices are likely to be required. VCC is a flat roofed building which does not have air conditioning throughout the building. In addition some air conditioning has been turned off due to NWSSP guidance on control of risks of Covid transmission. Some offices do not have windows that open. Currently following IP&C and NWSSP advice to the Trust Ventilation Group fans are not allowed in both clinical and non clinical areas. Working conditions for staff in non clinical areas are going to be extremely hot over the period of the Amber Weather warning this may have an impact both on health, stress and wellbeing and on the ability of our staff	15	8	01/09/2022

				to deliver services. Control measures are already in place but given the extreme nature of the forecast heat event these may not be sufficient in all areas of the buildings and further cooling/air movement may be beneficial which could involve the use of fans during this period.			

AUDIT COMMITTEE

AUDIT REPORT RECOMMENDATIONS ACTIONS

DATE OF MEETING	04/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Bunce, Executive 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**
EMB RUN	01/09/2022	NOTED
EMB RUN	03/10/2022	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

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

1.2 This report focuses on:

1.2.1 those actions that are overdue i.e. passed the identified implementation date (**Red Status**) and for which the Director and Officer leads are requesting Audit Committee agreement to an extension to the implementation date;

1.2.2 those actions that have been completed **(Green Status)** for which the Director and Officer leads are requesting Audit Committee agreement to close actions;

1.2.3 actions that are not yet due for completion, those assessed as on track for delivery by the agreed date **(Yellow Status)** and those that are assessed as currently not on track for delivery by the agreed date **(Orange Status);**

1.2.4 those actions that have been completed (Blue Status) for which the Director and Officer leads received Audit Committee agreement to close actions in previous meetings.

1.3 The Audit Committee is requested to consider the contents of the report and the attached action plan.

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Context

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

2.1.2 At the July ’22 Audit Committee it was was decided to review all audit report actions twice a year to ensure focus is maintained on actions, which will take place at today’s meeting 04 October 2022. This will include review of **all** actions as at the 30 September 2022. The full tracker will next be reviewed approximately 6 months from now depending on allocated 2023 Audit Committee dates. At other meetings it only reviews **Red Status** and **Green Status** actions.

2.1.3 The Internal Audit follow-up report recommendations in relation to the Audit Report Action Tracker highlighted that the current practice of deleting completed actions from the current tacker led to difficulties in following the audit trail of all actions relating to each Audit Report as it required multiple versions of the Tracker to be reviewed. This recommendation has been implemented with previous closed actions from meetings prior to July '22 being transferred to a separate section of the Tracker.

2.1.4 It was agreed that going forward the Audit Report Action Tracker includes a fifth category of **Blue Status (as noted above)** to denote completed actions that have been agreed by the Audit Committee to be closed. This is proposed to enable closed actions to remain in the section of the tracker for the audit report they relate to and be distinguished from completed actions **(Green Status)** not yet approved for closure. This enables all actions for each audit report to be easily mapped back to the audit report.

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

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

2.2 Internal Audit Actions Analysis

2.2.1 2 Internal audit reports were added to the Audit Action Tracker following the July 2022 Audit Committee and consisted of 12 recommendations of which 5 were high priority, 4 medium priority and 3 low priority. In response to these recommendations management identified 12 actions in total. The 2 reports added were:

- nVCC Financial Reporting 2021
- Follow up Previous Recommendations Final Internal Audit Report

Two advisory reports were added, plus one follow-up report to previous nVCC MIM Governance 2021/22 Audit where actions were complete, which are listed below:

- nVCC EW Security Contract 2021 (Advisory)
- Wellbeing Future Generation Act (Advisory)
- nVCC MIM Procurement 2021 Final Internal Audit Report (Follow Up)

			Summary of Recommendations				
Review	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
Infection Prevention & Control	Final report	Reasonable		4		4	Oct-21
CaNISC Replacement	Final report	Reasonable		2	1	3	Oct-21
Divisional review – Incident Management	Final report	Reasonable		4	1	5	Oct-21
Divisional review – Risk Management	Final report	Reasonable		2	2	4	Oct-21
Use of Technology – Fit for the Future	Final report	Advisory					Jan-22
Board Committee Effectiveness	Final report	Reasonable		2	4	6	Jan-22
Trust Assurance Framework	Final report	Reasonable	1	2		3	Jan-22
Financial Systems	Final report	Reasonable		5	2	7	May-22
Charitable Funds	Final report	Reasonable		4	6	10	May-22
Scrutiny of Expenditure above £100,000	Final report	Reasonable		2		2	May-22
Disclosure Barring Service Checks	Final report	Reasonable		2	2	4	May-22
Follow-up Previous Recommendations	Final report	Reasonable	1	2		3	Jul-22
Wellbeing of Future Generations Act	Final Report	Advisory					Jul-22
Finance & Service Sustainability: Budgetary Control & Savings Plans	Draft Report	Reasonable		4	4	8	Oct-22
Staff Wellbeing	Final Report	Advisory	N/A	N/A	N/A	N/A	Oct-22
Research & Development	Final Report	Substantial	N/A	N/A	N/A	N/A	Oct-22
Divisional Deep Dive (Managing Attendance)	Draft Report						Out of Committee Approval to be sought
Ways of Working	Cancelled	N/A					
Quality & Safety Framework	Deferred	N/A					
Private & Overseas Patients	Deferred	N/A					
Capital & Estates							
Estates Assurance – Waste Management	Final report	Reasonable		4		4	Oct-21

			Summary of Recommendations				
Review	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
New Velindre Cancer Centre Integrated Audit and Assurance Plan:							
Contract Management	Final report	Reasonable		3		3	May-22
Mutual Investment Model (MIM) Governance	Final report	Substantial		1		1	May-22
MIM Procurement 2021 Follow-up	Final Report	Substantial	N/A	N/A	N/A	N/A	Jul-22
Financial Reporting	Final Report						Jul-22
Design and Change Management	Fieldwork						Jul-22
Enabling Works Security Contract	Final Report	Advisory	N/A	N/A	N/A	N/A	Jul-22
Enabling Works	Final Report	Reasonable		2	4	6	
Total			**2**	**45**	**26**	**73**	
Final Report			**2**	**41**	**22**	**65**	
Draft Report			**0**	**4**	**4**	**8**	

2.2.2 Work undertaken by Management / Officer leads to complete actions since the July Audit Committee has resulted in 21 Internal Audit actions being completed which are recommended to the Audit Committee for closure.

2.2.3 The table below provides a summary of the movement in total internal audit actions from July '22 to October '22 Audit Committee:

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
July '22 Audit Committee					
Total Outstanding Actions	130	1	68	51	10
Less: Green Closed Actions - Changed to Blue	78	0	44	27	7
October '22 Audit Committee					
Add: Total Actions from new reports	12	5	4	3	0
Total Outstanding Actions @ October '22	**64**	**6**	**35**	**20**	**3**

			(+ 7 in wrong priority on previous table)	(-7 in wrong priority on previous table)	
Green Actions - Propose change to Blue	21	4	9	5	3

2.2.4 The tables below provide a summary of the audit action status position reported at the July '22 Audit Committee to provide an indication of the changes.

July '22 Audit Committee – Internal Audit

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

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports	1	2	5	13	**21**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE	1	2	13	114	**130**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete July 2022	Action complete May 2022	Action complete Jan 2022	Closed
High	1	1						2
Medium	68	11	2	11	34	5	5	6
Low	51	6	14	4	25	2		3
N/A (Advisory Audit)	10		1	2	7			4
Total	**130**	**18**	**17**	**17**	**66**	**7**	**5**	15
%	**100%**	**14%**	**13%**	**13%**	**51%**	**5%**	**4%**	

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete July 2022	Action complete May 2022	Action complete Jan 2022
Executive Director of Finance	42	2	1	3	36		
Director of Strategic Transformation, Planning & Digital	18	1	1	3	10	3	
Director of Governance & Chief of Staff	20	4	15			1	
Director of Nursing, AHPs & Health Science	1				1		
Director of OD and Workforce	9	2		3	4		
Chief Operating Officer	22	2			14	3	3
TCS nVCC Project Director	6			6			
Executive Director of Finance and Chief Operating Officer	2	2					
Chief Operating Officer and Director of Governance & Chief of Staff	10	5		2	1		2
Total	**130**	**18**	**17**	**17**	**66**	**7**	**5**

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

Priority	2019/20	2020/21	2021/22	Total
High		1		1
Medium	1		10	11
Low			6	6
N/A (Advisory Audit)				
Total	**1**	**1**	**16**	**18**

2.2.5 There were 78 actions (60%) reported to the July '22 Audit Committee that had been completed since the previous Committee, for which there were recommendations to close the actions.

2.2.6 There were 17 actions (13%) which were rated Amber as they were not on target for completion by the agreed date. There were 17 actions (13%) that were not due and were on target for completion by the agreed date (Yellow).

September '22 – Internal Audit

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports	1	2	5	15	**23**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE	0	2	5	57	**64**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
High	6	1	1			4	
Medium	79	8	9	9	2	7	44
Low	47	6	7	2	2	3	27
N/A (Advisory Audit)	10					3	7
Total	**142**	**15**	**17**	**11**	**4**	**17**	78
%	**100%**	**11%**	**12%**	**8%**	**3%**	**12%**	**54%**

Action Status by Executive / Director Lead

Executive Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Executive Director of Finance	47	4	2	1		4	36

Executive Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Director of Strategic Transformation, Planning & Digital	17				1	3	13
Director of Governance & Chief of Staff	20	4	15				1
Director of Nursing, AHPs & Health Science	1						1
Director of OD and Workforce	13	2		3	1	3	4
Chief Operating Officer	22				1	1	20
TCS nVCC Project Director	10			7		3	
Executive Director of Finance and Chief Operating Officer	2				1	1	
Chief Operating Officer and Director of Governance & Chief of Staff	10	5				2	3
Total	**142**	**15**	**17**	**11**	**4**	**17**	78

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

Priority	2019/20	2020/21	2021/22	Total
High		1		1
Medium	1		7	8
Low			6	6
N/A (Advisory Audit)				
Total	**1**	**1**	**13**	**15**

2.2.7 There are 21 actions (15%) since the July ’22 Audit Committee that have been completed. The October ’22 Audit Committee is asked for agreement to close these actions.

2.2.8 There are 17 actions (12%) which are rated Amber as they are not currently on target for completion by the agreed date. There are 11 actions (8%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.3 External Audit Actions Analysis

2.3.1 Management / Officer leads have completed 17 further actions since the July '22 Audit Committee which are recommended for closure.

2.3.2 The tables below provide a summary of the audit action status position that was reported at the July'22 Audit Committee to provide an indication of the changes.

July '22 Audit Committee – External Audit

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

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports		1			**1**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE		2			**2**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete
High	1				1
Medium	1	1			
Low					
N/A (Advisory Audit)					
Total	**2**	**1**	**0**	**0**	**1**
%	**100%**	**50%**	**0%**	**0%**	**50%**

Action Status by Executive / Director Lead

Executive Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete
Executive Director of Finance	1				1
Director of Governance & Chief of Staff	1	1			
Total	**2**	**1**	**0**	**0**	**1**

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

Priority	2015/16	2019/20	2020/21	2021/22
High				
Medium		1		
Low				
N/A (Advisory Audit)				
Total	0	1	0	0

September '22 – External Audit

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

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports		1		3	**4**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE		2		27	**29**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete Sept 2022	Action complete Aug 2022	Closed
High	3			1		1	1
Medium	3	1		1		1	
Low	2				1	1	
N/A (Advisory Audit)	21	8			2	11	
Total	**29**	**9**	**0**	**2**	**3**	**14**	**1**
%	**100%**	**31%**	**0%**	**8%**	**10%**	**48%**	**3%**

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Executive Director of Finance	7			2	1	3	1
Director of Governance & Chief of Staff (Change from August '22 as 2 Actions were with the COO below)	14	9				5	
Director of OD and Workforce	6				1	5	

Executive / Director Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Chief Operating Officer	2				1	1	
Total	**29**	**9**	**0**	**2**	**3**	**14**	**1**

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

Priority	2015/16	2019/20	2020/21	2021/22
High				
Medium		1		
Low				
N/A (Advisory Audit)				8
Total	0	1	0	8

2.3.3 3 External audits have been added since the July '22 Audit Committee:

- Addendum Management Letter 2021

Plus 2 from previous meetings that had not been included:

- WAO Structured Assessment 2021
- Taking Care of the Carers

2.3.4 There are 9 actions (31%) for which the implementation date has passed and management action is not complete (Red).

2.3.5 2 actions (8%) are identified as action on target (yellow) and 17 actions (58%) are identified as compete (Green). The October '22 Audit Committee is asked to formally close these actions.

2.4 Summary of the position as of 04 October 2022:

- There are 78 (54%) Internal Audit Report actions and 1 (3%) External Audit report action closed (Blue Status) following the July '22 Audit Committee.

- There are 21 (15%) Internal Audit Report actions and 17 (58%) External Audit Report actions that have been completed **(Green Status)** since the July '22 Audit Committee

- There are 17 (12%) Internal Audit Report actions not on target for completion by agreed date **(Orange Status)**

- There are 11 (8%) Internal Audit and 2 (7%) External Audit report actions that are on target for completion by the agreed date **(Yellow Status)**

- There are 15 Internal Audit report actions (11%) and 9 External Audit report actions (31%) that have passed their agreed implementation date (**Red Status**) since the July '22 Audit Committee.

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 asked to **NOTE** the contents of the report and the assurance it provides regarding the activities undertaken to address audit recommendations in response to audit report recommendations and associated risks.

4.2 There are 21 Internal Audit report actions (15%) and 17 External Audit report actions (58%) since the July '22 Audit Committee that have been completed **(Green Status)**. The Committee is asked to **APPROVE** closure of these actions. If agreed these actions will be formally Closed (**Blue Status).**

4.3 There are 15 Internal Audit report actions (11%) and 9 External Audit report actions (31%) that have passed their agreed implementation date (**Red Status)** which the Executive / Director lead is seeking extensions to the completion date. The Committee is asked to **APPROVE** the extension dates identified and where there has been no date identified agree extension to the next Audit Committee meeting in Jan '23.

4.4 The Committee are asked to **DISCUSS** and **AGREE** what further action should be taken in relation to actions not on target for completion by agreed date **(Orange Status)**. A number of the actions will require **APPROVAL** to extend dates.

4.5 The Committee are asked to **NOTE** the actions that are on target for completion **(Yellow Status).**

Audit Action Plan

Green - Action complete

Yellow - Action on targetto be completed by agreed date

Orange - Action noton targetfor completion by agreed date

Red - Implementation date passed- managementaction notcomplete

Blue - Action complete previous meeting

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

* Unless a more appropriate time scale is identified / agreed

VelindreUNHSTrust

INTERNAL AUDIT - ESTATES MAINTENANCE					Assurance Rating: Reasonable			Date received at Audit Committee: December 2015			
Column1	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
EV2015.1	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 partof the 3 year Integrated Medium Term Plan. The Trustwill aim to develop an estate strategy in accordance with the long term strategy for the future developmentofthe Velindre Cancer Centre and the future estate requirements of the Welsh Blood Service.	Carl James, Director of Strategic Transformation, Planning & Digital	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.**	Complete	Ongoing. Significant process made in this area including completion of engagement process with the wider organisation on supportstrategies	Further engagement is planned for the new year in supportof 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	Complete: Estates Strategy has been signed off by Trust Board May 2022

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 date passed - management action not complete

Blue - Action closed previous meeting

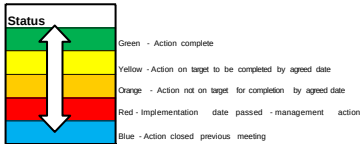
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless amore appropriate timescale is identified/ agreed

Velindre UNHS Trust

INTERNAL AUDIT -RISK MANAGEMENT					Assurance Rating: Reasonable			Date received at Audit Committee: 28 May 2019						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committe	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
RM2019.5	Managementneeds to ensure thatformal Risk Managementtraining is provided for relevantstaffthathave responsibility for identifying new risks, carrying outrisk assessments and updating the DATIX system. Managementshould review the arrangements in place for the provision of Risk Managementadvice.	Medium	A TrainingNeeds Assessment(TNA)willbe completed to identify training requirements forrelev ants taff whohaveresponsibility for identifying new risks, carrying outrisk assessments and updating the DATIX system. A reviewofthearrangements in placeforthe provisionofRis k Managementadvicewillbe undertaken as partofa wider Executive/Director portfolio rev iew.	Lauren Fear,Directorof Corporate Governance& Chiefof Staff	Lisa Heydon: This action now falls with Lauren Fear, Director of Corporate Governance & ChiefofStaff	August 2019 Extention to 30 June 2022 requested.	Overdue	• Datix formfinalised • Training tobec ompleted byend Nov 2021 • Approach tomigration ofrisksfrom version12ofDatix moduletov ersion 14 ofthe module to be agreed and implemented in full for VCC and Corporate - WBS in plan to followby end November • Updatedtoris k Polic ypackage, including user guidesetc, to be refreshed through Trust Board November 2021	Recommend Training completed by end March 2022 in line with currentservice 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 completeby end June2022 Boardtrainingscheduledas partof Board Development June session.	New Risk Management Policy and CorporateLevelProcedureneededtobe completed before training could commence.DuringtheperiodthePolic y and Procedure have beenfinalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjctto Audit Committee's AssuranceinJ uly meeting. Level2andLevel3trainingcommenced following the EMB endorsement. Currently over 100stafftrained, over 7 sessions to date with the remainder bookedinorbeingc onfirmingforbook ing over reaminder of July. Level 1 training will thenfollowin August.		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	

Audit Action Plan



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

* Unless amore appropriate timescale is identified / agreed

Velindre UNHS Trust

Final External Audit Report - WAO - Structured Assessment 2019 /20					Assurance Rating: N/A			Date received at Audit Committee: 06 February 2020						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
2019-R3	Board Assurance and Risk Management The Trustshould complete the developmentofits BAF with pace, ensuring that it is appropriately underpinned by up-to-date risk managementarrangements. Specifically, the Trustshould; a) review theprinc iplerisks toac hievingstrategic priorities and ensure the necessaryassurances hav e been mapped and reflected in the new BAF; b) update the risk managementframework, ensuring clear expression ofris k appetiteandarrangements for escalating strategicandoperational risks; c) provide risk managementtraining to staff and Board members on the resulting changes to the ris k 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 Truston the 2nd December 2019.	Lauren Fear, Director of CorporateGovernance& Chiefof Staff	Lauren Fear, Director of Corporate Governance& Chiefof Staff	Extention to 30 June 2022 requested. Update May 2022: Extension Requested to 19 July 2022	Overdue	a and b complete, regarding finalising framework and completing a first version of the BAF- and c, regarding training for Board, execs and s taff.	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Div is ions . 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. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjctto Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.			Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.
	TrackingInternal andExternal auditrecommendations 2018 R4b Implement a mechanism for ensuring thatwhen Internal Audit and External Auditactions are completed, the responsible officer provides a briefsummary ofthe actions taken to the Audit Committee, along with a request to close the action.	High		Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	No progress (overdue) No progress has been made on this recommendation. Update May 2022: Extension Requested to 19 July 2022	Action Closed			As part ofits 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 atthe time of writing and will be reported to the 19 July 2022 Audit Committee.	1) E-mails are sentfrom the DoF seeking updates from responsible officers to actions. These e-mails setout the requirementto privde as summary ofthe actions taken to respond to the audit recommendation and request to close the action 2) Paper setting outproposed changes to Audit Ac tion Tracking proces and draft procedure for teh process are presented to the Audit Committee in July '22	n/a	n/a	

Audit Action Plan

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

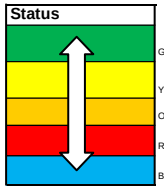
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

*** Unless a more appropriate timescale is identified / agreed**

Velindre UNHS Trust

Final Internal Audit 2019/2020 - Capital Systems: Financial Safeguarding					Assurance Rating: Reasonable			Date received at Audit Committee: 09 July 2020			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 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.	Carl James, Director of Strategic Transformation, Planning & Digital	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.** Update May 2022: Extension Requested to 19 July 2022	Action Closed	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. Extension Requested to 19 July 2022	Complete. The work in partnership with Gleeds has provided the a range of additional firms which has been used to update the approved contractors list to ensure VFM is tested. t is worth note that all tenders are presented to the open market to encourage competition as part of the procurement strategy. Further work will be undertake to develop this with a series of supplier days over the coming months to establish relationships with local SME's, to ensure the supplioer base is expanded further.

Audit Action Plan



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

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Velindre UNHS Trust

INTERNAL AUDIT - Governance Arrangements during COVID-19 Pandemic				Assurance Rating : N/A Advisory Audit				Date received at Audit Committee: 08 October 2020			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
11	**Information Governance** * The need to maintain privacy in the household when using video conference/telep ho ne 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/phishin g 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.	N/A		Matthew Bunce , Executive Director of Finance	Ian Bevan, Head of Information Governance	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.** **Extension requested to July 2022**	Action Closed	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.	IG policies and cover paper which gives overview of changes to Policies submitted to EMB Run for approval on 1st July 2022. Policies submitted are: • Data Protection and Confidentiality Policy • Records Management Policy • Confidentiality Breach Reporting Policy • Freedom of Information Act Policy All policies have been through a socialisation process within the Corporate area, WBS and VCC.

Audit Action Plan

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

* Unless a more appropriate time scale is identified / agreed

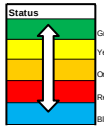
Velindre UNHS Trust

Final Internal Audit Report 2020/2021 - Velindre Cancer Centre Divisional Review | **Assurance Rating: Reasonable** | **Date received at Audit Committee: 22 March 2021**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
	Senior Management should ensure that all risks are managed in accordance with the Trust's risk mangement arrangements. Management should ensure that Datix training is provided for all appropriate staff.	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 liv e April 2021.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	July 2021 Extention to 30 June 2022 requested. Update May 2022: Extension Requested to 19 July 2022	Overdue	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	Recomm end Train ing comp leted by end Marc h 2022 in l ine w ith current servicepressures.	Datix form completed. Policy drafted and being finalised for with Div is ions . Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part o Board Development June session. Extension Requested to 19 July 2022	New Risk Management Polic y and Corporate Level Procedure needed to be completed before training could commence. During the period the Polic y and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjctto Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.			

TH IS IS AN ADVISORY AUD IT

Audit Action Plan



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Priority	
Low	< 3 months *
M edium	< 1 month *
High	Imme diate *

* Unles s a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Advisory Report					Advisory Audit			Date received at Audit Committee: 22 March 2021					
Ref	Recom m endatio n	Priority	Managem ent Response	Executive/Dir ect or Lead	Responsible Manager/Offic er Lead Depar tm ent wher e lead wor ks	Agr eed Im plem entatio n Date	Status	Update for October 2021 Committee	Update for Januar y 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Extension (Months)
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 equired to comply for areas such as: • BYOD; and • Change control.	N/A	Revised governance arrangements (including the establishment of a Digital Programme Board) will set out the approach for how all departments are equired 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.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	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. Extension Requested to 19 July 2022	Completed: appropriate documented procedures in place for management of ICT within Digital Service, managed in line with ITIL Service Management arrangements. Recommendation not related to overall goverance arrangments / new ways of working change programme not connected to this recommendatio n	n/a	
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.	N/A	A refreshed Digital Strategy to be approved by the Trust Board following a process of engagement and consultation with stakeholders.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 3 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022.	Digital Str at egy sc he dule d to be pr ese nte d for Tr ust B oa rd approval in May 2022. Extensi on R equ est ed to 19 July 2022	Action completed - Digital Strategy approved at May 2022 Trust Board.	n/a	
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.	N/A	A new pan Trust Digital Board will be established for the Trust to oversee and coordinate the digital strategy.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 3 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	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. Extension Requested to 19 July 2022	Complete: Digital Strategy approved in May 2022. Wider Trust governance arrangements under ongoing discussion. Consideration of need to establish Trust-wide Digital Board discussed with CEO as part of new organisational design (will be taken forward within Q5 / organisational design work)	n/a	
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.	N/A	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.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022.	Digital Str at egy sc he dule d to be pr ese nte d for Tr ust B oa rd approval in May 2022. Extensi on R equ est ed to 19 July 2022	Com plet ed - Digi tal Str ate gy app rov ed at May 2 02 2 Tr us t Board.	n/a	
13	SOPs should be developed that make clear the processes for AV software management and for web and email filtering.	N/A	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.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 2 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	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. Extension Requested to 19 July 2022	SOP drafted, awaiting final internal review / sign-off. Aim to complete before mid-July 2022 deadline. Request for extension until September 2022 to allow draft SOPs to go through required goverance process	**COMPLETED** Knowledge bases finalised, covering both AV and email/web filtering.	
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.	N/A	Baseline asset management audit to be completed Common asset management approach to be adopted VCC and WBS disposal procedures to be consolidated	Carl James, Director of Strategic Transformatio n, Planning & Digital	Deputy Chief Digital Officer	Quarter 1 2021/2022 Quarter 3 2021/2022 Quarter 1 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	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.	1) Baseline asset mgmt audit: Completed. 2) Well-established asset management approach within WBS - signficant amount of work involved, being managed alongside current operational workplan. Due for completion end of Q2 2022/23. On track for completion end of Q2 2223 (sept 2022) 3) VCC & WBS disposal procedures consolidated : Completed.	**COMPLETED** (1) and (3) completed as per July 2022 update. (2) Completed - all new assets now recorded on ServiceP oint (CMDB). Functional limitations mean alternative software solutions to ServiceP oint being explored nationally (part of All Wales Infrastructure Programme), which may result in change of approach in next 12-18months.	

TH IS IS AN ADVISORY AUD IT

Audit Action Plan

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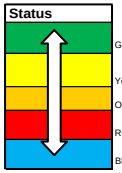
Priority	
Low	< 3 months *
M edium	< 1 month *
High	Imme diate *

* Unles s a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Advisory Report			Advisory Audit				Date received at Audit Committee: 22 March 2021					
Ref	Recom m endatio n	Priority	Managem ent Response	Executive/Dir ect or Lead	Responsible Manager/Offic er Lead Depar tm ent wher e lead wor ks	Agr eed Im plem entatio n Date	Status	Update for October 2021 Committee	Update for Januar y 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Extension (Months)
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.	N/A	Trust-wide patch management SOP to be developed.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 2 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	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. Extension Requested to 19 July 2022	Revelent SOPs in process of being updated - aim to complete internal review/sign-off by mid-July deadline.	**COMPLETED** PDQ in place to ensure consistent deployment of patches across VUNHST. Key policies updated and approved via QSP Committee in July 2022. Knowledge bases within the team to confirm technical procedure(s) to be followed by team members etc.	
17	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.	N/A	In progress Business Impact Assessment for Infrastructure complete Digital Services business continuity plans to be developed and fully tested	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2020/2021 Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	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. Extension Requested to 19 July 2022	Action completed - incident response plans approved via QSP Committee in May 2022.	n/a	
18	A formal Project Management SOP should be developed which sets out the requirements for managing projects, including how and when agile methoddologies may be used.	N/A	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.	Carl James, Director of Strategic Transformatio n, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022	Action Closed	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.	Completed Digital SOP developed as interim, whilst Trust wide approach considered. Process being established for accepting new projects outside of annual plan. New Service Request Form drafted and new internal digital governance structure agreed for the management and prioritisation of these requests, whilst ensuring to link with WBC SMT and VCC Velindre Futures.	n/a	

Audit Action Plan



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Medium	< 1 month *
High	Immediate *

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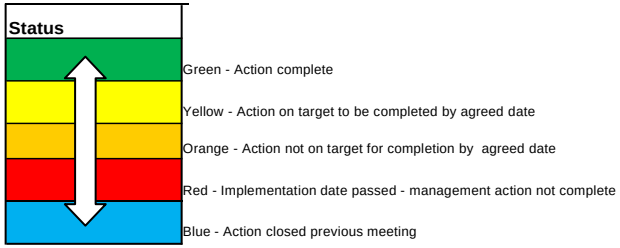
Velindre UNHS Trust

Final Internal Audit Report 2020/2021 New Velindre Cancer					Assurance Rating: Substantial			Date received at Audit Committee: 08 July 2021						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
2	Succession planning for vacant posts should be considered in readiness for the next stage of the project (O).	Low	Agreed. The Project reviews organisational structures for each phase of the EW and nVCC Projec t(s). If any post becomes vacant, the Projec t(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.	David Powell, Project Director	David Powell, Project Director	Ongoing	On Target	The project were subject to an Organisational Change Process which concluded on 6th August 2021. Existing project staff secured roles in the nextphases of both projects and vacant posts (structure was approved by the Trust Board on 19th April 2021)are being recruited into. Developmental opportunities have been / will contine to be identiied for existing project staff to ensure, staff development, continuity and succession planning are in place at all times	David Powell Update: We have continued the process of internal development/growing the talent within the team such that we can promote into vacancies should they arise during the project. Andrew Davies Update: This approach is still current. The nVCC Project is in the process of filling the remaining posts that were approved by Trust Board on 19th April 2021 and were outstanding post OCP. The project promotes develomental opportunities which has been successful in not only recruiting staff but also the retention of these staff members. This will continue	David Powell Update: The internal developmentprocess is on-going with all staff getting opportunities to get exposure to the Competitive Dialogue sessions in order to broaden understanding and knowledge.				

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

INTERNAL AUDIT - Core Financial Systems				Assurance Rating: Reasonable			Date received at Audit Committee: 21 January 2021			
Ref	Recommendati on	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee	Update July 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	~~Mark Osland, Executive Director of Finance~~ Matthew Bunce, Executive Director of Finance	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.** **Update May 2022: Extension Supported to Sep 2022**	Action Closed	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.	Extension Supported at May 2022 Audit Committee. New Budget Holders have received direct Financial support and training once in post. Financial Awareness session provided to INSPIRE cohorts of developing managers in May 2022. Refresher programme for existing budget holders provided as Business as Usual.

Audit Action Plan

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

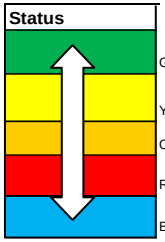
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Infection Prevention and Control Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendati on	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 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.	Nicola Williams, Director of Nursing, AHPs & Health Science	Muhammed Yaseen, Head of Infection Prevention & Control	March 2022 Update May 2022: Extension Requested to 19 July 2022	Action closed	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. Extension Requested to 19 July 2022	Revised IP C policy review and monito ring m echanism in place since April 2022

Audit Action Plan



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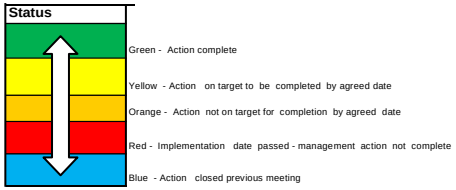
Velindre UNHS Trust

Digital Health & Care Record for Cancer (Canisc Replacement) 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendati on	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	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.	Cath O'Brien, Chief Operating Officer	Paul Wilkins, Interim Director of VCC	29/05/2022	Action Closed	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.	n/a - Complete May 2022
	b. Once formally approved changes to procedures and processes are documented and a revised business continuity plan should be prepared and distributed.	Low	b. The business continuity plans will be approved via the Senior Leadership Team	Cath O'Brien, Chief Operating Officer	Paul Wilkins, Interim Director of VCC	29/05/2022	Action Closed	The operational leads and Senior Leadership Team will approve the business continuity plans in line with any changes to ways of working.	5/7 disaster recovery plans have been approved within Directorates. The remaining 2 are being refreshed currently. Again, this will be an interative ongoing process.	**Complete.** Operational business continuity plans are in place which are being reviewed in light of 'go live' planning. These operational plans have been implemented on many occasions during previous issues with CANISC reliability. A 'go live' plan and associated risk assessment is under development working closely with the Digital Programme team and are being managed as part of the ongoing programme.

Audit Action Plan



Priority	
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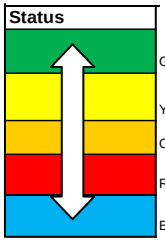
Velindre UNHS Trust

Waste Management - Reasonable Assurance 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
	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.	Carl James, Director of Strategic Transformation, Planning & Digital	Rhiannon Freshney, Environmental Development Officer	December 2021	Action Closed	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	n/a - Complete May 2021	n/a	n/a	
	1.1.b Associated Divis ion po licy / proced ural d ocume nts shoul d be update d to ens ure alig nment 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.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	December 2021 Update May 2022: Extension Requested to 19 July 2022	Action Closed	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. Extension Requested to 19 July 2022	COMPLETE - VCC proced ure aligned with Trust Policy COMPLETE - WBS. SOP reviewed and site practice alig ned with Trust Policy .	n/a	n/a	
	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.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins Assistant Director of Estates, Environment & Capital Development	January 2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	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. Extension Requested to 19 July 2022	Completed: Waste information is reported to The Cynefin Group in WBS and Operational Management Group in VCC. Central oversight is provided at the ISO14001 Management Group (along with any concerns/initiatives related to waste etc.). It is centrally reviewed against the Annual Net Zero Reporting tool to Welsh Government. Further opportunities may exist to enhance arrangements if the a Trust Sustainability Board is introduced as part of the refreshed organisational working arrangements.	n/a	n/a	
	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.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC	January 2022	Action Closed	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	n/a - Complete May 2021	n/a	n/a	

Audit Action Plan



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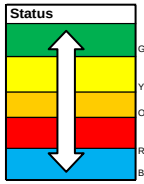
Velindre UNHS Trust

Waste Management - Reasonable Assurance 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
	Training (Operation). 3.1.a The targeted action plan for enviro nmenta l aware ness traini ng shoul d 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.	Carl James, Director of Strategic Transformation, Planning & Digital	Rhiannon Freshney, Environmental Development Officer	March 2022	Action Closed	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.	n/a - Complete May 2021	n/a	n/a	
	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.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	March 2022 Update May 2022: Extension Requested to 19 July 2022 **Extention requested to 17 October 2022**	Complete	VCC Operational Services have recenty re recenand Development tearecruited a new Training Supervisor, part of their role is to lease 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. Extension Requested to 19 July 2022	Complete: TNA completed VCC – Provision of training: the TNA identified the porters and domestic staff required clinical waste handling training. This is being delivered with compliance currently at 90% and on-track for 100% by the end of July 2022. Further clinical waste training is being piloted by Operational Services in August and following feedback will be rolled out across the division from September. 2022 WBS – Provision of training: the TNA identified porters required additional clinical waste training. This is being delivered and expected to achieve 100% compliance by end of July 2022. Laboratory staff are also receiving CPD, managed through Q Pulse, with 100% compliance expected by September 2022. Extension requested to October 17th review compliance against September 2022 100% training compliance.		98% of operational service staff dealing with clinical waste are now trained, the remaining are on long term sick or A/L. Training of all staff directly involved in waste segregation completed including Porters. Laboratory staff trained to relevant SOP / POL which includes a clinical waste section. Compliance up to date	

Audit Action Plan



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Priority	
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High	Immediate *

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Velindre UNHS Trust

Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasona ble			Date Received at Audit Committee: 14 October 2021					
Ref	Recommendation	Priority	Management Response	Executive/ Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
	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). D	Low	1.1a Recommendation agreed	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear Director of Corporate Governance, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Overdue	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. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
	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. •	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Rich ardso n, Head of Quality & Regul ati on WBS	October 2021 Extention to 30 June 2022 requested.	Complete	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	The training has been drafted and is due for approval by 24/06/2022 and delivery to managers by 10 July 2022.	Action completed. All documentation updates completed by July 17th with updated documents issued via Q-pulse with associated training records. Cutover from Datix v12/14 to Datix v14 commenced on July 22nd.	n/a	
		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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Tracey Langford VCC Quality & Safety Officer	October 2021 Update May 2022: Extention to 30 June 2022 requested. **Extension requested to August 2022.** **Extension requested to November 2022.**	Overdue	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.	Align ed Trust a nd VCC agreed and reflecte d in May Executiv e Management Board Risk paper	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. **Extension requested to August 2022.**	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. **Extension requested to November 2022.**	The SOP is currently being produced and will be finalised once the new Risk Management Policy has been approved by Trust Board and received by VCC Q+S team. The date has been changed to reflect the new timescales. Extension requested to November 2022 Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	2

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Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021					
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	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. D	Medium	2.1 a. Recommendation agreed	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Overdue	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. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subject to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over remainder of July. Level 1 training will then follow in August.		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
	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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Complete	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.	DATIX form complete. Policy drafted and with Executives for sign off. Training due for delivery to managers 10 July 2022.	Action completed. Training on new policy delivered to all managers by July 17th. Records of attendance are available for audit.	n/a	
		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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen VCC Quality & Safety Manager	October 2021 Update May 2022: Extention to 30 June 2022 requested. **Extension requested to August 2022.** **Extension requested to November 2022.**	Overdue	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. Extension Requested to 19 July 2022	VCC are waiting for Trust to confirm the training materials/guides. **Extension requested to August 2022.**	VCC are waiting for Trust to confirm the training materials/guides. **Extension requested to November 2022.**	VCC SLT due Level 2 training on 29th September 2022. Names being sought from SLT for senior colleagues that also require Level 2 training to arrange. All other staff will receive Level 1 trainig via e-learning which is not currently available. Extension requested to November 2022 for Level2 training to be completed. Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	2
	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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Overdue	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. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subject to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over remainder of July. Level 1 training will then follow in August.		Work has been undertaken that will combernate in a Workshop on the 13 October 2022. Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	

Audit Action Plan

Velindre UNHS Trust

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Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021					
Ref	Recommendation	Priority	Management Response	Executive/ Director Lead	Responsible Manager/ Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
		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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance& Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Action Closed	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. Extension Requested to 19 July 2022	**Complete.** The Policy is with EMB for approval and training is due to be delivered by 10 July 2022.	n/a	n/a	
		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	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance	Lauren Fear, Director of Corporate Governance& Chief of Staff / Paul Wilkins, Interim Director of VCC / Alan Prosser, Director of WBS	October 2021 Update May 2022: Extention to 30 June 2022 requested. **Requesting extention to September 2022.** **Requesting extention to November 2022.**	Overdue	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. Extension Requested to 19 July 2022	A Workshop with representative from both divisions and corporate services is planned for late July 2022. **Requesting extention to September 2022.**	VCC - A Workshop with representative from both divisions and corporate services is planned for late July 2022. **Requesting extention to November 2022.** WBS Update: The trust-wide process for managing risks has now been agreed and incorporated into revised SOPs at Welsh Blood. WBS team are supporting roll-out of training across both divisions and the corporate team to assure a consistent approach.	Work has been undertaken that will combernate in a Workshop on the 13 October 2022. Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	3
	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 tothe 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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	December 2021 Update May 2022: Extention to 30 June 2022 requested.	Overdue	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. Extension Requested to 19 July 2022	Whilst open risks are shared in OSG meetings, following the training on the new policy further consideration will be given to how these open risks are reveiewed in a consistent manor and this will be taken forward in line with 3.1a. This will be implemented following delivery of training week commencing 13 July 2022.	Training on the new VUNHST Risk policy has been completed and migration of risks to Datix v14 is now underway with completion of migration due by the end of September 2022. Dashboard development will take place in parallel with migration to support reporting into OSG meetings from October onwards. Anticipate this action being closed before the December Audit committee meeting.	Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
		Medium	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.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	All Directorate leads	Oct-21	Action Closed	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.	n/a - Complete January 2022	n/a - Complete January 2022	n/a	n/a	
		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	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen, VCC Quality & Safety Manager Sarah Owen, VCC Quality & Safety Manager	October 2021 **Recommended March 2022** **February 2022**	Action Closed	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.	n/a - Complete January 2022	n/a - Complete January 2022	m/a	n/a	

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 date passed - management action not complete

Blue - Action closed previous meeting

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

* Unless amore appropriate time scale is identified / agreed

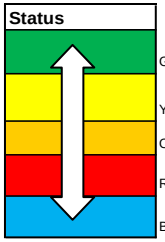
Velindre UNHS Trust

Divisional Review - Incident Management Final Internal Audit Report 2021/22 | **Assurance Rating: Reasonable** | **Date Received at Audit Committee: 14 October 2021**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
	IncidentReportingandInvestigationPolicy(Design). 1.1 a. As soon as theDatix O4W system is finalised,the Trus tshould: • review and update its Incident Reportingand InvestigationPolic y,incorporatingupdateddefinitions on incidents and the good practice identified in the WBS SABRE reporting flowc hart; • ensuretheupdatedPolic y is approvedby theBoard; and • ensurethediv is ions aremadeawareofthenewPolic y.	Low	1.1 a. Trust Incident Policy to be reviewed and approvedby theBoard.Rev isedPolic y tobetabledat EMB on 1stNovember2021. Thepolic y is toreflec tthenewOnc efor Wales system requirementsandtheWBS SABRE reporting flowchart. Both Divisional teams to supportthe policy developmentto ensure itmeets divisional requirements, including definitions alignedto legislation and regulatory requirements specific to WBS.	Cath O'Brien, Chief Operating Officer	Jennie Palmer Trust Quality & Safety Manager Quality leads at VCC & WBS - Sarah Owen (VCC) and Peter Richardson (WBS)	November 2021 **28 February 2022**	Action Closed	Policy to be completed by Februan 2022 for approval at EMB. Divisions unable to complete process flow charts and documents until policy approved. Scheduledfor completio ofthe Incident Managementpolicy has been changedto the 28th February 2022. Working to achieve this deadline.	Trust Incident Policy was approved atthe last Trust QSP Committee. Action can be closed.	n/a - Complete May 2022	n/a	n/a	
	1.1 b. Divisional managementshould • ensurelocalincidentmanagementSOPs areupdated to reflectheupdatedPolic y;and • ensureallrelev ants taffareawareoftheupdatedSOPs	Low	1.1 b. Divisional response: WBS: − RelatedincidentSOPs to bereviewedinlinewith new policy requirements. Revised SOPs to be issued. − Awareness/trainingtobeprov idedtoWBSs taffin relation to new SOPs and recorded as trainingevents in Q-Puls ein line with established processes.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS Peter Richardson, Head of Quality & Regulation WBS	April 2022 May 2022 **Extention requested to24th July2022.**	Complete	To be completed once the Trust IncidentMangementpolic yhasbeen reviewed and associated SOP's issued	Extension to May 2022 requeste	Further review ofincident managementof SOP's required following MHRA Audit. This will be completed by the 10th July 2022. Training will be completed by the 24th July 2022. **Extentio requested to 24th July 202**	The SOP has now been revisedandupdated.Thedraft SOP is undergoing final operational suitability checks beforeit is formally issued inQ pulse on September 5th. The Management Procedure has been reviewed anddid not requireanyfurtherupdates.	Complete. The SOP has now been issued and is in place.	
		Low	1.1 bVCC: Div is ionalQuality andSafety Managerwill writetheinc identmanagement SOP to reflectany changes to the Trust Incident Reporting andInvestigation Polic y.	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCCQuality andSafety Manager	November 2021	Action Closed	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.	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a	
		Medium	VCC: 2.1 a. The Divisional incidentmanagement SOP will reflectthe requirementofstaffto record incidents within the expected timeframe. Incidentmanagement SOP will be reviewed by SLT outofcommittee to ensure timeliness ofaction.	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCCQuality andSafety Offic e to fac ilitate	November 2021	Action Closed	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.	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a	
	2.1 c. We understand the Datix O4W system will have the functionality to reporton timeliness ofrecording in Datix. This should be incorporatedinto divisional reporting on incidents – see matter arising4 also.	Medium	WBS: 2.1 c. Timeliness ofincidentreporting will be introducedintoOperationalServ iceGroup,Regulatory Assurance and Governance Group, and Senior Management Team meetings. once reporting dashboards areavailable from Datix O4W (Expected Q3 2021/22)	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head ofQuality & Regulation WBS	January 2022	Action Closed	On track to be implemented Januar 2022		**Complete.** Timeliness of recording DATIX has been implemented and has been incorporated into SMT reports since January 2022.	n/a	n/a	
		Medium	VCC: 2.1 c. The Divisional incidentmanagement SOP will reflectthe required reporting and escalation	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality & Safty Manager (VCC), supported by the Tracey Langford, Quality & Safety Officer (VCC)	November 2021	Action Closed	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.	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a	
		Medium	VCC: 3.1a. The Divisional incidentmanagement SO will reflectthe need for all staff to record incident investigations in DATIX and the closure process.	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCCQuality andSafety Manager	November 2021	Action Closed	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.	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a	
	3.1 b. Divisional managementshouldmaintain a robust audittrail for incidentmanagementtraining delivered.Quality assurance ofinvestigations	Medium	VCC: 3.1b.All incidenttrainingrecordswillbemaintained and held by theVCC Quality and Safety Offic erand departmental managers. VCC to review WBS use of Q-Pulse to assess if transferrableto VCC.	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCCQuality andSafety Offic er Amanda Jenkins, WorkforceBusiness Partner / Lis a Miller, Head of Operational Services and Deliv ery	September 2021 October 2021	Action Closed	Training recordsare being maintained by Quality & Safety Offic er. **Complete.** Managers required to maintain training records for staffwithin their directorates. WOD exploring how these can be added to ESR which should be the repositoryfor such information. The use of QPULSE requires further exploration ona Trustwide basis.	**Complete January 2022** Complete Complete Managers reminded of responsibilities to maintain their s taff records.Theus eofQPULSE or alternative document respositorywill be explored during 2022/2023 butrequiresa full Trus wide review.	n/a Complete January 2022.	n/a	n/a	

Audit Action Plan

Velindre UNHS Trust



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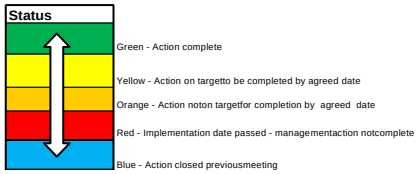
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Divisional Review - Incident Management Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
	3.1 c. Divisional managementshould:ensurethatthe qualityofincidentinvestigationsandcompliancewiththe Policy are incorporated into their auditplanson a cyclical basis; and • considerwhethera jointauditof investigations should beundertaken to support further identification ofinconsistencies, good practiceand/or training needs for incidentmanagementacross the Trus t.	Medium	3.1 c. WBS Quality team to engage with their VCC counterparts to agree a planfor reciprocal jointaudits focussing on the quality ofincidentinvestigations	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head ofQuality & Regulation WBS	March 2022	Action Closed	This action has been awaiting appointmentofnewQuality Manager at VCC. Initial introductions made and will be followed up during Janury 2022.		**Complete.** Across Divisional Audits will take place in Quarter 3.	n/a	n/a	
		Med ium	3.1. c. VCC: Formalise work to includeDivisional incidentac tiv ity tobe v is ibleontheClinic alAuditPlan.	Cath O'Brien, Chief Operating Officer	Sara Walters, VCCClinic alAudit Manager / Sarah Owen, VCCQuality andSafety Manager	December 2021	Action Closed	A meeting has been arranged with Quality & Safety Team and Clinical Audit Team for 07.01.2022 to instigate discussions.	A quality forum has been setup t include Quality & Safety, Service ImprovementandClinical Audit. A successful pilot forum has bee held for the Ambulatory and Assessment Units. This will be rolled outto the First Floor Ward. An evaluaton to nextsteps and resoruce requirements will be presnted to a future Quality and Safety Management Group.	n/a - Complete May 2022	n/a	n/a	
	Incident Reporting and Scrutiny (Design). 4.1 a. Divisional managementshouldensure that incidentreportingandscrutiny is undertakenregularly at divisional and directorate / OSG level. The approach should be consistentacrossthe Trust, where appropriate.	Medium	4.1 aWBS response:a.WBSQuality Assuranceteam to produce a standard KPItemplate based on the Laboratories OSGforInc identreportingtobeus edby all OperationalServiceGroup,RegulatoryAssurance and GovernanceGroup, and Senior Management Team reports. (also 4.1 c)	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head ofQuality & Regulation WBS	31 December 2021	Action Closed	Templatewill beintroducedfollowing approval atthe January 2022 Regulatory Assuranceand GovernanceGroup meeting		The template was introduced. **Proposal to close.** To note further enhancements are being made to the document following MHRA feedback.	n/a	n/a	
		Medium	4.1 a VCC response:a. Incident Reporting and InvestigatingPolic ywilloutlinethe requiredapproach to incidentreporting and scrutiny. This will bereflected inthe Div is ionalInc identManagementSOP	Cath O'Brien, Chief Operating Officer	Jennie Palmer, Trust Quality and Safety Managerand Sarah Owen, VCC Quality and Safety Manager	30 June 2022	Action Closed	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.	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a	
	4.1 b. Incidentreporting atall levels should include:• defined KPIs (including targets) for incident management,forex ample,timelines sofrecordingand investigationclosure,levelofopenincidents,recording ofinvestigations and learningin Datix, etc;• trend monitoring on the above KPIs and other metrics, for example,incidentsbytype,severityandlocation;•KPIs and narrative aroundlearning (see matter arising 5); and• the requirementto clearly identify ofareas of concern.	Med ium	WBS: 4.1 b. This template will take accountofthe KPI's identified in this auditand will incorporatethem in the template oncethereportingfunc tionality is inplac efor Datix O4W.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head ofQuality & Regulation WBS	31 December 2021	Action Closed	Delayed to February 2022, awaiting BI reporting tool for Datix OfW.		**Complete.** This work has beencompletedtos upportthe Trust PMF and includes a BI v is alis ation tool.	n/a	n/a	
		Medium	VCC: 4.1 b. Divisional Incident Management SOP will documentthes etKPI's for theDiv is ionands upporting learning narrative. These will be monitoredat Directorate meetings by DATIX leads. Any areasof concernescalatedtoQuality andSafety Management Group	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCCQuality andSafety Manager and Tracey Lanford, VCC Datix leads	30 June 2022	Action Closed	Div is ionalQuality &Safety Manager will documentthe setof KPIs within theinc identmanagementSOPwhen the 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.	**Complete.** Trust Incident Policy received in VCC on Friday 8th April 2022. SOP approved at SLT 30 June 2022.	n/a	n/a	
	4.1 c. Divisionaland directorate/OSGmeetingminuteshould clearly ev id en ce the scru tiny of incid en trepo rts.	Medium	VCC: 4.1c. DATIX leadswillprov ideinformationto directoratemeetings tofac ilitate scrutinyand escalation	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Datix leads	31-Oct-21	Action Closed	Datix incidents are being discussed atdepartmental level and the DirectorateLeadwilles calateas and when required.	**Complete January 2022 Audit Committee meeting.**	n/a Complete January 2022.	n/a	n/a	
		Medium	5.1 a VCC response:a. The Divisional incident management SOP will reflectthe need for all staff to record incidentinvestigationsin DATIX and the closure process	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCCQuality andSafety Manager	20 June 2022	Action Closed	Div is ionalQuality &Safety Manager will documenttheneed for all s taffto record incidentinvestigation within theinc identmanagementSOPwhen the 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.	**Complete.** Trust Incident Policy received in VCC on Friday 8th April 2022. SOP approved at SLT 30 June 2022.	n/a	n/a	
	5.1 b. ensure thatincidentreporting atall levels (see matter arising 4 also) includes:• KPIs around recording lessonslearnedinDatix ;and•therequirementtoc learly identifyconcerns intrends andlessons forwiders haring (the new reporttemplate for Infection Prevention and Control performance could be used to develop this requirement).	Medium	WBS: 5.1 b. The WBS Donor and Patient Clinical Governancegroupswillamendtheirmonthly incident reporttemplates to include details incidents where lessonslearnedhavenotbeenrecorded,andtoallow for review and challengewhereappropriate. This is dependentonthereportingfunc tionalitybeinginplac e forDatix O4W.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head ofQuality & Regulation WBS	January 2022	Action Closed	Delayed to February 2022, awaiting BI reporting tool for Datix OfW.		**Complete.** This work has beencompletedtos upportthe Trust PMF and includes a BI v is alis ation tool.	n/a	n/a	
		Medium	VCC: 5.1 b. Divisional Incident Management SOP will documentthes etKPI's for theDiv is ionands upporting learning narrative. These will be monitoredat Directorate meetings by DATIX leads. Any areasof concernescalatedtoQuality andSafety Management Group	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCCQuality andSafety Manager and Tracey Langford, VCC Datix leads	30 June 2022	Action Closed	Div is ionalQuality &Safety Manager will documentthe setof KPIs within theinc identmanagementSOPwhen the 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.	**Complete.** All Dashboard in place and being reviewed.	n/a	n/a	
	5.1.c. ensure consistency of approachacross the Trustto lessonslearn ed ,including th euseofth eAARd atab ase. Should th is ap pro ach be used , it shouldbe logged in Datix rath er than maintained as aseparate database.	Medium	VCC 5.1 c. Incident Reporting and Investigating Policywill reflectthe learning requirements from an incident investigation This will be included in departmentmeetingsand will inform VCC Quality and Safety Management Group. We will continue to work with O4W module once available. implementthe learning	Cath O'Brien, Chief Operating Officer	Trust Quality and Safety Manager Sarah Owen, VCCQuality andSafety Manager	March 2022 April 2022	Action Closed	The Quality & Safety Teamhave scheduled monthly meetingswith departments to discussincidents, themes and lessons learned, linking in with Service Improvementand Education & Development. A highlightreportwill be submitted to each VCC Quality & Safety Management Group meeting. **Complete.**	n/a Complete January 2022	n/a Complete January 2022	n/a	n/a	

Audit Action Plan



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

Velindre UNHS Trust

External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
Exhibit 1: 2021 Recommendations	**Transparency of Board business** R1 Some committee meeting papers are mis s ing from the website, as are link s to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign off and timely publication of: •Committee meeting papers; and •Dec ordings of Board meetings .		The Corporate Governance team have introduced a new end to end Board Committee tracker, to strengthen and tighten the process for effective management of Trust Board and Committee meetings and papers.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Complete	n/a	n/a	Complete on May 2022 Audit Committee Report		
Exhibit 1: 2021 Recommendations			A review of the website content has been completed and all missing content has been added	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Complete	n/a	n/a	Complete on May 2022 Audit Committee Report		
Exhibit 1: 2021 Recommendations			All of the Corporate Governance team are to be trained to upload papers direc tly on the Trust website to further increase resiliience.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	March 2022	Overdue	n/a	n/a		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Exhibit 1: 2021 Recommendations			An error led to the deletion of the June 2021 Board meeting recording. A governance note to explain the missing recording was added to the minutes of the July 2021 Board meeting. On the website, the links to the Board meeting recordings were updated to make clear the June 2021 recording isunavailable.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Complete	n/a	n/a	Complete on May 2022 Audit Committee Report		
Exhibit 1: 2021 Recommendations	**Articulation of strategic priorities** R2 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.		We recognise that there are differences in the granularity of the information provided by the service divisions, which in some cases is due to the different type of strategic priority, however, we acknowledge that there are improvements to be made including the identification of timelines and this will be included in the Integrated Medium Term Plan 2022-25.	Cath O'Brien, Chief Operating Officer	Cath O'Brien, Chief Operating Officer and Carl James, Director of Strategic Transformation Planning and Digital	March 2022	Complete	n/a	n/a		All of the objectives within the IMTP are SMART. The Trust strategy 'Destination 2032' and supporting strategies agreed in May 2022 will further enhance the solidification of strategic priorities supported by SMART objectives	

Audit Action Plan

Velindre UNHS Trust

Status

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

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

* Unless a more appropriate timescale is identified / agreed

External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
Exhibit 2: progress made on previous year recommendations	**Transparency of Board business 2018** R1 The Trust publishes agendas for public committee meetings in advance of meetings, but not the full set of papers. The Trust should publish all committee papers in advance of public meetings.		Superseded We have made a new recommendation that the Trust should ensure that it strengthens the process for the collation, sign off and publication of committee meeting papers in advance of meetings, and unconfirmed minutes added shortly after meetings. See 2021 Recommendation 1.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	N/A	Complete	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	
Exhibit 3: progress made on previous year recommendations	Closing capacity and capability gaps 2018 R8 The Trust should prioritise a review of support services in the two divisions to identify areas that could be integrated to reduce the duplication of effort, increase organisational learning and to inform plans to address capacity andcapability gaps.		Complete The Trust has aligned some business support functions where similar services are provided by separate teams within the two div is ions. The Trust told us that aligning support functions has enabled it to work more efficiently and ensure organisational learning across the div is ions .	Cath O'Brien, Chief Operating Officer	Cath O'Brien, Chief Operating Officer			n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	
Exhibit 4: progress made on previous year recommendations	**Monitoring delivery of strategic priorities 2019** R3 The Board should agree the information it requires to support its scrutiny of progress made to deliver all strategic priorities (and supporting actions) set out in the Integrated Medium Term Plan. Information should include as a minimum, progress to date and, where milestones are not met, resulting remedialactions.		Complete The Board has agreed the information need to scrutinise delivery of strategic priorities, and reviews progress on a quarterly basis.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	N/A	Complete	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	
Exhibit 5: progress made on previous year recommendations	Risk management 2016 R7c The Trust should standardise the format of its various risk registers, ensuring the good practice elements of each register are spread across the organisation.		In progress (overdue) The Trust is reviewing all operational risks. Risk registers will be migrated to a new version of DATIX. The Trust has developed a standardised approach to reporting and escalating risks Trus t-wide.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Overdue	N/A	N/A		Policy signed off - training to complete by December for all level 1. Level 3 and the majority of level 2 is complete.	

Audit Action Plan

Velindre UNHS Trust

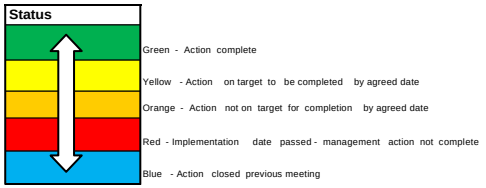
Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - management action not complete
	Blue - Action closed previous meeting

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

* Unless a more appropriate timescale is identified / agreed

External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Extension (Months)
Exhibit 5: progress made on previous year recommendations	Board assurance and risk management 2019 R2 The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up to date risk management arrangements. Specifically, the Trust should •Review the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; •Update the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and •Provide risk management training to staff and Board members on resulting changes to the risk management framework.		In progress (overdue) The Board Assurance Framework template and key strategic priorities are complete. Key controls and sources of assurance are being developed. The aim is for the Board Assurance Framework to be operationalised in September 2021. Work on the Risk Management Framework and Risk Appetite is complete. Work on operational risks and risk registers is ongoing, with the aim of completion by the September 2021 Board meeting. Risk management training for staff has been developed and due for roll out later in 2021.		Lauren Fear, Director of Corporate Governance and Chief of Staff		Overdue	N/A	N/A		Policy signed off - training to complete by December for all level 1. Level 3 and the majority of level 2 is complete.	
Exhibit 6: progress made on previous year recommendation	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.		No progress (overdue) No progress has been made on this recommendation.		Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		DoF led on improvements to format and process for action tracking with new Procedure completed	
Exhibit 7: progress m	Clinical audit scrutiny 2018 R5a The Quality and Safety Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	
Exhibit 7: progress made	Clinical audit scrutiny 2018 R5b Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	
Exhibit 7: prog	Clinical audit scrutiny The Quality and Safety Committee should assure itself that clinical audit findings are addressed.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	
Exhibit 7: progr	2018 R5d Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	

Audit Action Plan



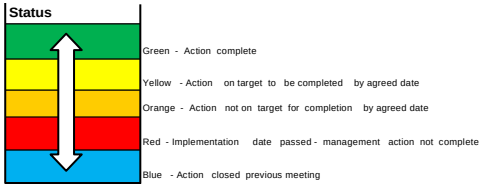
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Board Committee Effectiveness 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for May 2022 Committee	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter arising 1	**Matter arising 1: Cycles of Business and Committee Agendas (Design)** The Trust should: 1.1 a. link the committee cycles of business and agendas to its objectives and risks through: i. cross-referencing with the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) – this should also help to ensure a more streamlined agenda for the QSPC and greater clarity in the Committee's role; ii. consideration of the TAF and TRR during agenda setting, alongside identification of any significant matters arising at the time (for example, the recent issues noted in Radiotherapy); iii. ensuring the running order of, and allocated timing for committee agendas reflects the importance of individual items, potentially with significant matters scheduled earlier in the meeting;	Medium	1.1 a. The TAF/TRR will be cross-referenced with the cycles of business and agendas and will be used during agenda setting. Running orders will reflect the importance of items scheduled for discussion.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work on 2022-23 nearing completion across Committee strcuture - & mapping against the TAF to be incorporated into Governance manual for Agenda setting stage of Committee management cycle. Updated documents to be finalised in line with refreshed paper template and goivernance manual documentation - by July 2022.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise and hard-wire in this improved way of working.		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 1	1.1 b, include relevant committee sections of the TAF dashboard and TRR at the beginning of all meetings and demonstrate (for example, via the cover report) where key risks are addressed during the meeting;	Medium	1.1 b. Relevant sections of the TAF/TRR will be included at the beginning of all Committee meetings.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Mapping to Committee strcuture outlined in this paper. Work as outlined to be finalised, including for Charitable Funds Committee.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise and hard-wire in this improved way of		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 1	1.1 c. we concur with including the committee cycle of business at the beginning of all meetings and further recommend this be accompanied by a cover report identifying and providing explanations for any departures from the cycle of business;	Medium	1.1 c. A log to capture any deviations from Committee Cycles of Business will be established as part of standard practice across all Board / Committees and matters arising / action logs will track progress	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 1	1.1 d. allow committee members to bring forward items relating to important issues at the beginning of each committee meeting, similarly to when members are asked if they want to move items from the consent agenda to the main agenda; and	Medium	1.1 d. Committee members may bring forward agenda items for earlier discussion if required.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 1	1.1 e. consider calling for and, where appropriate, answering Independent Members' questions in advance of committee meetings to enable more efficient use of time during the meetings (an approach that has proven successful at other NHS Wales organisations);	Medium	1.1 e. We will consider using a 'questions in advance' approach for committee papers.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Board Committee Effectiveness 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for May 2022 Committee	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter arising 1	1.1 f. ensure effective use of the Board and committee action logs to capture and present items not on cycles of business at the appropriate meeting and hold individuals to account for providing requested reports; and	Medium	1.1 f. As per above captured under point 1.1 (c)	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 1	1.1 g. consider whether the NWIS transfer provides opportunity for the Audit Committee to support the cycles of business of other committees.	Medium	1.1 g. Consideration will be given to whether the NWIS transfer has provided opportunity for the Audit Committee to support the cycles of business of other committees.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Cycle of Business for Audit Committee to be brought back to July Audit Committee.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 3	**Matter arising 3: Committee Reporting (Design)** 3.1 The Trust should develop a quality assurance mechanism for committee reports, including: a. communicating with report writers for each committee meeting to make them aware of the audience, the purpose of the required reports and the level of detail that will be required; and	Low	3.1 a. Report authors will be informed of the purpose of committee reports and the level of detail required.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise and hard-wire in this improved way of		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 3	3.1 b. reviewing reports in advance of issue to Independent Members to verify that they address the report purpose, include a succinct executive summary identifying key matters for escalation and assurance and contain an appropriate level of detail.	Low	3.1 b. A mechanism to review reports in advance of issue will be developed to ensure the points in recommendation 3.1 (b).	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 4	**Matter arising 4: Gaps or Duplication in Reporting (Design)** 4.1 The Trust should: a. review and clearly define the RDISC reporting lines to minimise the risk of gaps or duplication in reporting; and	Low	4.1 a. The RDISC reporting lines will be reviewed and defined to minimise the risk of gaps or duplication.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise and hard-wire in this improved way of		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 4	4.1 b. provide clarity on the purpose for reporting where a subject matter is reported to more than one committee, ensuring reports are tailored according to the audience and purpose.	Low	4.1 b. Clarity will be provided on the purpose for reporting where a subject matter is reported to more than one committee.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 5	**Matter arising 5: Timeliness of Committee Paper Availability (Operation)** 5.1 The Trust should: a. remind staff reporting into the committees of the importance of timely submission of their reports; and	Low	5.1 a. Staff will be reminded of the importance of timely submission of committee reports.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 5	5.1 b. monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	Low	5.2 b. The Corporate Governance team will monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise and hard-wire in this improved way of		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	
Matter arising 6	**Matter arising 6: Record of meetings (Operation)** 6.1 The Trust should accurately record those present at committee meetings in the minutes, including the status in which individuals attend.	Low	6.1 Management will ensure committee minutes accurately record those present at meetings, including the status of individuals in attendance.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022	Not on Target	Work underway to ensure consistent format across Committees - will be included in refreshed governance manual documentation by July 2022. IM and wider Board input into this final review process to help support consistent implementation by Committee Chairs.	Work to finalise refreshed processes and templates delayed, some discussion in 28th June session however further Board Development slot to be confirmed to finalise. Work to implement continues however the completion of the refreshed processes and templates will clearly formalise		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	

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 date passed - management action not complete

Blue - Action closed previous meeting

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Trust Assurance Framework 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for May 2022 Committee	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter arising 2	**Matter arising 2: Operational ri sk reporting (TRR) (Operation)** 2.1 The Trust should: a. ens ure the rev iew an d refi ne me nt of the risk s on the T RR is c omp let ed as pl an ne d by the end of March 2021; and	Medium	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	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022	Action Closed	Complete	n/a - Complete May 2022	n/a		
Matter arising 2	2.1 b. update the Risk Management Framework process documentation to provide a monthly timetable of actions for departments/divisio ns/pr oj ects to adhere to when updating and reporting risk, and that a definitive list of which departments, divisions and particularly projects are required to review their Datix risk records and report to the Corporate Governance Team monthly.	Medium	2.1 b. To complete	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022	Not on Target	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.	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.		Policy signed off - training to complete by december for all level 1. Level 3 and the mojority of level 2 is complete.	

Audit Action Plan

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

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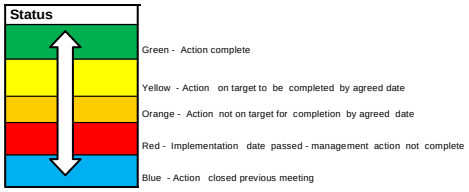
Velindre UNHS Trust

nVCC MIM Governance 2021/22					Assurance Rating: Substantial			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter Arising 1	**Matter Arising 1: Effectiveness of Governance Arrangements (Operation)** 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	1.1 Noted. The Project will endeavour to ensure that matters for decision making are taken through the appropriate forum and documented for audit purposes.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials) in conjunction with the responsible reporting officer and Communications team.	Immediately	On Target				
Matter Arising 1	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	1.2 Noted. The Project will ensure that all reports for endorsement / approval are full, complete and appropriately referenced.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials) in conjunction with the responsible reporting officer.	Immediately	On Target				

Audit Action Plan



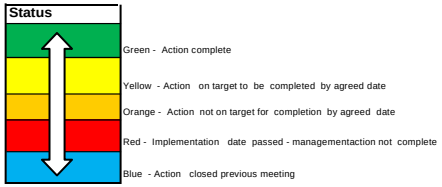
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

nVCC Contract Management 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter Arising 1	**Matter Arising 1: Contract Documentation (Operation)** 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	1.1 Noted. The Project will improve the management of the contractor appointment process by implementing a quality assurance process that signs off contract documentation.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Immediately	On Target				
Matter Arising 1	1.2 Contract documentation should be signed in a timely manner and prior to the commencement of works.	Medium	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.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Immediately	On Target				
Matter Arising 2	**Matter Arising 2: Appointment Process (Operation)** 2.1 The procurement exercises, which have been ongoing since April 2021, should be finalised as soon as possible.	Medium	2.1 The Project has now concluded all appointments of TA's for the nVCC Project; and appointed Technical Project Manager and Cost Consultants.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Actioned since fieldwork	On Target				
Matter Arising 3	**Matter Arising 3: Contractor Performance and Key Performance Indicators (Operation)** 3.1 Reporting on contractor performance and Key Performance Indicators should be undertaken in line with expectation.	Medium	3.1 Noted. The Project will ensure that balanced scorecards for appropriate contractors will be reported to the Project Board on a quarterly basis.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Immediately	On Target				

Audit Action Plan



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

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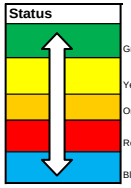
Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter arising 1	**Matter arising 1: Late payment of invoices (Operation)** 1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary;	Medium	1.1 a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Matthew Bunce, Executive Director of Finance	N/A	Complete	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	
Matter arising 1	1.1 The Trust should: b. liaise with NWSSP Procurement Services and Accounts Payable to understand: i. why such late fees are being charged by BT; and why they have signed agreements that they cannot deliver on; ii. how late fees are accounted for (i.e., are they coded to an appropriate loss account in Oracle); and iii. what the wider performance monitoring and accountability mechanisms are to ensure invoices are paid by their due dates (when this is less than 30 days) and to monitor the level of late payment fees	Medium	b. The recommendation is accepted. Will liaise with NWSSP Accounts Payable to review and understand as per the recommendations and implement as necessary. 31/07/2022	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/07/2022	Overdue	In process. The telephone lines are currently under review with an option to migrate service onto the SIP circuit.	This is currently still in process with additional work required to migrate service which will remove any potential charges from BT, and expectation that overall costs of the service will be reduced. The initial implication date did not consider a complete review of the service which explains the reason for the delay in implementation.	Work still ongoing with Digital colleagues. Implementation requires additional work not initially anticipated. Extenstion requested until end of December.	5 months
Matter arising 2	Matter arising 2: Exception reporting (Operation) 2.1 The Finance team should: a. undertake a formal, documented monthly review of the exception reports, even if no specific matters are identified through the informal weekly reviews;	Medium	2.1 a. The recommendation is accepted. The Divisions will undertake a more formal review which will be signed off by a senior finance business partner. The review will be put in place by the target date.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	**Complete** - The Divisional Finance Teams operate a monthly review of reports, the formal sign off has been established from Q1 2022.	n/a	n/a	
Matter arising 2	2.1 The Finance team should: b. take action to address the aged items on the exception reports; and	Medium	2.1 b. The recommendation is accepted. Discussion will take place amongst the Senior Finance Team to agree action to be taken on aged invoices to address the immediate issue and long-term approach which will form part of the review process under item 2.1.a	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	**Complete -** SFT has requested a T&F Group to review causation of aged items and establish an action plan for improvement. T&F Group met in May and June 2022, with feedback to be discussed at July Financial Management Meeting	n/a	n/a	
Matter arising 2	2.1 The Finance team should: c. formally monitor progress in clearing aged items at an appropriate forum to ensure action is effectively implemented	Medium	c. The recommendation is accepted. This will be added to the standard agenda of the Financial management meeting under PSPP.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	**Complete -** PSPP is a standard agenda item, on the Financial Management Meeting, supported by the T&F Group for improvements	n/a	n/a	
Matter arising 3	Matter arising 3: Authorisation of proforma invoices (Operation) 3.1 The Trust should: a. remind its authorised signatories only to approve proforma invoices for payment under appropriate circumstances; and	Low	3.1 a. The recommendation is accepted. A reminder will be issued to all staff.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	28/02/2022	Action Closed	A Financial Guidance note in this respect has been developed and was shared with all Trust staff via the Trust newsletter issued on 22/06/2022. It is therefore requested that these actions are **COMPLETED**. To support this work, in addition, Finance Business Partners will highlight this to budget holders via emails / meetings as appropriate.	n/a	n/a	
Matter arising 3	3.1 b. consider producing documented guidance on authorisation of proforma invoices.	Low	b. The recommendation is accepted. Consideration will be given to producing documented guidance on authorisation of proforma invoices.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Action Closed		n/a	n/a	

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter arising 3	3.2 The Finance team should investigate the specific circumstances of the exception noted in our testing (details have Low been provided) to understand: a. whether a duplicate payment has been made;	Low	3.2 a. The recommendation is accepted. The item has been investigated and no duplicate payment made.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	
Matter arising 3	3.2 b. whether the goods were received; and	Low	b. The recommendation is accepted. The item has been investigated and goods received.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	
Matter arising 3	3.2 c. why the proforma was authorised for payment, liaising with NWSSP Accounts Payable if necessary.	Low	c. The recommendation is accepted. NWSSP has advised that this specific supplier operates a cash account requiring payment against estimate before items are released. Practice is not local to the Trust and NWSSP would be required to undertake any further actions in particular ensuring the process for this supplier (and any other suppliers operating cash accounts requiring payment against estimate) is incorporated into any existing documented guidance in place or developed for proforma invoices.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	
Matter arising 4	Matter arising 4: Compliance with Fixed Assets FCP (Operating effectiveness) 4.1 The Finance team should remind the divisions of the requirement to complete, approve and submit asset disposal forms prior to asset disposal, not least to ensure value for money is obtained from assets' residual values.	Medium	4.1 The recommendation is accepted. Reminders will be provided at the Capital Planning Group and Divisional Business Planning Group meetings.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed	**Complete -** This was discussed at the Capital planning group. Capital team are also now emailing out to the Divisional capital leads as part of month end closedown querying if there are any disposals within month.	n/a	n/a	
Matter arising 4	4.2 a. The Trust should update its Fixed Assets FCP to: − reflect actual practice regarding maintenance of the FAR, capital ledgers and AUC and the related reconciliations to the general ledger; and − incorporate the asset verification coverage target of 80%.	Medium	4.2 a. The recommendation is accepted and the FCP will be updated.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed	**Complete -** FCP has been updated per recommendation and is currently going through due process for final approval by audit committee.	n/a	n/a	
Matter arising 4	4.2 b. The Audit Committee should approve the updated FCP.	Medium	4.2 b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee. .	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	31/05/2022	Overdue	The FCP is currently going through the due process for final approval by audit committee.	FCP has be en circ ulate d to Ca pital P lan nin g group an d will go to next audit committee in October for final approval.	Following feedback work is ongoing to fully review and update the Captial FCP to fully align with other Capital Procedures, manual of accounts and Trust SO SFIs. Will now require approval at next Audit committee which is not until December following EMB approval.	7 months

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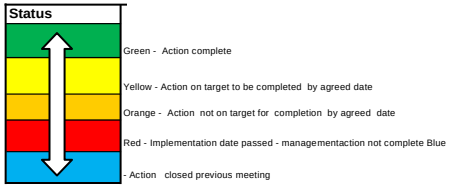

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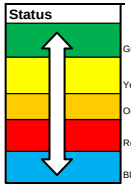
Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Previous Matter arising 1	Previous Matter arising 1: Pursuance of Private Patient (PP) debts (Operating effectiveness) 1.1 a. We concur with the actions taken by the Trust to address the aged Private Patient debt balance. The Trust should maintain its focus on this area through formal continuous monitoring, including reporting to Audit Committee until an acceptable position is reached.	Medium	1.1 a. The recommendation is accepted. A detailed aged debt position has been documented, with monitoring arrangements in place including the status of each debt line and the outcome of actions taken to-date. A standard report will be developed for continuous monitoring by the VCC SMT and EMB and reported to the Audit Committee detailing the position and progress made until the Audit Committee agree they have assurance that private patient debt management is acceptable.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	31/05/2022	Complete	20.06.22 A report template has been submitted and approved by the Audit Committee to support on-going monitoring arrangements of the Private Patient Debt position. The report is submitted to the VCC SLT via the Operational Delivery Directorate Highlight Report.	16.08.22 An Aged Debt Report template has been approved by the Audit Committee. This Report is submitted to the VCC Private Patient Management Group, VCC Senior Leadership Team and the Trust Audit Committee. Good progress has been made and acknowledged. Regular reporting and monitoring to continue.	15.09.22 Standard Report, which includes agreed KPIs has been developed to monitor the aged debt position. This Report is included as part of the regular reporting cycle to the Private Patient Management Group, VCC Senior Leadership Team and Audit Committee. Standard Operating Procedures are in place and significant aged debt reduction has been achieved. Healthcode, electronic billing/incoiving solution (Insurance Companies) introduced 15.09.22. The timeline for payment of	
Previous Matter arising 1	1.1 b. To support reporting on Private Patient aged debt, the Trust should consider identifying formal key performance indicators with clear targets, for example: • split of debt between self-payers and insured; • percentage of aged amounts vs total debt; • percentage of debt recovered vs total debt (with a similar sub-metric for aged debts); • maximum accepted level for Private Patient aged debts (by percentage and / or value) and monitoring performance against this at an appropriate forum to ensure accountability.	Medium	b. The recommendation is accepted. Key performance indicators are being collated from a patient and financial perspective and the measures identified within this recommendation will be considered and presented to VCC SMT and then EMB for formal approval / sign off.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	30/04/2022	Complete	20.06.22 The Audit Committee are asked to agree an extension of the delivery date to the 31st August 2022. A report template has been developed which details the debt position against private patient classifications, the movement between each month and the position against key performance indicators. The report will be presented to the VCC SLT	16.08.22 Aged debt key performance indicators have been drafted and approved by the Trust Audit Committee. These indicators are included within the Aged Debt Report submitted and monitored by the VCC Private Patient Management Group, VCC Senior Leadership Team and the Trust Audit Committee.	n/a	
Previous Matter arising 2	Previous matter arising 2: Unallocated and Unidentified Receipts (Operating effectiveness) 2.1 a. The Trust should: i. discuss the aged unallocated/unidentified receipts position with Counter Fraud, Audit Wales and Welsh Government to understand their view on how this balance should be addressed; and ii. based on the above discussions, take appropriate action to address the aged unallocated/unidentified receipts balance.	Medium	2.1 a. The recommendation is accepted. Discussions will take place with relevant parties and appropriate action taken. Due to the upcoming year end, it is likely that Audit Wales and Welsh Government will wish to prioritise discussions on that, and the target date is therefore reflective of that.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	30/06/2022 **Extension requested to 30/09/2022** **Extension requested to 30/11/2022.**	On Target	Counter Fraud have advised that they would not get involved with this as there is no false representation, no failure to disclose information, no abuse of position, and no financial gain to individuals. A view from Audit Wales has been sought and is awaited. Welsh Government will then be asked for their view. **An extension to 30/09/2022 is requested to enable conversations to take place and conclude, and then agreed action taken.**	Audit Wales have confirmed that if all reasonable efforts have been exhausted, they can't foresee any issues in the values being written back, as long as records are held in case of future queries. Welsh Government have confirmed that they are content to agree with the advice of both Counter Fraud and Audit Wales.	Work is now underway to review the appropriate action needed to clear the aged receipts. **Extension requested to 30/11/2022.**	2 months
Previous Matter arising 2	2.1 b. We concur with the Finance team's intention to increase the frequency of its Long Term Agreement reconciliation. We recommend that the Finance team should undertake this review at monthly to support and ensure aged unallocated and unidentified receipts balances are reduced to a minimum level, ensuring the review is documented, and evidenced.	Medium	b. The recommendation is accepted. Monthly reconciliations of LTA money due and received are now standard practice.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report Action Taken: Monthly reconciliations of LTA money due and received are now standard practice	n/a	n/a	
Previous Matter arising 2	c. The Trust should ensure the SOP for Private Patients unallocated and unidentified receipts is approved at an appropriate forum (e.g., by the Audit Committee).	Medium	c. The recommendation is accepted. A Departmental SOP has been drafted for the management of unallocated and unidentified receipts, with significant work undertaken to date resulting in a reduction in the reported aged debt position. The SOP will be submitted for approval to the Audit Committee.	Cath O'Brien, Chief Operating Officer	Ann-Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Service	30/04/2022	Complete	15.06.22 SOP drafted in readiness for submission to the Private Patient Operational Management Group, scheduled for 06.07.22.	16.08.22 SOP submitted to the VCC Private Patient Management Group for comment on 06.07.22 and formally approved by the Group on 03.08.22.	n/a	
Previous Matter arising 3	Previous matter arising 3: Management of Aged Debts (Operating effectiveness) 3.1 We concur with the Trust's continued focus on general and charity aged debts. We further recommend: a. Charity debts: the Trust should formally review its processes for charity invoicing and debt collection, both internally between finance and the divisions and through discussions with relevant charities (particularly Macmillan and Marie Curie) to identify inefficiencies within the process:	Low	3.1 a. The recommendation is accepted. Increased frequency of liaison and enhanced formal processes will be put in place both internally and with partners	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/03/2022	Action Closed	This action is **COMPLETE**. In parrallel with systems audit, historic aged debt balances were cleansed, with periodic reconciliations established with cash receipted, volume of aged debt significantly reduced. Regular meetings with Divisional Leads to ensure Charity submissions are completed on time and bi-annual meeting with Charity.	n/a	n/a	

Audit Action Plan

Velindre UNHS Trust



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - managementaction not complete

Blue - Action closed previous meeting

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

* Unless a more appropriate timescale is identified / agreed

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Previous Matter arising 3	3.1. b. General debts: the Trust should consider identifying and monitoring formal key performance indicators with clear targets for general debts, similar to those set out in recommendation 1.1(b) of prior year recommendation 1.	Low	b. The recommendation is accepted. Consideration will be given to identifying and monitoring formal key performance indicators with clear targets for general debts.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022 Complete but request to keep action open until **October 2022 meeting** to allow review	Overdue	Consideration has been given to identifying and monitoring formal KPIs with clear targets for general debts. It has been agreed that from July 2022 onwards the Senior Finance team will receive a monthly update detailing outstanding balances, in month collection and performance metrics to inform ongoing actions needed to reduce and / or maintain the aged debts at an appropriate level. The action as written has therefore been completed, but to ensure the work taken supports effective debt management, it is suggested that the action is kept open until t**he October 2022 Committee meeting** to allow review and update of the metrics as appropriate.	Reports being sent to SFT as per action.	Reports being sent to SFT as per action. Discussions taking place as required. Request that the action is closed.	

Audit Action Plan

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

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Velindre UNHS Trust

Scrutiny of Expenditure >£100k 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (months)
Matther arising 1	Matter arising 1: Proposals Documentation (Design and Operation) 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;	Medium	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.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022 Complete	Action Closed	**Complete.** The guidance has been enhanced further to request the inclusion of a do nothing option and 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. It should be noted that this will be enacted for all new proposals received and will not be expected to be captured for those proposals already submitted for approval through the various governance stagegates.	n/a	n/a	
Matther arising 1	1.1 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	1.1b 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.	Matthew Bunce, Executive Director of Finance		Complete	Action Closed	**Complete.** Ref. Management Response included with submission of Final Report, column D for further details.	n/a	n/a	
Matther arising 1	1.2 Furthermore, we su ggest th at all prop osal doc umentati on shoul d inc lud e deta ils of future m onit orin g to be c ompl eted at a divisional level.	Low	1.2 The guidance will be enhanced to require details of any planned future monitoring arrangements proportionate to the scheme proposal.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	**Complete.** The guidance has been enhanced to request where applicable / proportionate to the scheme any planned divisional monitoring arrangements are included. It has been highlighted by the divisions that for a large number of schemes this will not be appropriate / proportionate given the nature of some captial schemes.	n/a	n/a	
Matther arising 1	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	1.3 Management will consider the development of register of proposals to support future monitoring of expenditure.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	**Complete.** A register has been developed to track all Trust Board Approval Submissions from July 2022 onwards.	n/a	n/a	

Audit Action Plan

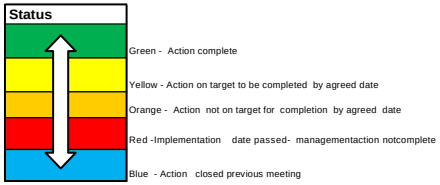
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Scrutiny of Expenditure >£100k 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (months)
Matther arising 2	Matter arising 2: Pre-Board Scrutiny Evidence (Design) 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;	Medium	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.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	**Complete.** Engagement with key service leads has been undertaken to emphasise the requirements to ensure that all sections of the proposal prior to the submission to EMB and Trust Board are fully detailed as required. This process has been augmented and 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.	n/a	n/a	
Matther arising 2	2.1 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;	Medium	2.1 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.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	**Complete.** The guidance has been 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.	n/a	n/a	
Matther arising 2	2.1 c. meeting minutes (or equivalent) should clearly demonstrate that scrutiny and discussions were undertaken over each proposal;	Medium	2.1 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.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	**Complete.** Guidance / information has been discussed with 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 was already in place for corporate services prior to audit.	n/a	n/a	
Matther arising 2	2.1 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	2.1 d. The guidance will be enhanced to include reference to the agreed out of committee approval process / arrangements in place.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Not on Target	This has been progressed via discussion with the relevant leads and is anticiapted to be fully completed by September 2022			

Audit Action Plan



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

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Velindre UNHS Trust

DBS Check 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			Extension (months)
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	
Matther arising 1	Matter arising 1: Job Descriptions (JDs) (Design) 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	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.	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Oct-22	On Target	First Task and Finish group met on 21st June. Terms of reference agreed. Action on course		All Wales Job Description development group has commenced to re-design the current JD requirements including the elements of DBS. Managers guide for understanding DBS requirments of job roles completed, in current Trust governance process.	
Matther arising 1		Medium	1.1 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.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager (Job Evaluation Lead)	Jun-22	Action Closed	**Complete.** A standard operating procedure has been written to add the DBS quality check to the Job Evaluation process.	n/a	n/a	
Matther arising 2	Matter arising 2: Trust Recruitment and DBS Policy / Procedure (Design) 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	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	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce / Tina Jenkins, Senior Nurse Safeguarding & Public Protection	Sep-22	On Target	Draft policy in development and on course to be completed by September to allow for engagement - DBS procedure in place in the interim		The draft DBS procedure is currently with Trade Union colleagues for comment as all documents are developed in Partnership. Comments requested back by 7th October. Two responses received so far. Once this has been collated and amendments made this will be progressed to SLT/SMT for comment and then to	
Matther arising 2		Medium	2.1 a. (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	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Apr-23	Action Closed	**Complete.** Task and Finish grou p establis hed and terms of referenc e agreed	n/a	n/a	
Matther arising 2	2.1 b. ensure the policy / procedure is communicated to all relevant staff and is made available on the intranet; and	Medium	2.1 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.	Sarah Morley, Director of OD and Workforce	Victoria Davies Project Manager – Workforce Planning	Jul 22 **Extension Requested September 2022**	Overdue	Request to Extend to September given policy will be completed in September. Engagement on policy ongoing - Policy to be completed by September. Clear procedure in place in interim		Attraction, Recruitment and Retention intranet page completed, section on DBS ready to go and managers guides and SOP's ready to be uploaded once approved	
Matther arising 2	2.1 c. put in place a mechanism to monitor compliance with the Trust's new policy.	Medium	2.1 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.	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Jul 22 **Extension Requested September 2022**	Overdue	Request to extend deadline to September. In progress to be completed by September in line with the policy completion - clear procedure in place in interim		Attraction, Recruitment and Retention intranet page completed, section on DBS ready to go and managers guides and SOP's ready to be uploaded once approved	

Audit Action Plan

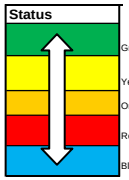
Velindre UNHS Trust

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

* Unless a more appropriate timescale is identified / agreed

DBS Check 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			Extension (months)
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	
Matther arising 3	Matter arising 3: Out of Date Countersignatory (Operating effectiveness) 3.1 The Trust should update its DBS countersignatories and ensure this remains up to date in the future.	Low	3.1 Action: The Trust will contact DBS to update countersignatories for the Trust.	Sarah Morley, Director of OD and Workforce	Sarah Morley, Director of OD and Workforce	May-22	Action Closed	**Completed.** DBS has beem contacted to update countersignatories for the Trust	n/a	n/a	
Matther arising 4	Matter arising 4: Backlog in NWSSP Completion of Personnel Files (Operating effectiveness) 4.1 The Trust should: a. monitor NWSSP's resolution of the backlog to ensure this is undertaken on a timely basis; and	Low	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.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager (with support from NWSSP Recruitment Services)	Sep-22	Complete	In progress and on course for completion		Completed The personal files have now been sent to managers and the People and Relationship Team for filing.	
Matther arising 4	4.1 b. formally document the process carried out by the Workforce team to check that appropriate pre-employment checks are completed by NWSSP.	Low	b. Action: A standard operating procedure will be written for monthly checks of new starter files undertaken within the workforce team.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager	Jun-22	Action Closed	**Complete.** Delay in completing as awaiting on files from NWSSP, to be completed by July	n/a	n/a	

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022			Extension (months)
Ref	Recommendat i on	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	
Matter arising 1	Matter arising 1: Charitable Funds Policies (Design) 1.1 Management should ensure that all out of date policies are reviewed, updated, approved and made available on the Trust's intranet site as soon as possible.	Low	1.1 Accepted - Due to Covid and capacity issues within the finance team the policy/ procedures were not reviewed las t financial year, however the policies and procedures are still relevant so per the recommendation is low priority but recognise that they need to go through the formal process for re-approval.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Jul-22	Overdue	All policies have been reviewed and are currently going through the due process for final sign off at the Charitable funds Committee in September. Polic ies as they stand are still relevant with minor changes / updates.	Reviewed polices are going to the Charity SLG on18th August for initial review, with formal sign off still on course for September CFC.	Two of the three policies were formally approved at the September Charitable funds Committee. Following the review process it was requested that the third policy 'Scheme of Delegation and stages for the purchasing and authorising of goods and services' should have further consideration on whether the delegation levels for authorising expenditure is still	5 months (Dec Committee) for one of the three Policies. (two of the three polices have been approved)
Matter arising 2	Matter arising 2: Retrospective Purchase Orders (Operation) 2.1 Management should remind requisitioners and approvers that purchase orders should be placed on the Orac le system prior to the goods and services being ordered and received.	Medium	2.1 Accepted – This is policy and should be followed. The Charitable funds finance manager will review monthly reports shared by NWSSP Accounts Payable team and specifically target repeat offenders. A reminder will be sent to all Fund holders and requisitioners.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	May -22	Action Closed	Complete - An e-mail has been sent to all Fundholders and requisitioners reminding them of their responsibilities. The e-mail referred to the relevant polic y and included a quick guide to procuring the supply of goods and services. Repeat offenders will als o continue to be targeted as part of the review process of retrospective orders.	n/a	n/a	
Matter arising 3	Matter arising 3: Appropriate evidence for, and timely claiming of, expenses (Operation) 3.1 Management should: a. communicate to relevant individuals and authorisers the requirement for timely submission of expense claims supported by appropriate evidence; and	Low	3.1 a. Accepted. Whilst we do request a timely submission of claims, the reason this was held up was due to Covid, and this has been confirmed by the consultant in question when asked for the reason in the delay. We do however recognise that this delay is excessive and the employee has been reminded of the importance in submitting c laims in a timely manner.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Action Closed	Complete - Consultant was contacted as part of the audit.	n/a	n/a	
Matter arising 3	3.1 b. ensure that expenses submitted late or without appropriate evidence are appropriately challenged before payment and the challenge and jus tific ation for payment are c learly documented.	Low	3.1 b. Accepted. This is linked to the above and it is not uncommon for receipts to go missing, however we were aware that the named individual went by flight to Sierra Leone and the costof the ticket / rec laim was in line with what you would expect to pay. We do however recognise that this needs to be c learly documented, such as printing off an illustration of the cost of a flight to Sierra Leone in order to accompany and support the claim, and articulating this with the employee at the time.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Action Closed	Complete - Consultant was contacted as part of the audit.	n/a	n/a	
Matter arising 4	Matter arising 4: Acknowledgement letters (Operation) 4.1 Ma nage m ents houl d up date the 'D atabase Dona tion E ntry ins truc tio ns' docu m en t to d etail when acknowledgment letters are not issued.	Low	4.1 Accepted – the manual will be updated	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	Complete - The manual has been updated to include examples of when acknowledgment letters will not be issued. These include circumstances where no contact details are provided by donors are a spec ific request not to receive a letter.	n/a	n/a	
Matter arising 4	4.2 Management should review the 13 receipts identified above to satisfy itself that it was appropriate that an acknowledgement letter was not issued.	Low	4.2 Accepted – review is being undertaken	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	Completed - Audit on database has been undertaken. Satisfied that acknowledgement letters were not required?	n/a	n/a	

Audit Action Plan

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

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

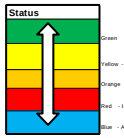
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Charitable Funds 2021/22	Assurance Rating: Reasonable	Date Received at Audit Committee: 03 May 2022	Extension (months)

Ref	Recommendat i on	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	
Matther arising 5	Matter arising 5: Allocation of funds (Operation) 5.1 Management should: a. develop guidance on when funds should be allocated to funds other than the general-purpose fund and what supporting evidence should be retained in such circumstances;	Low	5.1 a. Accepted – All funds are donated into the General funds unless specifically requested from a Donor or a fundraising event / activity is raising money for that particular fund. We can develop a quick guide to demonstrate this. It will be in the guidance that we expect written confirmation when donations are requested to be received into another fund, and we will make every effort to ensure that the guidance is followed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	Complete - Donor must indicate in writing that they would like the donation to be attributed outside the general fund. This is included within the 'how to enter a donation on database' guidance	n/a	n/a	
Matther arising 5	5.1 b. confirm that the four above receipts have been posted to the correct fund number code and update the donation database as necessary; and	Low	5.1 b. Accepted – All donations have been reviewed and confirmed that they are in the correct place.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	Complete - All donations have been reviewed and confirmed that they are in the correct place.	n/a	n/a	
Matther arising 5	5.1 c. consider whether a review of the accuracy of the information in the database is required.	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	Complete - Review of the database accuracy has been undertaken, remedial action needed in 14 cases the outcome was minor. Going forwards weekly reports are produced to ensure accurate assigment of funds to each donor	n/a	n/a	
Matther arising 6	Matter aris ing 6: Incorrect fundraising event noted (Operation) 7.1 Management should: a. remind staff of the need for accurate recording of fundraising events in the donation database;	Low	7.1 a. Accepted - the Fundraising team are aware and have been reminded that it is important that information is recorded accurately in the database.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	Complete - the Fundraising team are aware and have been reminded that it is important that information is recorded accurately in the database. There are now weekly reports to ensure that all donor's and event funds are allocated correctly	n/a	n/a	
Matther arising 6	7.1 b. confirm that the four above receipts have been allocated to the correct fundraiser and update the donation database as necessary; and	Low	7.1 b. Accepted - A review will be undertaken to ensure that the receipts have been allocated to the correct fundraiser, however we are confident that they are in the correct fund for accounting purposes.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	May -22	Action Closed	Complete - review of reciepts undertaken, there were 2 changes to be made. Weekly reports are now undertaken to ensure funds are allocated correctly	n/a	n/a	
Matther arising 6	7.1 c. consider whether a review of the accuracy of the information in the database is required (see als o MA5).	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	Complete - Daily reports are now completed for fundraisers to check assignment. New sytem being procured will allow for greater transparency	n/a	n/a	
Matther arising 7	Matter arising 7: Advancing Radiotherapy Fund Board Terms of Reference (Operation) 8.1 Management should ensure the ARF Board ToR is formally approved and kept under review.	Low	8.1 Accepted – The ToR has been reviewed and regularly updated, however due to the lac k of meetings whic h were stood down for a period during Covid it has delayed formal approval for the latest version. The latest version of the ToR is going to ARF Board on 27th April for approval.	Matthew Bunce, Executive Director of Finance	Moondance Programme Manager / ARF Programme Manager (Elizabeth Crompton) / ARF Admin Support (Hannah Fox)	Apr-22	Action Closed	Complete - Revised ToR were discussed at the 27/04/22 ARF Board at which no ammendments were identified, however it was agreed to re-circulate to ARF Board members to allow one further opportunity for members who were not in attendance at the April meeting to suggets changes. The ToR were circulated on 03/05/22 with one member seeking clarification on clinical membership which was responded to. The revised ToR will be ratified at the next ARF Board meeting on 18th July 2022. So status has been shown as green as whilst formal ratification will be at July ARF meeitng, in reality the revised ToR were agreed in the April ARF Board as no changes have been made to the version presented at that meeitng	n/a	n/a	
Previous matter arising 3	Previous matter arising 3: Desktop Procedure - Monies Received (Control design) 3.1 Management should draw up a desktop procedure that details the processes to be followed by the fundraising staff and finance staff for recording, safeguarding and banking of Charitable Funds income.	Medium	3.1 Accepted – a new procedure will be developed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	Complete - All new proceedures have been completed and embedded	n/a	n/a	
Previous matter arising 3	3.2 Management should ensure that the original recommendation is reinstated on the Trus t's audit tracker.	Medium	3.2 Accepted – original recommendation will be reinstated.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	Complete - original recommendation has been re-instated on Tracker.	n/a	n/a	

Audit Action Plan



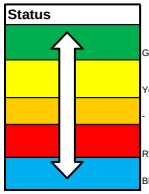
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHSTrust

External Audit Report - Taking Care of the Carers?					Assurance Rating: N/A			Date Received at Audit Committee: 03 May 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where the lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
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 to safeguard and support staff identified as being at		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	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Complete	Complete on May 2022 Audit Committee Report	n/a	n/a	
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	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Complete	Complete on May 2022 Audit Committee Report	n/a	n/a	
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.	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Jun-22	Complete	N/A	The Healthy and Engaged Steering Group commissioned a review of the effectiveness of our wellbeing offer through Audit services in July 2022. The findings and recommendations will be reported to the Executive Director of OD and Workforce on 26 August 2022 and these will inform our next steps in developing our wellbeing offer. Quarterly reports on the use of the Employee Assistance Programme are being recieved and used to inform future provision of support. The Staff Psycholgoist has been appointed and will start on 5 September 2022.	The Advisory Audit Report has been completed and will be presented to October Audit Committee. The recommendations will be adopted by the Healthy and Engaged Steering Group at its October meeting and the Trust work programme will be amended accordingly. Actions will then be monitored via the HESG.	
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. The provider services	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Complete	Complete on May 2022 Audit Committee Report	n/a	n/a	
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		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	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Complete	Complete on May 2022 Audit Committee Report	n/a	n/a	
R6	Buildingonloc alandnationals taff engagement arrangements NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staffhave continued opportunities tohighlighttheirneeds andshare their views, particularly onissues relating to recovering, restarting, and resetting services. NHSbodiesshouldensurethesearrangements supportmeaningful engagementwith underrepresenteds taffgroups,s uchas ethnic		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	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Complete	Complete on May 2022 Audit Committee Report	n/a	n/a	

Audit Action Plan



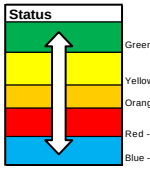
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified /agreed

Velindre UNHS Trust

nVCC Financial Reporting 2021/22					Assurance Rating: Substantial			Date Received at Audit Committee: 19 July 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Extension (Months)
Matter Arising 1	1.1 The finance reports should present consistent and up to date information regarding revenue funding.	Low	1.1 Agreed. The finance reports will be checked, before presentation, by the Assistant Project Director (Finance & Commercials) to ensure consistency of reported figures and to have no transposition errors.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jun-22	Complete	Completed in June 2022	Complete on July 2022 Audit Committee Report	n/a	
Matter Arising 1	2.1 Narrative and financial information should be finalised for the separate Project Progress Reports (nVCC and EW projects) for the next submission to Welsh Government.	Medium	2.1 Agreed. The WG Project Progress Reports will include all the relevant narrative and financial information relating to the specific project. Separate Project Progress Reports, for May 2022, were submitted for the nVCC and EW Projects.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jun-22	Complete	Completed in June 2022	Complete on July 2022 Audit Committee Report	n/a	
Matter Arising 1	2.2 Figures reported to Welsh Government should align with those reported, internally, in the finance reports, and vice versa.	Low	2.2 Agreed. As per 1.1, the finance reports will be checked, before presentation, by the Assistant Project Director (Finance & Commercials) to ensure consistency of reported figures and to have no transposition errors.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jun-22	Complete	Completed in June 2022	Complete on July 2022 Audit Committee Report	n/a	

Audit Action Plan



Green - Action complete

Yellow - Action on targetto be completed by agreed date

Orange - Action noton targetfor completion by agreed date

Red - Implementation date passed- Actionnot complete

Blue - Action closed previousmeeting

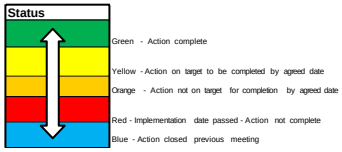
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate time scale is identified / agreed

VelindreUNHSTrust

nVCC Enabling Works Security Contract					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Matter Arising 1	4.1 The Single Tender Action for the security arrangements on the advanced works should be reported to the Audit Committee		4.1 The Assistant Project Director (Financ e & Commerc ials) will liais e with the Director of Finance to ensure that the STA is reported to the Audit Committee in July 2022.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jul-22		
Matter Arising 2	4.2 Contracts should be in place before duties/works commence. The contract documentation pertaining to the security arrangements for March 2022 should be addressed by all parties		4.2 The Enabling Works Project Manager(s) need to ensure that appropriate approvals are sought, and contracts varied where needed, if activities go beyond a contractend date. The approvals need to be in writing so that contract variations can be actioned. Failure to obtain approvals will be addressed using the normal Trustperformance procedure.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commerc ials)	Ongoing Process		
Matter Arising 3	4.3 Purchase orders should reconcile with the approved contractsum.		4.3 The Assistant Project Director (Finance & Commercials) will ensure that the Project Contracts Team have purchase orders for approved contract sums. The Project Finance Team will reconcile the purchase orders on a monthly basis.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Ongoing Monthly Process		
Matter Arising 4	4.4 Board approval is required for the increase to the purchase order value relating to the security provision for the tree clearance works. Prior to this, a full review of variations to contract should be undertaken, in conjunction with the Security Manager, to confirm accuracy ofthe additional costs incurred.		4.4 The Project Finance Team and the Enabling Works Senior Project Manager have completed a review of the contractvariations to confirm the accuracy ofthe additional costs incurred. A Board reporthas been prepared to obtain approval for the increase in costs. It has been endorsed for Board approval by the Enabling Works Project Board and it is expected to be presented to the July Trus t Board.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jul-22		
Matter Arising 5	4.5 Changes to base contractdetails should follow a formal change management procedure. All changes should be documented, costed, approvedaccordingly, and reported to an appropriate forum, to further facilitate appropriate financial managementofthe approved contract.		4.5 The Enabling Works Project Manager(s) need to ensure that appropriate changes to base contract details follow the Project's formal change management procedure. The Project Finance Team will costany such changes. The approvals ofthe changes to base contracts will be undertaken in accordance with the Trusts delegated limits process. The changes to base contracts will be reported to the Enabling Works Project Board.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Ongoing Process		
Matter Arising 6	4.6 Management should undertake a 'lessons learned' exercise regarding the requirements/expectations of security provision, noting the currentprocurement exercise for security resource atthe next stage ofthe Enabling Works programme. Management comment:		4.6 The Assistant Project Director (Finance & Commercials) will undertake a lessons learned exercise with the Enabling Works Project Team in July 2022.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jul-22		

Audit Action Plan



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

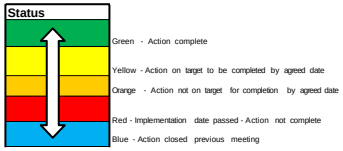
* Unless a more appropriate timescale is identified/ agreed

Velindre UNHS Trust

Wellbeing of Future Generations Act					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Recommendation1	When an agile approach is used, the Trust may wis h toc onsider,and identifyup front, the level ofevidence neededto demonstrate the process andsupportthe actions taken. Examples include maintaining a lis tofmeeting dates (identifyingthemeetingpurpos e),retaining informal meeting notes, and maintaining anactionlog.		Conclusion: The Trustused an agile approach to developing its overarchingandenablings trategies , with clearly identified strategy leads, outputs and an indicative timeline. The joined-up approach supported the threading ofcommon themes throughoutthe strategies, underpinned by the principlesofthe FGA. Engagementwas undertaken with staff, the public and other stakeholdersandwas takenseriously by the Trust; changes made to the Trust Strategy as a result. Progress on strategy developmenthas been regularly reportedto the Strategic Development Committee.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & CapitalDevelopment and Rhiannon Freshney, Environmental Development Offic er	N/A		
Recommendation2	Wherenotyetset, the Trus tshould ensure clear targets and milestonesfor the performance indicators identified in the Sustainability Strategy are clearlydefined inthe tac tic alimplementationplans.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & CapitalDevelopment and Rhiannon Freshney, Environmental Development Offic er	N/A		
Recommendation3	a.The Trust may wis h to undertake a widerself-ass essmentofits baseline positionagainsttheFGA. The AW positive indicators and FGC Trackers canbe used to supportthis process, recognising thesetools are neither prescriptivenor exhaustive, therefore the Trustmay be taking actions notincluded in either whilstsitill contributing to the seven wellbeing goals and implementing the SDP.		Conclusion: The Trustis demonstratingaclearcommitmentto embedding the SDP and 5 ways of working. Whilstitcan demonstrate contribution to the wellbeing goals and application ofthe SDP in places, the Trus tacknowledges its notyetat a pointwhere this is consistently embedded into the organisation's waysofworkinganddecisionmaking. Recommendations madethroughou this reportaim to support the Trus to its FGAjourney .	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & CapitalDevelopment and Rhiannon Freshney, Environmental Development Offic er	N/A		
Recommendation3	b. As partof thes elf-assessmentproc ess, the Trustshould consider undertaking analysis toidentify its currentsustainability culturetos upportdevelopmentofeffec tiv e actions toenhanc eits currentposition.See Appendix Six for guidance on howthis couldbecarriedout.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & CapitalDevelopment and Rhiannon Freshney, Environmental Development Offic er	N/A		
Recommendation4	a.The Trust may wis hto consider whetherincreasedfocusontheFGAand sustainability atan Executive or senior managementlevelwouldbebeneficialin supportingits FGAjourney .		Ideas identified through other NHS Wales organisations •Embedding Sustainability Into Corporate Thinking And Decision-making through inclusion ofsustainability risks inBoardpapers .	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & CapitalDevelopment and Rhiannon Freshney, Environmental Development Offic er	N/A		
Recommendation4	b. In reviewing the job description ofthe Estates Development Officer, the Trust should considerwhatother NHS Wales organisations have in placein terms of operational leadership and support.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & CapitalDevelopment and Rhiannon Freshney, Environmental Development Offic er	N/A		

Audit Action Plan

Velindre UNHS Trust

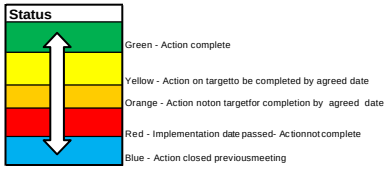


Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified/ agreed

Wellbeing of Future Generations Act					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Recommendation5	leadership for the FGA, it should consider including finance and communications representation in the membership: •Finance representation: to support the Trust's goal to triangulate performance reporting and to consider the impact sustainability has on finance and the need to ensure financial sustainability; and •Communications representation: to support clear, coordinated organisational communication on FGA / sustainability matters and support increased visibility throughout the organisation.		•Using the SMB or other means to undertake deep dives to verify if the SDP and 5WoW are being implemented and embedded throughout the organisation.	Transformation, Planning & Digital	Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer			
Recommendation6	The Trust should ensure it has a coordinated FGA communications plan and that all communications avoid the use of, or clearly explain, any jargon and terminology used.		Ideas identified through other NHS Wales organisations •Incorporating sustainability into job descriptions. •Engaging all staff in developing action plans, whether it be those that support implementation of the strategies or those arising from any self-assessment undertaken. •Embedding the FGA and sustainability into staff awards. •E-guides covering different themes (e.g., biodiversity, travel, procurement) to get staff thinking and empower them to make individual choices. •Online workshops encouraging teams to look at their impact (e.g., around biodiversity, travel, emissions, etc) and how they can improve in these areas to support positive actions. •FGA / sustainability webpage to increase visibility internally and externally. •Running divisional / directorate workshops or undertaking staff surveys to as certain awareness levels and establish a baseline position. •Developing FGA delivery plans on a divisional / directorate level.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation7	The Trust should work with other NHS Wales organisations to identify and developing mechanisms to effectively capture and report on contributions to the wellbeing goals.		Ideas identified through other NHS Wales organisations •Maintaining / publishing a directory of projects identify which wellbeing goals, ways of working and organisational wellbeing objectives the projects contribute to.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation8	As the Trust reviews its policies and procedures during the normal course of business (i.e., when each documents next due for review), it should ensure the FGA (including the SDP and 5 ways of working) is considered during the review process. The updated documents should clearly link to the wellbeing objectives and 5WoW.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation9	The Trust should seek further opportunities to pursue joined up working within NHS Wales and throughout the wider Welsh public sector. Examples include: •Making links with the Public Health Wales Health & Sustainability Hub; •Joining the Sustainable Development Coordinators Cymru Plus network (SDCC+); and •Making links, and developing relationships with, the Public Service Boards in the areas the Trust works.		Conclusion: The Trust is generally in a positive position regarding the success factors. We have identified recommendations for further enhancement, the key areas being around understanding the organisation's sustainability culture, developing mechanisms to capture and report on contributions to the wellbeing goals and SDP, and seeking further opportunities for joined up working across Wales.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation10	The Trust should consider how it can effectively and effectively incorporate FGA considerations / gap analysis into its projects and bidding processes for expenditure (capital and non-capital) going forward, including where the spend does not meet the criteria for more formal project management processes.		Conclusion: A comprehensive FGA gap analysis has been undertaken on the development of the new Velindre Cancer Centre. Areas for improvement are being identified and the analysis is being revisited at key stages of the project to demonstrate improvements made and identify further action required.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		

Audit Action Plan



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

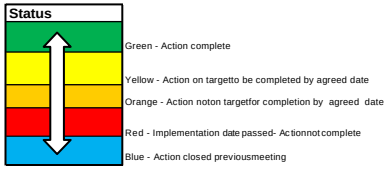
* Unless a more appropriate time scale is identified / agreed

VelindreUNHSTrust

Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Satus	Update August 2022	Update September 2022	Extension (Months)
New Matter Arasing	**Trust Audit Action Tracker (Design)** 1.1 a. The Trustshould develop a documented process for the governance ofits Audit Action Tracker, considering the findings of this reportand covering: i. roles and responsibilities of: • the Board and Audit Committee; • Internal and External Audit (and other reporting bodies where appropriate); • Executive Leads and responsible individuals identified in reports, including the requirement for oversight, accountability and scrutiny by the Executive Leads;and • those chargedwith maintaining the Tracker. ii. the process for providing managementresponses to audit recommendations, including expectations on the quality ofthe responses; iii. mechanisms to ensure all recommendations are included within the Tracker, including recommendations raised in follow upreports; iv. . the process for managing updates to recommendations on the Tracker; v. expectations on the quality of updates andjus tific ations for extensions to deadlines or recommendation closure; vi. . c larity on the expectations of Internal and External Audi t (and other reporting bodies, for example Healthcare Inspectorate Wales) on what is required to close a recommendation; vii. . regular reviewof the Tracker to identify themes, e.g., lac k of progress in implementing recommendations or common issues occurring which may benefit from a Trust-wide solution or an alternative approach toens ureeffec tiv e resolution; and viii. . Audit Committee reporting requirements – this should consider the appropriate level ofinformation required by the Audit Committee to provide an overview of implementation status and to hold the Trust to accountfor timely implementation of recommendations.	High	1.1 a. Recommendation accepted Meeting held with Internal Audit on 5th May to discuss to the governance process for the Audit Action Tracker and how this process can be improved. Ac tion: A paper to be presented to Division SLT/SMT and EMB identifying learning and recommending improvements to the Audit Action Tracker process including a documented process covering items setout in 1.1(a) and using other learning from examples provided from other NHS Wales organisations	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	Jun-22	Complete	A Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking Paper was endorsed for Committee approval in EMB 01 July 2022 and was taken to the Audit Committee 19 July 2022. The paper identified learning and recommended improvements to the Audit Action Tracker process and included documented processes.	n/a	
New Matter Arasing	1.1 b. The Audit Committee should approve the Audit Action Tracker Governance process.	High	b. Recommendation accepted Action: Paper to be presented to EMB and documented process for Audit Action Tracker to be approved by Audit Committee.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Direc tor of Finance	19th July 2022 Audit Committee	Complete	The Audit Committee noted, discussed, reviewed and approved all recommendations in the Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking Paper that was brought to the Audit Committee 19 July 2022	n/a	
New Matter Arasing	1.1 c. The approved process should be communicated to all relevant staff, for example, through inclusion of a link when Internal Audit (or other reports) are sentout.	High	c. Recommendation accepted Action: The approved process will be communicated to all relevantstaff	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	By end July 2022	Complete	The Audit Action Tracker governance process was approved by the Audit Committee on 19 July 2022. The process document will be sent out by 31/8/22 to all staff that were asked to proivde audit action updates un August. It will also be included as an attachment to the Action Tracker update requet e-mails thatwill be sent to relevantstaff each month. A link to the procedure will also be embedded in the Audit Tracker itself.	DoF led on improvements to format and process for action tracking with new Procedure completed.	

Audit Action Plan

VelindreUNHSTrust



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

* Unless a more appropriate time scale is identified / agreed

Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Extension (Months)
New Matter	1.2 The Trustshould undertake a thorough review of the current Tracker to ensure: • all recommendations are included as appropriate; • action updates and justifications to deadline extensions are clear and appropriate; and • all relevantinformation is included in the Tracker where parts of recommendations with multi-part responses have been closed.	H	1.2 Recommendation accepted Action: The DoF Business Support Officer has already undertaken an initial review of the action tracker and sought from action owners clarity on specific actions and target dates as well as formal requestto close actions requiring a summary confirming the key actions taken to justify closure. The DoF will ask a senior member of the Finance Team to undertake a further review of the current Tracker specifically in relation to the 3 points identified.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	19th July 2022 Audit Committee	Complete	The Audit Action Tracker is now circulated monthly for updates to Responsible Manager and Executive Leads, with their BSOs Ccd in an attempt to obtain clarity on specific actions and target dates. A paper will be taken monthly to EMB to follow up on any outstanding recommendations with Executive Leads. All past closed action have been agreed by the Audit Committee to remain on the tracker and be marked as Blue. The DoF has reviewed the tracker to ensure: • all recommenations areincluded; • the governance procedure sets out requirement for justifications to deadline extensionsand action updates are clear; • all relevantinfo is included in tracker where parts of recommendations with multi-part responses havebeen closed	n/a	
New Matter Arising	1.3 We concur with the decision to keep all action updates (not justthe previous two) to create a more robustaudit trail and allow for effective trend monitoring. Going forward, the Trust should also ensure the Tracker spreadsheet includes closed recommendations / actions rather than deleting them (filters or separate worksheets could be used to achieve this effectively).	High	Recommendation accepted Action: As the report states the Trust has already decided it would be more helpful to keep all action updates (not just the previous two) to create a more robustaudit trail, assistthe action lead in the quality & consistency of their action updates and enable effective trend monitoring. Action: The Trust has already agreed thatgoing forwardthe	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	Already Actioned Already Actioned	Complete	n/a	n/a	
Previous Matter Arising	2.1 The VCC WLWG and WLDG should ensure formal deadlines and actions are setto supportcompliance with the Welsh Language Standards, both in the meeting action logs and the RAG-rated compliance document.	Medium	2.1 Recommendation accepted The Action plan for VCC WLWG is being developed along with the introduction of new meetings and attendances. Deadlines for compliance against WL actions are set by the WL Standards document itself and the RAG rating demonstrates these timescales. Internal timescales will be set by the WLWG once the action plan has been finalised. Action: Action plan including deadlines to be agreed by VCC WLWG and WLDG.	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jul-22	Complete	Welsh language Action plan developed and agreed. New meeting shedule agreed.	n/a	
Previous Matter Arising	**Velindre Cancer Centre Working Group (Operation)** 2.2 The ToR for the WLWG and WLDG should be updated and approved, including: • ensuring reference to appropriate group names throughouttheToR; • clearly defining roles and responsibilities of Group members; and • completing the quorum section (or deleting if not considered necessary).	Medium	2.2 Recommendation accepted Action: The TOR for the VCC WLWG and WLDG will be updated in line with recommendations	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jun-22	Complete	Action Ccmplete. The TOR for the VCC WLWG and WLDG have been be updated in line with recommendations.	n/a	
Previous Matter Arising	2.3 The Trustshould ensure the WLWG and WLDG meetings now take place at an appropriate frequency and attendance is monitored, with action taken to address issues with meeting frequency or non-attendance.	Medium	2.3 Recommendation accepted WLDG meetings have been formally agreed and a timeline for this yearset. VCC WLWG meetings as stated above will now be held every month with the next meeting on the 30th of May. Action: WLDG and VCC WLWG to agree attendance monitoring process	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jun-22	Complete	Action complete. WLDG and VCC WLWG have agreed the attendance monitoring process.	n/a	
Previous Matter Arising	Medical Workforce Planning – Action Plans (Design) 3.1 We concur with the approach taken by the Trust to incorporate workforce planning into the Velindre Futures programme. To provide assurance to the Audit Committee that medical workforce planning is in hand going forward, the CSQR Programme's Senior Responsible Officer should provide the Audit Committee an update reporton work undertaken around medical workforce planning, for example, annually. This should be included on the Audit Committee Cycle of Business.	Low	3.1 Recommendation accepted Action: The CSQR Programme / medical workforce planning update report will be added to the Audit Committee Cycle of Business to be presented annually.	Sarah Morley, Director of Workforce and OD	Sarah Morley, Director of Workforce / Lauren Fear, Director of Corporate Governance / Senior Responsible Officer	Jun-22	On Target			

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 date passed - Action not complete

Blue - Action closed previous meeting

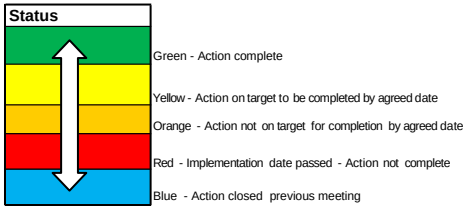
Priority
Low
Medium
High

*** Unless a more appropriate timescale is identified / agreed**

Velindre UNHS Trust

nVCC Development: MIM Procurement Final Internal Audit Report					Assurance Rating: Substantial Assurance			Date Received at Audit Committee: 19 July 2022	
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Extension (Months)
Detailed Audit Find	Procurement Strategy: Assurance that a Procurement Strategy had been adequatel defined and appropriately applied.		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A	
Detailed Audit Fin	Governance Structure: Assurance that an appropriate governance structure was in place in respect of the PQQ process and compliance was demonstrated against the same.		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A	
Detailed Audit Fin	PQQ Evaluation Process: Assurance that a defined evaluation process was in place for PQQ's in preparation for key stakeholder approval (Trust and Welsh Government).		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A	
Detailed Audit Fi	Document Management: Assurance that adequate document management has been retained to demonstrate the fair and equitable treatment of all bidders		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A	
Detailed Audit Fi	Declarations of Interest: Assurance that appropriate guidance and procedures exist for the declarations of interest and compliance was demonstrated in respect of the same.		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A	

Audit Action Plan



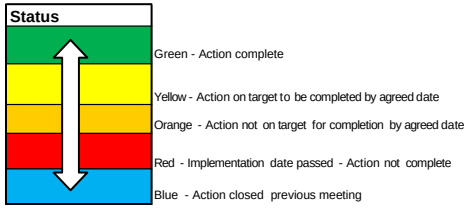
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless amore appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Audit of Accounts Addendum Management Letter					Assurance Rating: N/A			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Extension (Months)
Matter Arising 1	Exhibit 1: Recommendations from 2021-22 audit of accounts **NWSSP IT assets with a gross book value of £570,000 that were disposed of in year remained in the Trust's Financial Statements in error .** Procedures for recording and approving the disposal of IT assets should be reviewed to ensure that all disposed assets are removed from the FAR on a timely basis, and prior to the production of the Trust's Financial Statements.	High	It is agreed that all assets should be disposed in a timely manner in line with the Trust Financial Control Procedure (FCP), "management of non-current / fixed assets and maintenance of asset register". This procedure will be reviewed in line with the recommendation and amended as appropriate. We will then ensure all staff across the Trust are familiar with the procedure and any amendments resulting from the review. NWSSP will in addition provide awareness sessions to all staff with responsibility for capital asset verification during 2022/23 to ensure they are fully aware of their obligations with regard to the disposal and reporting of fixed assets.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting & Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services	31/12/2022	On Target	Capital asset verification and disposal training to be provided to NWSSP staff at the Capital Planning Group meeting in September 2022	Capital Planning Meeting scheduled for 28th September for training on asset verification and disposal.	
Matter Arising 2	**Our analysis of the FAR has identified that a significant percentage of some classes of asset have been fully depreciated but are still in use.** A review of the asset lives should be undertaken and consideration given as to whether there is sufficient evidence to depart from the suggested asset lives in the Manual for Accounts.	Medium	A review will be undertaken to see whether there is significant evidence to warrant departing from the manual of accounts.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting	31/08/2022	Complete	It is extremely difficult to determine an asset life and unless there is clear evidence that can support the true lifespan then the Manual of Accounts will be followed. The Trust is currently benefiting which is in part due to the prolonged life of owned assets, but also the sound use of resources which is linked to the building of the new Cancer Centre. All new assets will be reviewed in line with evidence of asset life, the Manual of Accounts and in conjunction with current assets held by the Trust.	n/a	

Audit Action Plan



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Medium	< 1 month *
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Velindre UNHS Trust

External Audit Report - Audit of Accounts Addendum Management Letter					Assurance Rating: N/A			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Extension (Months)
Matter Arising 3	**There are weaknesses in the process for producing the TFR6 and we anticipate this will may impact on the LMS2 return for the Whole of Government Accounts.** The process of identifying the NHS Matrix agreed transactions in the ledger needs strengthening so that the production of the TFR6 can be produced more efficiently and reduce the risk of any balancing figures being needed. This should include once again reminding colleagues to ensure that transactions are coded to the appropriate codes.	Medium	We will continue to build on the work done last year to improve coding of transactions in the financial ledger. This will include reminding colleagues to ensure that the transactions are coded to the appropriate codes.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2023	On Target	Meeting in diary 13th September for leads in Financial Accounts to discuss approach for 2022/2023 accounts.	Meeting postponed due to illness. Will be rearranged for late October. Action still on track to be completed by the deadline.	
Matter Arising 4	**The Accounts Receivable Control account reconciliation has had an unreconciled difference of £141,000 since October 2021.** This reporting issue should be investigated to see if this issue can be resolved to remove this reconciling item from future reconciliations.	Low	This reporting issue has been subject to ongoing investigation since it occurred in October, and discussions will continue to identify both the cause and the action required to correct the AR reconciliation going forward.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2023	Complete	Review at the end of period 4 indicates this has been resolved. Suggest reviewing again at the end of period 5 before closing action.	Reviewed again post August close and the item still appears resolved. Request to close action.	
Audit Year 2020-21	Exhibit 2: progress against previous years' recommendations 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	Addressed in the 2021-22 Financial Statements Recommendation implemented	Matthew Bunce, Executive Director of Finance	n/a	2021/22 Accounts submission	Complete	Complete on July 2022 Audit Committee Report	n/a	
Audit Year 2020-21	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	Not fully addressed Recommendation included in the 2021-22 recommendations above. See Matter arising 3	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Complete	Complete on July 2022 Audit Committee Report	n/a	

Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: September 2022

Document reference: APS202209

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.

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Contents

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 was 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 2021-22 Financial Statements	We have completed the audit of the 2021-22 financial statements in June 2022 and presented our recommendations in an additional 2021-22 Financial Audit report which went 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 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 and Health Science	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. Scoping was informed by the Joint Review of Quality Governance at Cwm Taf Morgannwg UHB.	**Ongoing** Report issued to the Trust for clearance. Review was postponed in 2020 due to the pandemic. Fieldwork was restarted in 2021, although progress impacted due to continuing need for the Trust to respond to the pandemic. Interviews and staff survey were delayed at the request of the Trust.
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).	**Commenced** June – November 2022
All-Wales Thematic work	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine	October 2022 – January 2023

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
Director of Corporate Governance / Executive Director of Organisational Development & Workforce	how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	
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
NHS Wales Finances Data Tool - up to March 2022	**August 2022**
Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report	**July 2022**
Public Sector Readiness for Net Zero Carbon by 2030	**July 2022**
The Welsh Community Care Information System update	**July 2022**
Tackling the Planned Care Backlog in Wales	May 2022
Unscheduled Care in Wales	April 2022
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

Title	Publication Date
Picture of Public Services 2021	September 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
NHS quality governance	2022
Collaborative arrangements for managing local public health resources	2022

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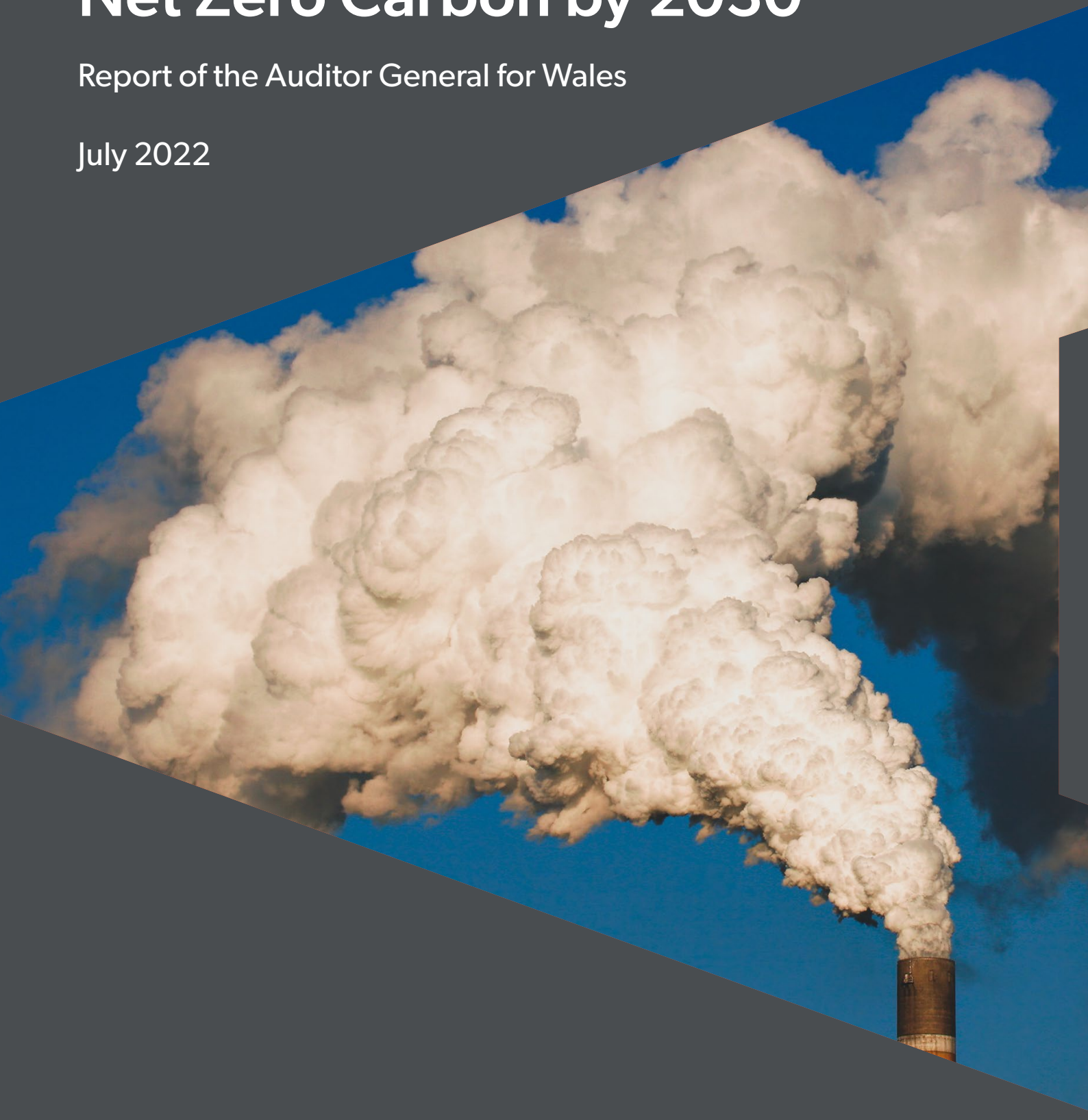
Archwilio Cymru
Audit Wales

Public Sector Readiness for Net Zero Carbon by 2030

Report of the Auditor General for Wales

July 2022



This report has been prepared for presentation to the Senedd under the Government of Wales Act 2006, the Public Audit (Wales) Act 2004 and the Well-being of Future Generations (Wales) Act 2015.

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

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

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Exhibit 2 of this report was amended on 9 August 2022 to correct a minor error.

Contents

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Detailed report

Background

1 Climate change is one of the world's defining challenges and it requires immediate action from everyone. A landmark report by the United Nations in August 2021 said that human activity is changing our climate in unprecedented ways and that drastic reductions in carbon emissions are necessary.

2 The latest climate projections for Wales show an increased chance of milder, wetter winters and hotter, drier summers, rising sea levels and an increase in the frequency and intensity of extreme weather events. The implications are clearly stark.

3 A crucial way to mitigate the impacts of climate change is to reduce carbon emissions. In March 2021, following advice from the Climate Change Committee[1] in December 2020, the Welsh Government set new targets for a 63% carbon reduction by 2030, an 89% reduction by 2040, and a 100% reduction by 2050[2]. In addition, the Welsh Government set out a more challenging collective ambition for the Welsh public sector[3] to achieve net zero carbon by 2030 (the 2030 collective ambition).

4 In June 2021, the Welsh Government published its Programme for Government 2021-2026 which puts tackling the climate and nature emergencies at the heart of the new government. The Programme for Government also makes a series of commitments to embed a response to climate change in everything the Welsh Government does.

1 The Climate Change Committee (CCC) is an independent, statutory body established under the Climate Change Act 2008. Its role is to advise the UK governments on emissions targets and to report on progress made in reducing greenhouse gas emissions and preparing for and adapting to the impacts of climate change.

2 Net zero does not mean eliminating greenhouse gas emissions but balancing the greenhouse gas emissions with the amount of gases being removed from the atmosphere.

3 The Welsh Government's definition of the 'public sector' in this case covers 65 bodies as set out in Appendix 2 of the Welsh Government, Public sector net zero data: baseline and recommendations, June 2022.

5 The Welsh Government has also published Net zero carbon status by 2030: A route map for decarbonisation across the Welsh public sector (the public sector route map) to support the Welsh public sector in achieving the 2030 collective ambition. Alongside the public sector route map, the Welsh Government published the net zero reporting guide and associated spreadsheet to allow the public sector to capture and report emissions on a consistent basis.

6 The Auditor General has committed to carrying out a long-term programme of work on climate change. Our first piece of work is a baseline review that asks: **'How is the public sector preparing to achieve the Welsh Government's collective ambition for a net zero public sector by 2030?'**. To inform the baseline review, 48 public bodies, including the Welsh Government, completed a call for evidence. **Appendix 1** explains our audit approach and methods.

7 We are publishing two reports to share our findings:

- **this key findings report**: this report targets senior leaders and those with scrutiny roles in public bodies, with the aim of inspiring them to increase the pace of their work on achieving the 2030 collective ambition. We have included questions at the end of each section of this report for organisations to reflect on. While these questions are not exhaustive, they provide important pointers for organisations to consider.
- **evidence report – to follow**: a report that will provide more detailed findings and data from the call for evidence and our wider work.

Overall conclusion

8 There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions. Organisations need to be bold and innovative and share experiences of their successes and failures. The Auditor General will not criticise organisations for taking well-managed risks to address this unprecedented challenge.

9 We have set out five calls for action for organisations to tackle the common barriers to decarbonisation in the public sector. These are:

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

2 Clarify your strategic direction and increase your pace of implementation

3 Get to grips with the finances you need

4 Know your skills gaps and increase your capacity

5 Improve data quality and monitoring to support your decision making

10 We are not making specific recommendations given the high-level nature of our review. However, we encourage public bodies to consider the messages in this report, and through their internal governance structures, set out publicly how they intend to respond to the calls for action.

Calls for action

Strengthen your leadership and demonstrate your collective responsibility through effective collaboration

11 The Welsh Government showed leadership when it declared a climate emergency in 2019. Many of the other public bodies have followed suit, for example, 18 out of 22 Welsh councils have now declared a climate emergency.

12 The Welsh Government also demonstrated leadership when it set the 2030 collective ambition and in May 2021 when it established a new Ministerial portfolio for climate change. A related change to the Welsh Government's organisational structure came into effect from 1 April 2022.

13 We have found considerable activity by public bodies, supporting the move towards decarbonisation. So, public bodies are clearly taking this agenda seriously.

14 Despite this, they must do more because there is considerable uncertainty (and clear doubt from some organisations) about whether the 2030 collective ambition will be met. In the NHS, we found uncertainty that even a 34% reduction in emissions would be achieved across that sector[4]. Bodies told us about significant barriers to progress in decarbonising, such as difficulties in translating strategy into action, uncertainty about finances, a lack of skills and capacity, and issues with decarbonisation data. These matters are discussed throughout this report.

15 Now is the time for bold leadership. Public bodies must reduce carbon emissions from their estates, from their services, and from the goods and services they procure. On top of that, they must adopt a wider leadership role in championing the decarbonisation agenda in all sectors within the communities they serve to work towards a 'just transition'[5].

16 Public bodies will need to demonstrate stronger collective leadership because collaboration between organisations will be critical to achieving the 2030 collective ambition. Some respondents told us that a wholesale change of thinking is required, with a more co-ordinated and joined-up approach across the public sector.

4 The NHS Wales Decarbonisation Strategic Delivery Plan sets out 46 initiatives that are estimated to reduce carbon emissions by 34% by 2030.

5 A 'just transition' means taking action on climate change and greening the economy in a way that is as fair and inclusive as possible to everyone concerned. Policy 1 in Net Zero Wales Carbon Budget 2 (2021-2025) sets out the Welsh Government's views on a just transition.

17 Several cross-organisational panels and programme boards already exist to collaborate on climate issues including decarbonisation. And while public bodies expressed largely positive views about the way they are collaborating, there was also recognition that these efforts need to be ramped up. There is a collective responsibility on the public sector to make existing structures work. Public bodies also need to consider what additional collaboration is needed within sectors and across the public sector.

18 Senior leaders must do more to demonstrate they fully grasp the urgency and scale of the challenge and clearly identify this as a top priority for their organisation if they are to achieve their ambitions. Decarbonisation (and wider climate risks) must be at the core of day-to-day business decisions and operations. This agenda must be integrated into all services and operations, so that decarbonisation is delivered alongside other outcomes.

19 The frameworks provided by the Well-being of Future Generations (Wales) Act 2015 (including public services boards and the setting of well-being objectives) can be used to help organisations decarbonise. Application of the sustainable development principle in key areas such as procurement, workforce planning and finance will also help delivery of the decarbonisation agenda.

20 Those charged with governance and scrutiny roles in individual organisations need to support the direction of travel while at the same time challenging whether enough is being done.

Questions that senior leaders and those who scrutinise them may want to ask

- Are we treating the climate crisis and the need to decarbonise as a real ‘emergency’?
- Can we demonstrate that decarbonisation is at the core of day-to-day business decisions and operations?
- Is the urgency and scale of the challenge well communicated by senior leaders and understood throughout our organisation?
- Do we have specific and effective scrutiny and governance arrangements for managing the journey to net zero?
- Do we understand the main barriers to progress and how well are we collaborating to overcome them?

Clarify your strategic direction and increase your pace of implementation

21 To deliver the 2030 collective ambition, it is essential that Wales has clear, joined-up, integrated strategies across the public sector. The action plans resulting from those strategies will also have to be implemented at pace.

22 In response to our call for evidence, public bodies were generally positive about the strategic direction set out by the Welsh Government and that it had been communicated well through the public sector route map (**Appendix 3**). In response to our question about the extent to which they were using the public sector route map, most public bodies said they were using it, to varying degrees, and only five said they were not.

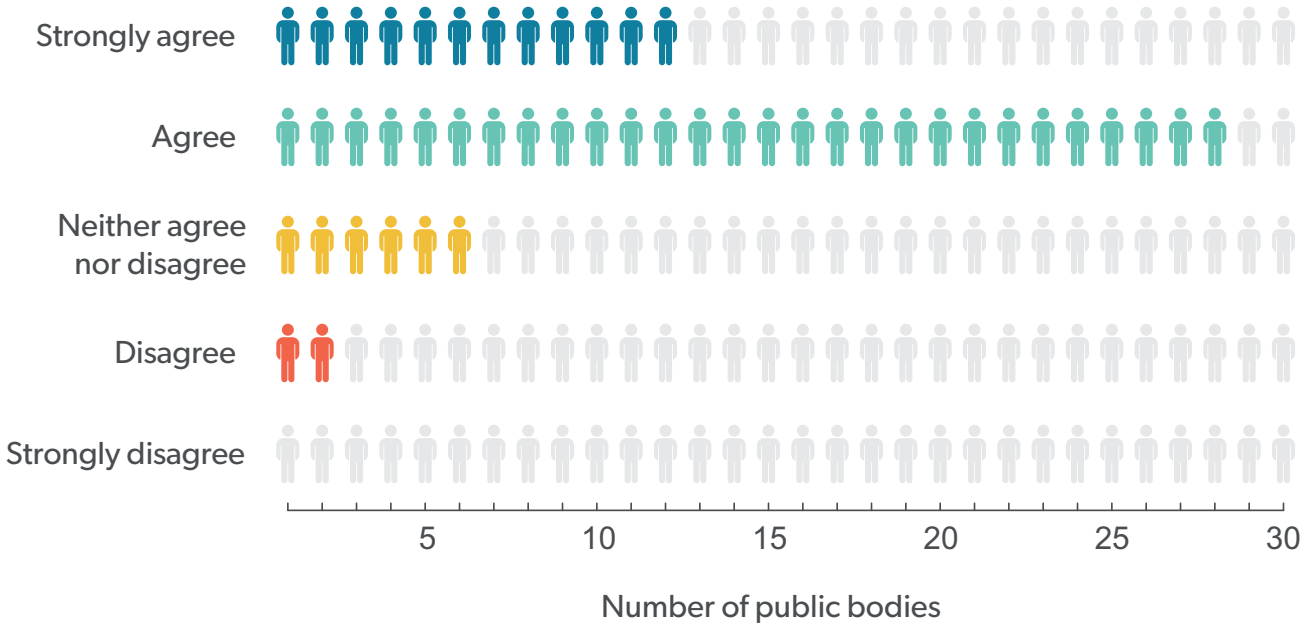
23 Despite generally positive views about the national strategic direction, public bodies want more help to translate the strategy into action. Several organisations told us that while the public sector route map provides a high-level template, they need more clarity, support and guidance on how to decarbonise.

24 The Welsh Government told us that it deliberately designed the public sector route map to be a high-level framework to assist public bodies in developing local solutions based on individual circumstances, rather than a one-size-fits-all approach. The Welsh Government is providing other forms of central assistance on decarbonisation, including support through the Welsh Government Energy Service, grant funding for various programmes and funding of the Welsh Local Government Association transition and recovery support programme.

25 Some sector-specific guidance is available to support public bodies to translate the vision into action. For the NHS, the Carbon Trust and the NHS Wales Shared Services Partnership have set out more detailed actions in the NHS Decarbonisation Strategic Delivery Plan. In local government, the Welsh Local Government Association is developing more tailored support and guidance for councils.

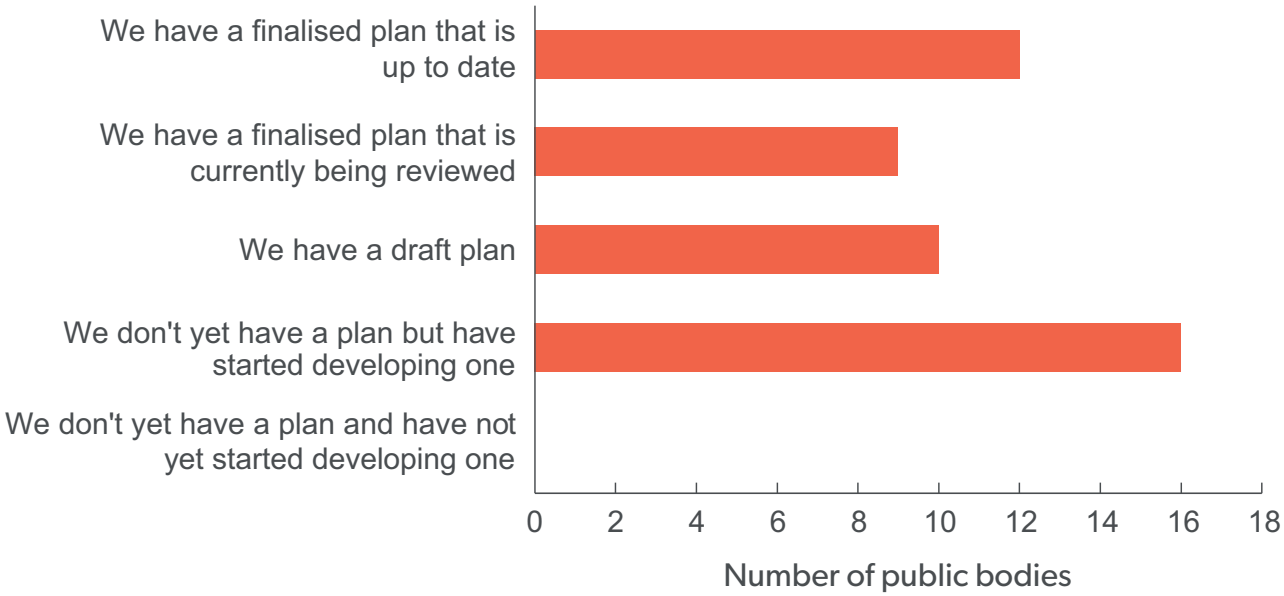
26 Overall, our work has shown that public bodies are at very different stages in setting out their action plans for decarbonisation. While **Exhibit 1** shows most public bodies feel they have set a clear strategic direction, **Exhibit 2** shows that just over a third of organisations did not have a decarbonisation plan at the time of our call for evidence. All organisations had at least started to develop their plan, and under Welsh Government policy they have until April 2023 to develop one.

Exhibit 1: public bodies' responses to the statement, 'Our organisation has set a clear strategic direction to support the achievement of the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 2: status of public bodies' action plans



Note: One public body did not respond to this question.

Source: Audit Wales call for evidence

27 The public sector route map sets out milestones for 2021-22, during which the Welsh Government expects the public sector to be 'moving up a gear'. The Welsh Government considers there has been good progress and the public sector is picking up the pace. However, the Welsh Government recognises there is still significant work to be done and to date, the public sector has not fully achieved the 'moving up a gear' milestones.

Questions that senior leaders and those who scrutinise them may want to ask

- Have we set out a clear strategic approach and action plan for decarbonisation? If not, why not?
- Have we given due consideration to recommendations from the Future Generations Commissioner on decarbonisation, including those within the Future Generations Report 2020[6]?
- Are we involving our staff, stakeholders and citizens in the development and delivery of our strategic approach?
- Have we collaborated with others to develop our overall approach?
- How will our approach to decarbonisation help us deliver against other strategic objectives (including well-being objectives) as well as meeting the 2030 collective ambition?
- Do our other corporate strategies, policies and operations reflect the strategic approach we have set out for decarbonisation?
- Does our action plan set out clear milestones that align with the 2030 collective ambition and is it being implemented at sufficient pace?

6 The Future Generations Commissioner for Wales, Future Generations Report 2020, May 2020.

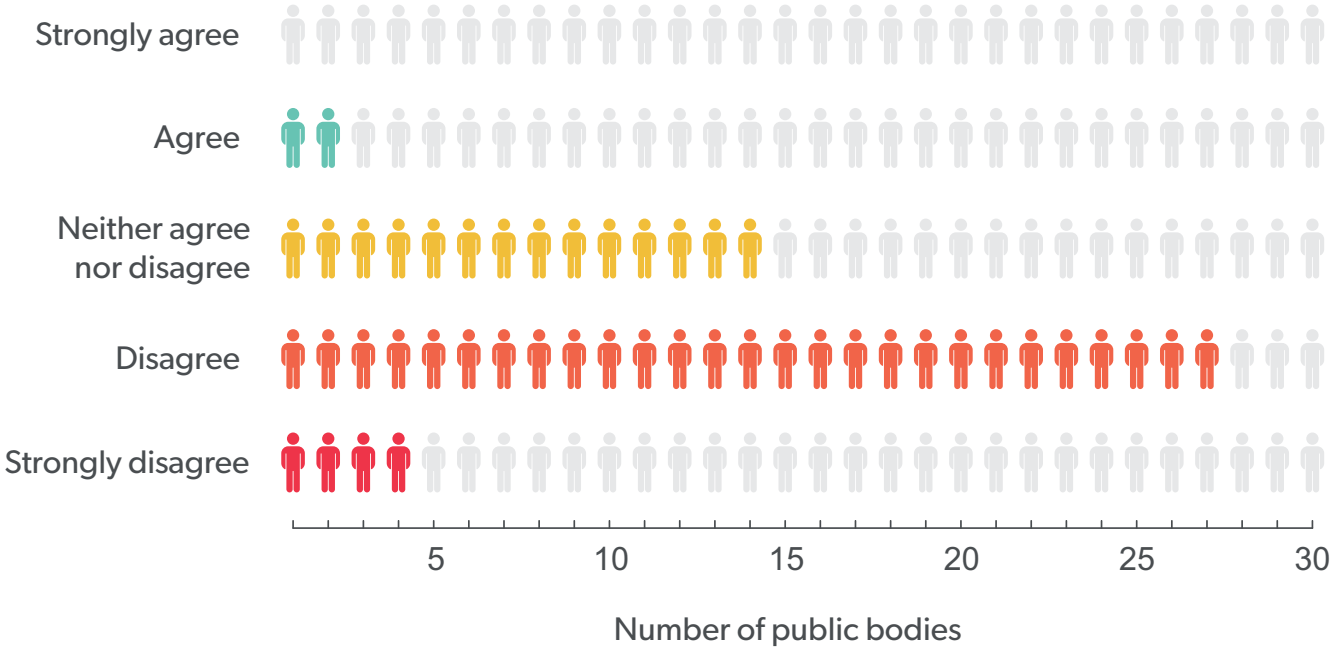
Get to grips with the finances you need

28 Public bodies need to plan their finances in such a way that they can deliver their decarbonisation strategies and action plans. This will require long-term planning because decarbonisation will need investment for many years. It will also require immediate expenditure because if the 2030 collective ambition is to be met, urgent action is essential.

29 Public bodies recognised that significant investment in decarbonisation will be required, particularly for upfront infrastructure costs. But they were uncertain about where the funding for this investment would come from. The Welsh Government is providing funding to public bodies in various ways, but it has said it cannot fund everything. Public bodies will therefore need to think carefully about how they can use their existing funding in different ways, explore potential additional funding opportunities and consider how they might share costs with partner organisations.

30 Overall, public bodies told us that finances are a significant barrier to achieving the 2030 collective ambition. This is because of uncertainty in relation to the long-term additional funding they will have available to them, and about difficulties in getting to grips with the costs of decarbonising. **Exhibit 3** shows that most public bodies have not fully assessed the financial implications of the 2030 collective ambition. In some cases, this is because they have not yet set out a clear set of actions and activities to achieve net zero.

Exhibit 3: public bodies' responses to the statement, 'Our organisation has fully assessed the financial implications of meeting the 2030 carbon reduction targets'



Note: One public body did not respond to this question.

Source: Audit Wales call for evidence

Questions that senior leaders and those who scrutinise them may want to ask

- Do we know what we are currently spending on activities to help meet the 2030 collective ambition?
- Do we know how much we would need to spend to help achieve the 2030 collective ambition?
- How are we deciding how much to spend on decarbonisation?
- If we have not yet assessed the financial implications of the 2030 collective ambition, do we understand why we have been unable to?
- What are we doing to collaborate with others, to understand the financial implications, and to share costs?
- Do our budgets and expenditure reflect the need to reduce carbon emissions urgently?
- Are we setting out a good level of detail in our financial statements in relation to decarbonisation spending? (See our blog on this matter).

Know your skills gaps and increase your capacity

31 Within public bodies it is everyone's responsibility to take action towards the 2030 collective ambition. Delivering that ambition will require public bodies to have staff in place with some specialist expertise. Our work found enthusiasm to deliver, but we also found widespread capacity issues and skills gaps. Skills gaps in relation to decarbonisation are not unique and are symptomatic of a wider challenge across the public sector. For example, in our Picture of Public Services 2021 report, we highlight that staffing numbers have fallen and skills deficits have emerged.

32 Public bodies told us their resources are stretched in delivering their core services, and they are lacking specialist skills in carbon reduction and in monitoring carbon emissions. In addition, the complex nature of the field means that bodies are competing for limited expertise and knowledge.

33 Public bodies need to understand the staff capacity and skills they have in place through robust workforce planning. Training will play a crucial role in ensuring staff understand their decarbonisation responsibilities and are best equipped to deal with the task at hand. There is also an opportunity to share the knowledge, expertise and capacity that exists within the public sector as well as the private and third sectors.

Questions that senior leaders and those who scrutinise them may want to ask

- Do we know what skills are needed, both now and in the future, to ensure we can deliver against the 2030 collective ambition?
- Do we have a plan in place to deal with any identified skills and capacity gaps through training, recruitment or working with peers and stakeholders to share resources and expertise?

Improve data quality and monitoring to support your decision making

34 Public bodies need to understand where their emissions are coming from so they can check if they are making progress. We found that data issues are a major barrier to having a shared understanding of the problem and to taking strategic decisions about the solutions.

35 Carbon emissions monitoring and reporting is a complex and rapidly developing area worldwide. The Welsh Government has published a common reporting methodology for public bodies to report their emissions through the Welsh Public Sector Net Zero Reporting Guide and the net zero reporting spreadsheet. In doing so, the Welsh Government is trying new ways of improving emissions data. Welsh public bodies responded by putting new arrangements in place and by submitting their first set of annual data in October 2021.

36 The Welsh Government commissioned independent consultants, to review the first submission of emissions data from public bodies and in June 2022, the Welsh Government published the consultancy report in full. The report[7] provides the first estimate of the full range of emissions by the public sector in delivering services for the people of Wales. The report states that the figures include significant uncertainty, particularly in relation to supply chain emissions, and that the data has not been thoroughly audited. The figures suggest emissions across Wales for the public sector reduced by 5% between 2019-20 and 2020-21.

37 In response to our call for evidence, public bodies recognised the usefulness of having a common reporting methodology. However, some responses pointed to concerns over some calculation methods, particularly regarding supply chain and land use, and called for further clarity of definitions to ensure consistent interpretation and reporting. Some responses also noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive. NHS bodies also raised concerns about duplication with existing reporting arrangements on carbon emissions.

7 See Footnote 3.

38 It is important to get the data right because this information will underpin decision making and monitoring of progress for decades to come. However, we acknowledge this is the first year of the new arrangements to report a complex issue and the Welsh Government is committed to developing the guidance further to address the issues identified in the consultancy report (**paragraph 36**) and to reflect wider feedback. The Welsh Government published revised reporting guidance in July 2022. We also acknowledge that while there are concerns about supply chain data, the requirement to report this data reinforces the findings from previous studies that show the importance of reducing emissions from procurement and the supply chain[8].

Questions that senior leaders and those who scrutinise them may want to ask

- Are we playing our part in building a system that will provide consistent, accurate, high-quality data on carbon emissions across the public sector to support transparency and scrutiny?
- Do we know what the existing data is telling us and what further data do we need to support decision making?
- Based on our understanding of our own data, do we have plans in place to take appropriate action?
- How can we improve our understanding of emissions resulting from our supply chain and relevant third parties?

8 Welsh Government, A route map for decarbonisation across the Welsh public sector (Appendix A), May 2021.

Appendices

1 Audit approach and methods

2 Legislative and policy framework underpinning decarbonisation

3 The public sector route map and reporting guide

1 Audit approach and methods

In November 2021, we issued a call for evidence to 48 public bodies, asking questions about their baseline position in achieving the 2030 collective ambition. Most public bodies responded in the period December 2021 to January 2022. We sent the call for evidence to the bodies covered by the Well-being of Future Generations (Wales) Act 2015 at the time. This included all principal councils, fire and rescue authorities, national park authorities, health boards and NHS trusts, and the larger Welsh Government sponsored bodies.

We also sent the call for evidence to the Welsh Ambulance Services NHS Trust, Digital Health and Care Wales, and Health Education and Improvement Wales to ensure we had a more complete picture across the NHS. We also sent the call for evidence to NHS Wales Shared Services Partnership (NWSSP), which is an independent mutual organisation, owned and directed by NHS Wales, that delivers a range of services for and on behalf of NHS Wales. NWSSP is hosted by and operates under the legal framework of Velindre University NHS Trust, which is itself covered by the Well-being of Future Generations (Wales) Act 2015.

We received responses from all bodies that were sent the call for evidence, although in a small number of instances not all questions were answered. Where questions were not answered by all public bodies, this is set out in a note to each relevant graph.

To inform our work, we held discussions with relevant stakeholders including the Welsh Government, the Office of the Future Generations Commissioner for Wales, representatives of NHS Wales and the Welsh Local Government Association. We also reviewed key documents, including policies and guidance, and other relevant information provided to us by the Welsh Government and other stakeholders.

We did not undertake a detailed review at each of the public bodies. While we have largely relied on what they reported through their call for evidence responses and any supporting documentation, we have also sought to triangulate our findings through discussions with stakeholders and evidence from our wider document and data review. We also shared and discussed our emerging findings at a public webinar held in May 2022. 109 people from outside Audit Wales attended the webinar, representing a range of public, private and third sector organisations.

As stated earlier in this report, the Auditor General for Wales has committed to a long-term programme of work on climate change. We have already reported on the decarbonisation efforts of fire and rescue authorities, we have begun to review council decarbonisation action plans and we are preparing a report on flood risk management. Following a recent consultation on our future work programme, we are considering our next steps in relation to auditing actions to decarbonise and to adapt to the changes already happening to our climate.

2 Legislative and policy framework underpinning decarbonisation

The graphic below sets out the key legislation, policies and guidance related to decarbonisation and climate change that apply across the Welsh public sector. We refer to sector-specific legislation and policies in the main body of this report where relevant.

April 2016

The Well-being of Future Generations (Wales) Act 2015 came into force and required public bodies covered by the Act to act in accordance with the sustainable development principle. The five ways of working set out in the Act aim to help bodies work together better, avoid repeating past mistakes and tackle long-term challenges.

March 2016

The Environment (Wales) Act 2016 came into force and placed a duty on Welsh Ministers to set targets for reducing greenhouse gas emissions and to set carbon budgets.

July 2017

The Welsh Government set an ambition of achieving a carbon neutral public sector by 2030.

March 2019

The Welsh Government published the first statutory Low Carbon Delivery Plan, Prosperity for All: A Low Carbon Wales (LCDP1).

April 2019

The Welsh Government made a Climate Emergency Declaration.

November 2019

The Welsh Government published Prosperity for All: A Climate Conscious Wales, its most recent climate adaptation plan.

March 2021

Following advice from the Climate Change Committee in December 2020, the Welsh Government set new legal targets for a 63% carbon reduction by 2030, 89% by 2040, and 100% by 2050.

May 2021

The Welsh Government published the Welsh public sector net zero reporting guide and the net zero carbon reporting spreadsheet. **Appendix 3** provides further detail.

June 2021

The Welsh Government published its Programme for Government 2021-2026 which puts tackling the climate and nature emergencies at the heart of the new government and makes a series of commitments to embed climate change in a number of ways.

July 2021

The Welsh Government published Net zero carbon status by 2030: A route map for decarbonisation across the Welsh public sector. **Appendix 3** provides further detail.

October 2021

The Welsh Government published Net Zero Wales Carbon Budget 2 (2021 to 2025). This sets out specific policies for the public sector, including a target for decarbonisation plans to be in place by March 2023, targets relating to buildings, vehicles and procurement, and development of a new health and social care decarbonisation plan.

July 2022

The Welsh Government published updated versions of the Welsh public sector net zero reporting guide and the net zero carbon reporting spreadsheet.

3 The public sector route map and reporting guide

To support the public sector to achieve net zero, the Welsh Government published its public sector route map in July 2021. The route map sets out four priority areas for action: buildings, mobility and transport, procurement, and land use. It also sets out key milestones for the public sector to achieve, which are:

Moving up a gear: Where understanding the context and what needs to be done is vital, and where action needs to accelerate.

Well on our way: Where there is an expectation that low carbon is becoming the norm and the public sector is definitely on the way to net zero.

Achieving our goal: Where choosing zero carbon has become routine, culturally embedded, and self-regulating.

In May 2021, the Welsh Government published the Welsh Public Sector Net Zero Carbon Reporting Guide. The aim of the guide is to develop a universal set of instructions for use by public bodies to assist in meeting the 2030 collective ambition, in particular to:

- **Baseline:** To understand the current situation and quantify organisational emissions and removals for a consistently drawn boundary. And to quantify the likely emission gap to carbon neutral operations by 2030.
- **Identify mitigation potential:** An assessment to identify significant sources of emissions enabling organisations and the public sector to prioritise action needed to move to carbon neutral operations by 2030.
- **Monitor progress:** A need to gather, collate and analyse data to assess whether organisations are on track to achieving their goal of carbon neutrality by 2030.

Alongside the guide, the Welsh Government published the Net zero carbon reporting spreadsheet for use by public bodies to capture and report their emissions data in a consistent way. The Welsh Government asked public bodies to submit the first data by October 2021 for the 2020-21 financial year. The second submission is required by September 2022 for the 2021-22 financial year.

The guide states that public bodies should report actions to reduce emissions and move to carbon neutral operations by 2030, but the format and narrative of that reporting are not prescribed. The guide does suggest it could be in the form of an annual report on progress against a published action plan or a separate document. It also suggests that management information used in collating an emissions report will provide a good basis for the narrative report. As part of our work, we have not reviewed any narrative reports produced by public bodies, although **paragraphs 34-38** of this report comment on the challenges relating to the carbon emissions data and reporting. Following feedback from public bodies and a review of the first year's data submissions, the Welsh Government published revised reporting guidance in July 2022.

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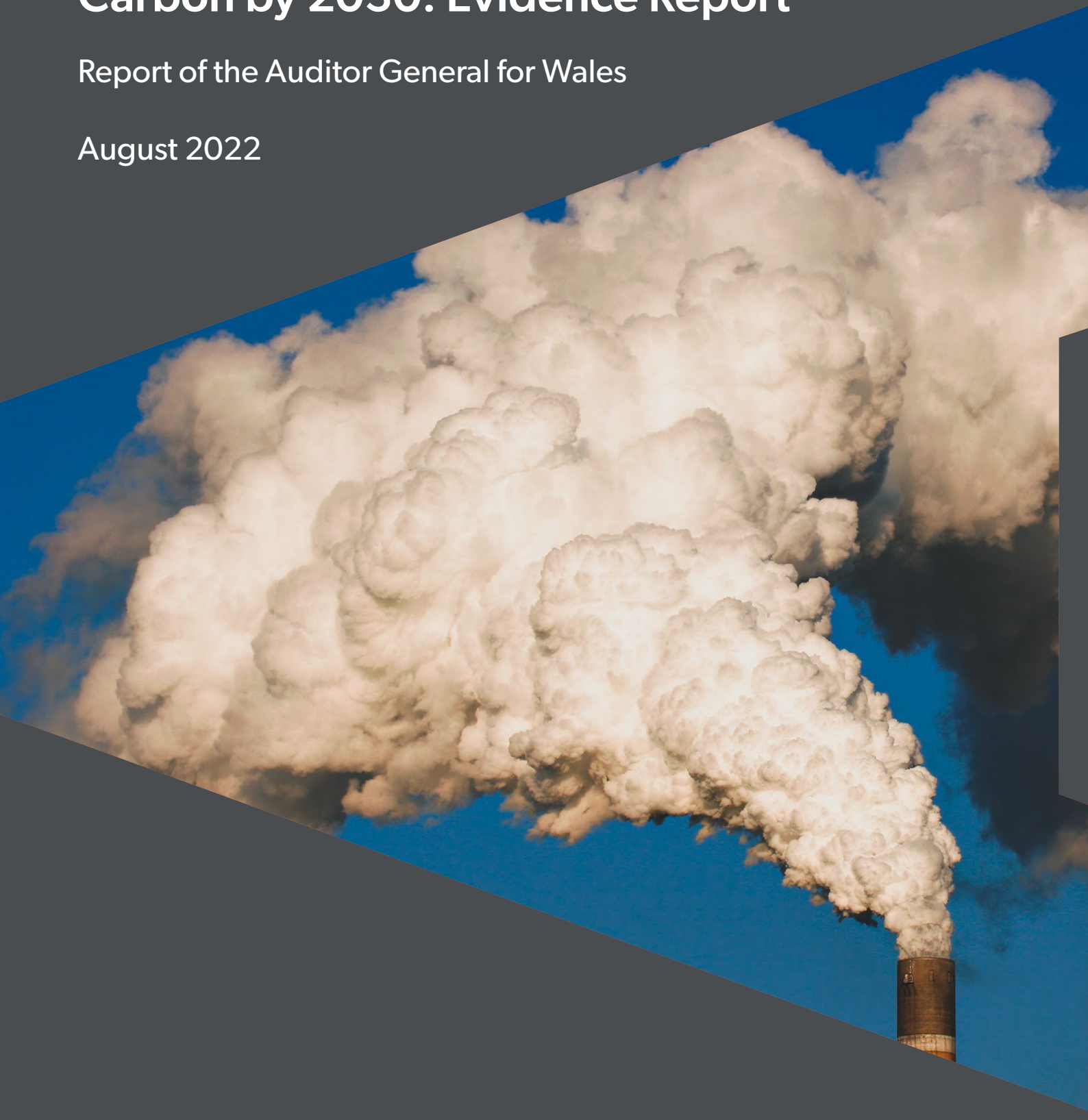
Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report

Report of the Auditor General for Wales

August 2022



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Detailed report

Background

1 Climate change is one of the world's defining challenges and it requires immediate action from everyone. A landmark report by the United Nations in August 2021 said that human activity is changing our climate in unprecedented ways and that drastic reductions in carbon emissions are necessary.

2 The latest climate projections for Wales show an increased chance of milder, wetter winters and hotter, drier summers, rising sea levels and an increase in the frequency and intensity of extreme weather events. The implications are clearly stark.

3 A crucial way to mitigate the further impacts of climate change is to reduce carbon emissions. In March 2021, following advice from the Climate Change Committee[1] in December 2020, the Welsh Government set targets for a 63% carbon reduction by 2030, an 89% reduction by 2040, and a 100% reduction by 2050[2]. In addition, the Welsh Government set out a more challenging collective ambition for the Welsh public sector[3] to be net zero carbon by 2030 (the 2030 collective ambition).

4 In June 2021, the Welsh Government published its Programme for Government 2021-2026 which puts tackling the climate and nature emergencies at the heart of the new government. The Programme for Government also makes a series of commitments to embed a response to climate change in everything the Welsh Government does.

1 The Climate Change Committee (CCC) is an independent, statutory body established under the Climate Change Act 2008. Its role is to advise the UK governments on emissions targets and to report on progress made in reducing greenhouse gas emissions and preparing for and adapting to the impacts of climate change.

2 Net zero does not mean eliminating greenhouse gas emissions but balancing the greenhouse gas emissions with the amount of gas being removed from the atmosphere.

3 The Welsh Government's definition of the 'public sector' in this case covers 65 bodies as set out in Appendix 2 of the Welsh Government, Public sector net zero data: baseline and recommendations, June 2022.

5 The Welsh Government has also published Net zero carbon status by 2030: A route map for decarbonisation across the Welsh public sector (the public sector route map) to support the Welsh public sector in achieving the collective ambition. Alongside the public sector route map the Welsh Government has published the net zero reporting guide and associated spreadsheet to allow the public sector to capture and report emissions on a consistent basis. Our separate key findings report provides further detail on the national strategic direction for decarbonisation and its underpinning policy and legislative framework.

6 The Auditor General has committed to carrying out a long-term programme of work on climate change. Our first piece of work is a baseline review that asks: '**How is the public sector preparing to achieve the Welsh Government's collective ambition for a net zero public sector by 2030?**'. To inform the baseline review, 48 public bodies, including the Welsh Government, completed a call for evidence. **Appendix 1** explains our audit approach and methods.

7 We have published two reports to share our findings:

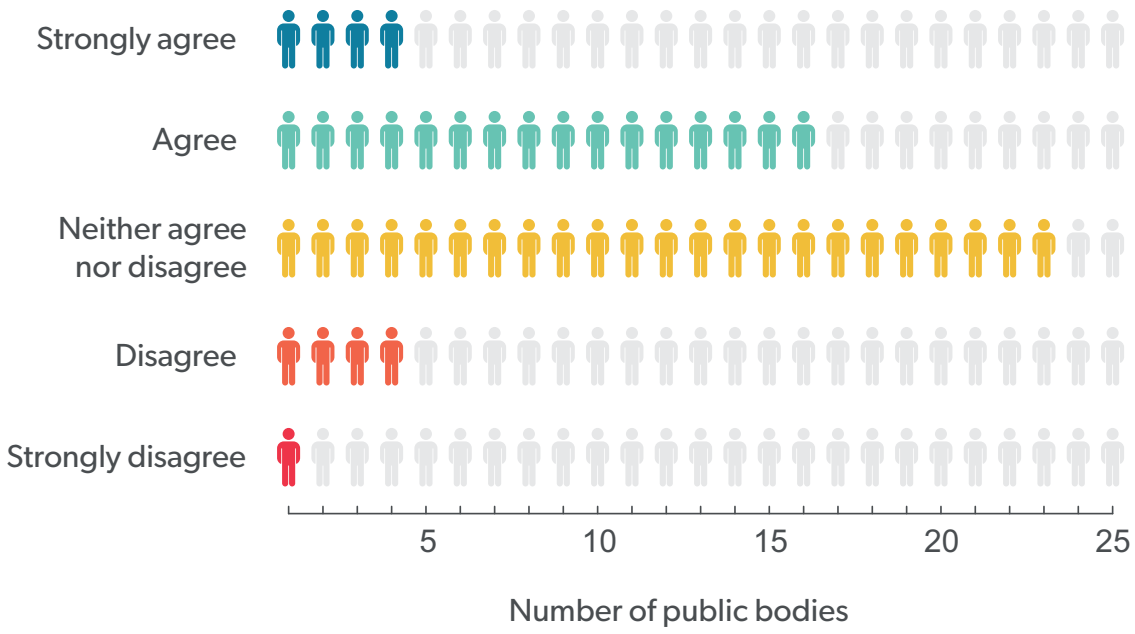
a **key findings report**: a summary report, published in July 2022, that targets senior leaders and those with scrutiny roles in public bodies, with the aim of inspiring them to increase the pace of their work on achieving the 2030 collective ambition. In that report, we set out the overall conclusion from our work and five calls for action for organisations to tackle the common barriers to decarbonisation in the public sector. The key findings report also notes that application of the sustainable development principle and the frameworks provided by the Well-being of Future Generations (Wales) Act 2015 can be used to help organisations to decarbonise.

b **this evidence report**: supplementing the key findings report by providing more detailed findings and data from the call for evidence and our wider work.

Confidence in meeting the 2030 collective ambition

8 We found considerable uncertainty (and clear doubt from some) about whether the collective ambition for a net zero public sector will be achieved by 2030. **Exhibit 1** shows that in our call for evidence, 20 out of 48 bodies agreed or strongly agreed they were confident that their organisation would meet the 2030 collective ambition, whereas 23 said they neither agreed nor disagreed and five disagreed or strongly disagreed.

Exhibit 1: public bodies' responses to the statement, 'Our organisation is confident that it will meet the 2030 target to have net zero carbon emissions'



Source: Audit Wales call for evidence

9 For NHS bodies, the NHS Wales Decarbonisation Strategic Delivery Plan (the NHS plan) includes a target to deliver a 34% reduction in carbon emissions by 2030. This target is based on a calculation about the reduction in emissions that can be realistically expected from the 46 initiatives set out in the plan. Our evidence from NHS bodies indicates considerable uncertainty about meeting this target (as well as the more challenging net zero ambition). **Paragraph 50** provides further consideration of the barriers to achieving the 2030 collective ambition.

10 The evidence suggests there is a need for greater clarity on how the 34% target fits within the wider context of the 2030 collective ambition. The Welsh Government has deliberately set a stretching collective ambition to stimulate action, although it is not a statutory target. At the same time, the NHS has set itself a less stretching target of a 34% reduction by 2030, while other parts of the public sector do not have separate targets. The health sector accounts for around a third of the public sector carbon emissions in Wales[4]. If the NHS was to achieve only a 34% reduction in emissions, it would make it significantly more difficult to achieve an overall net zero position across the public sector.

11 **Exhibit 2** provides examples of what public bodies told us in relation to the 2030 collective ambition and the likelihood of it being achieved.

4 As set out in Public Sector Net Zero: data and recommendations, health boards and trusts produced 1,134,000 tonnes of CO2 against a total of 3,279,000 tonnes produced by the public sector as a whole in 2020-21.

Exhibit 2: some comments from public bodies about the 2030 collective ambition

- ‘We recognise the enormity of the challenge we face.’
- ‘We are committed to contributing to the Welsh Government’s ambition for the public sector to be net zero by 2030 and will endeavour to deliver on or exceed the targets it sets.’
- ‘Not yet sufficiently clear what it will mean in practice.’
- ‘We do not have complete confidence that we will be able to measure the results of our actions.’
- ‘It will involve decarbonisation action in areas that we have yet to develop decarbonisation expertise, for example, in procurement and local area energy planning.’
- ‘If our entire supply chains are not zero carbon, then we cannot be either.’
- ‘The council is committed to achieving its net zero ambitions, notwithstanding the challenges.’
- ‘The level of financial investment will be a driver in whether or not we achieve our ambition and how quickly we’re able to act.’

Source: Audit Wales call for evidence

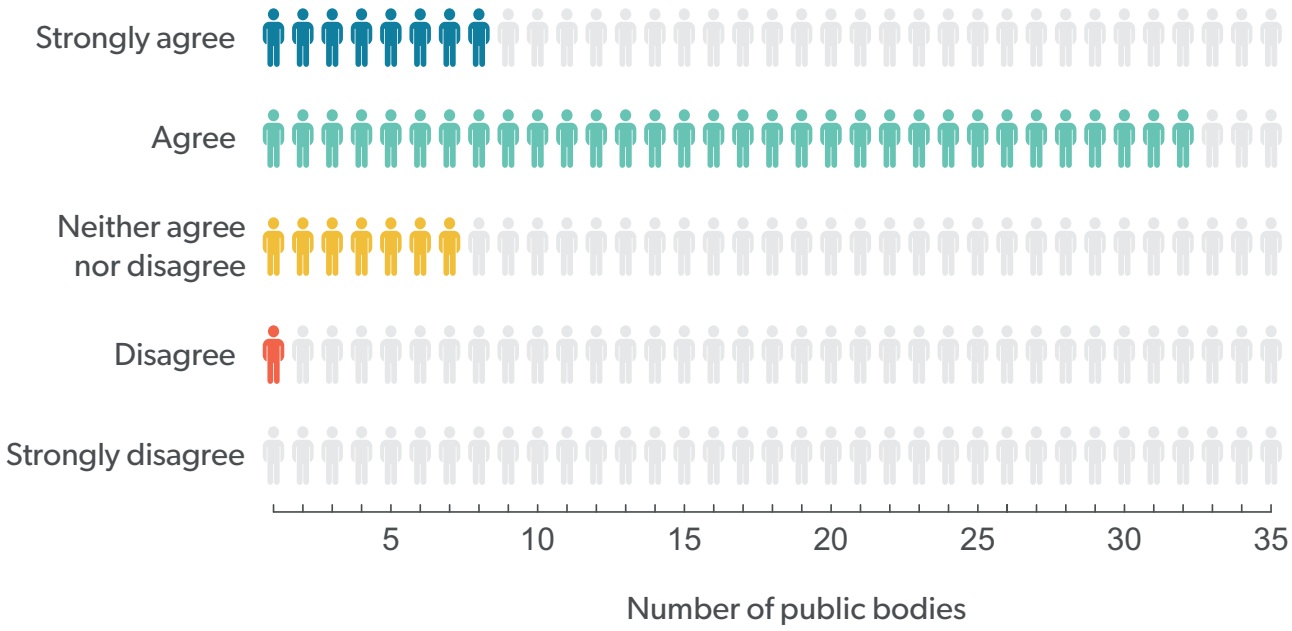
“We recognise the enormity of the challenge we face”

Strategic direction and action planning for decarbonisation

National strategic direction

12 **Exhibit 3** shows that public bodies were generally positive about the Welsh Government's strategic direction on decarbonisation. Public bodies were also largely positive about the way in which the Welsh Government had engaged with them through various channels over the approach to achieving net zero.

Exhibit 3: public bodies' responses to the statement, 'The Welsh Government has set a clear strategic direction for public bodies in Wales to support the achievement of their 2030 carbon reduction targets'



Source: Audit Wales call for evidence

13 **Exhibit 4** provides examples of what public bodies told us in relation to the national strategic direction.

Exhibit 4: some comments from public bodies about the national strategic direction

- 'Welsh Government have set a clear strategic direction in terms of ambition and there is a clear and consistent message in terms of where we need to get to.'
- 'We have used the strategic direction and guidance as a framework to develop an organisational climate change plan.'
- 'The strategic direction has been set out clearly by Welsh Government but how we get there as local authorities, and the support we receive is not clear.'
- 'I believe that the government could be offering more support ensuring that the guidance provided is consistent for everyone.'
- 'Further work is required by (Welsh Government) to publicise the wider strategic narrative and tools available.'
- 'The National (NHS Wales) Strategic Decarbonisation Plan provides a clear direction of travel for Wales and robust evidence base for the priorities within (our area).
- 'The NHS Wales Decarbonisation Strategic Delivery Plan sets out a number of actions with clear timelines.'

Source: Audit Wales call for evidence

"The strategic direction has been set out clearly by Welsh Government but how we get there as local authorities…is not clear"

14 The public sector route map is a key part of the national strategic direction. Some public bodies told us they view the public sector route map as a high-level thematic and strategic framework. They told us it sets the overall direction, and is an accessible, well-presented and user-friendly document. Several bodies made comments about the usefulness of the route map as a tool for explaining, identifying, developing and delivering actions. Some also told us that the route map was a valuable aid for explaining responsibilities and requirements to senior management, members and board members.

15 Nevertheless, several non-NHS bodies said they wanted more help to translate the strategy into local, day-to-day operations, through their action plans. These organisations told us that while the public sector route map provides a high-level template, they need more clarity, support and guidance on how to decarbonise. The Welsh Government told us that it deliberately designed the route map to be a high-level framework to assist public bodies in developing local solutions based on individual circumstances, rather than a one-size-fits-all approach. In addition, the Welsh Government does provide other sources of support to public bodies through the Welsh Government Energy Service and through the Wales Funding Programme, as set out in **paragraph 22**.

16 **Exhibit 5** provides a summary of some concerns public bodies expressed about the public sector route map. **Exhibit 18** expands on some of these concerns as part of a discussion about wider barriers to decarbonisation.

Exhibit 5: summary of concerns from public bodies about the public sector route map

- **Timeliness**: Overall, public bodies felt there was consistency between the direction set by the Welsh Government and their individual approaches. However, due to the timing of the route map's publication[5], some bodies had already started developing their own strategies and action plans so there is not always complete read across to the route map. There is an opportunity to fully align when strategies and action plans are refreshed.
- **Detail**: the public sector route map needs additional clarity, support and guidance on how to decarbonise.
- **Targets**: some of the targets and the timeframes to achieve them are very challenging.
- **Funding**: there is a lack of planned, long-term, external investment from the Welsh Government to support delivery.
- **Inconsistency**: potential for inconsistent interpretation of the guidance and the reporting requirements.
- **Calculations**: further detail and clarity are needed in the carbon calculator, specifically in relation to the procurement and land use themes.

Source: Audit Wales call for evidence

5 The Welsh Government chose to delay publication of the route map during the COVID-19 pandemic because it did not want to overburden public bodies at such a difficult time.

Sector-specific strategies and support for decarbonisation

17 In the health and care sector, the Welsh Government has convened the Climate Change and Decarbonisation Programme Board for Health and Social Care, to help lead, support and give strategic oversight to decarbonisation work. Guidance on decarbonisation is available to NHS bodies through the NHS plan which was published alongside the public sector route map in May 2021. The Carbon Trust and the NHS Wales Shared Services Partnership developed the NHS plan, which sets out 46 initiatives for decarbonisation that will be assessed and reviewed in 2025 and 2030.

18 The NHS plan aligns with the public sector route map, provides more detail and allocates responsibility for initiatives and actions to different parts of NHS Wales. The NHS plan focuses on traditional areas of decarbonisation, such as buildings and transport. While these remain important areas of focus, the Welsh Government has acknowledged that the section on decarbonising healthcare[6] is less detailed, reflecting the developing practice in this area.

19 Our call for evidence responses from NHS bodies demonstrated a focus on and commitment to delivering the actions set out in the NHS plan. And while there appears to be support in the health sector for the NHS plan, the Welsh Government recognises there is scope to strengthen its co-ordination and leadership.

20 In local government, the Welsh Local Government Association is developing tailored support and guidance for councils on decarbonisation. The Welsh Government funds the Welsh Local Government Association transition and recovery support programme. Focussing on the key themes of the public sector route map, the programme provides a range of support including toolkits, commissioned research on interventions to achieve net zero, training to build knowledge and expertise, and events to facilitate sharing of best practice. The Welsh Government is also part of the Local Government Climate Strategy Panel which supports and gives strategic overview to decarbonisation work in local government.

21 The Welsh Government does not currently plan to produce specific decarbonisation plans for other sectors covered by the public sector route map. However, it acknowledges that more support and guidance may be needed for bodies outside of the NHS and local government.

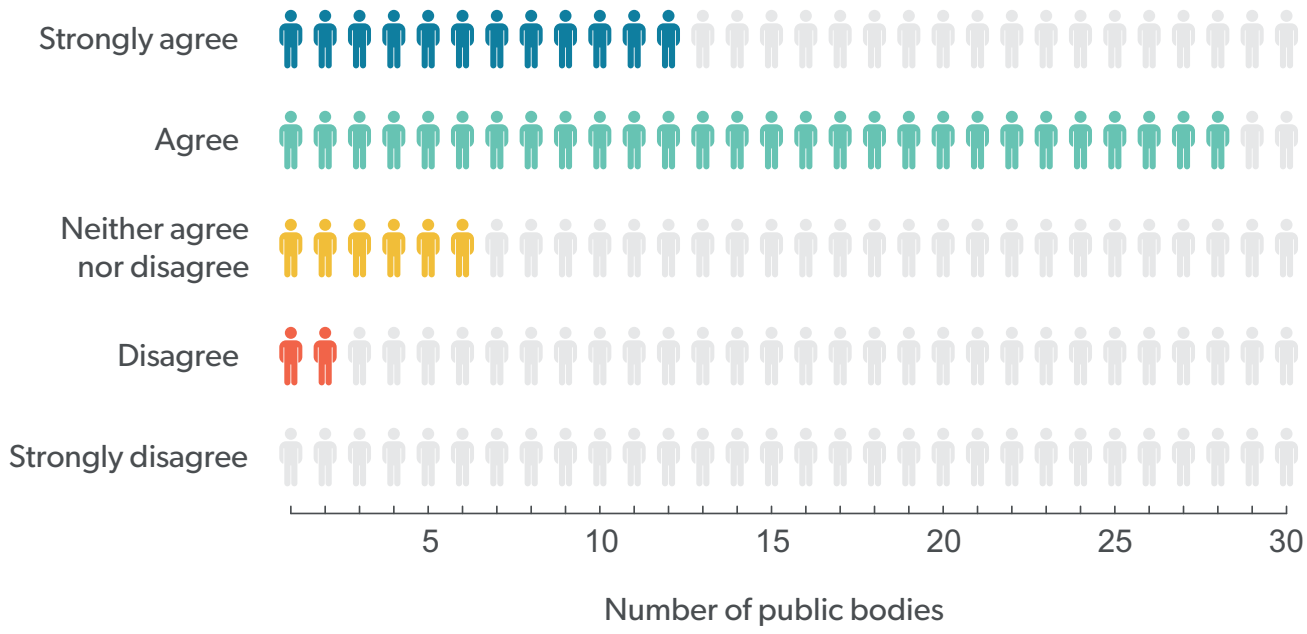
6 Decarbonising healthcare refers to reducing carbon emissions in health services rather than decarbonising the physical infrastructure surrounding healthcare. Examples include the use of medical gases and inhalers that involve greenhouse gases.

22 The Welsh Government is providing other central assistance on decarbonisation, including support through the Welsh Government Energy Service (WGES) and grant funding for various programmes. The WGES provides technical advice and other support to public sector bodies and community enterprises on energy efficiency, renewable energy projects and fleet improvements. The WGES annual report provides further information about the support it provides. The Welsh Government has made funding available for public sector decarbonisation projects through the Wales Funding Programme, which aims to make buildings and assets more energy efficient.

Local strategic direction

23 **Exhibit 6** shows that most public bodies were confident their organisation had set a clear, local strategic direction to deliver the 2030 collective ambition.

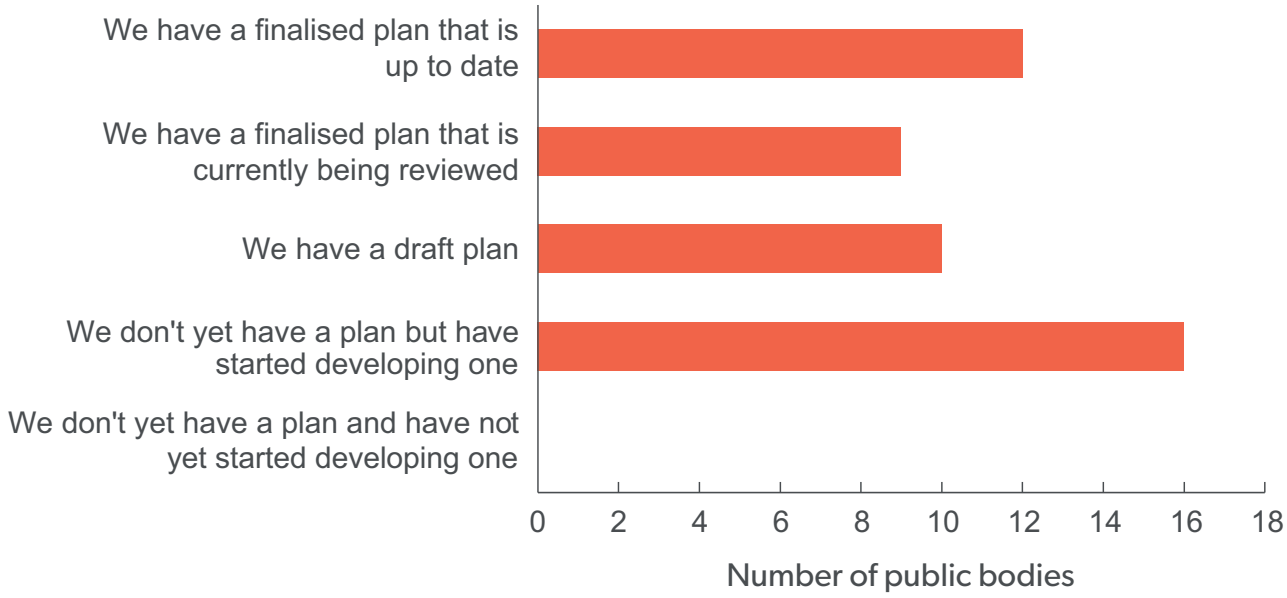
Exhibit 6: public bodies' responses to the statement, 'Our organisation has set a clear strategic direction to support the achievement of the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

24 However, **Exhibit 7** shows that public bodies are at very different stages in setting out their action plans for decarbonisation. Within these responses, NHS bodies appeared to be a bit further behind local government.

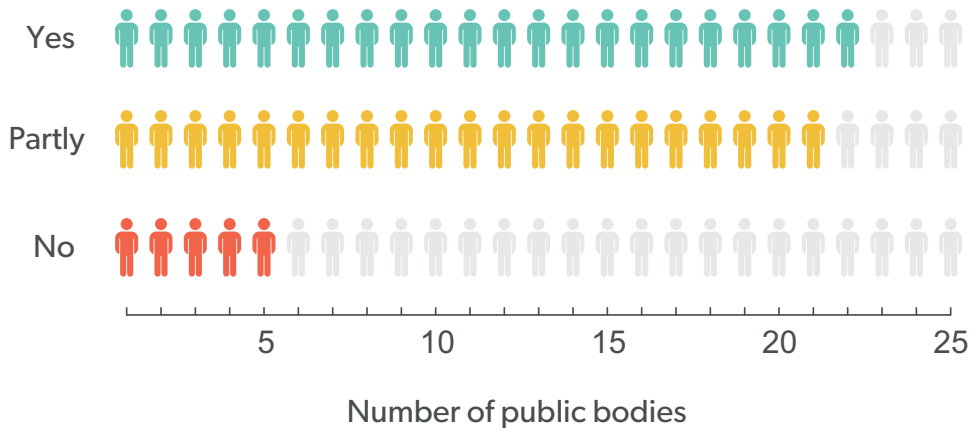
Exhibit 7: status of public bodies' action plans



Note: One public body did not respond to this question.
Source: Audit Wales call for evidence

25 **Exhibit 8** shows variation in the extent to which public bodies are using the public sector route map to guide their own strategic approach, with five responding to say that they are not using it at all.

Exhibit 8: public bodies' responses to the question, 'Is your organisation using the Welsh Government's public sector route map to guide its approach to reducing carbon emissions?'



Source: Audit Wales call for evidence

Governance and leadership arrangements for decarbonisation

26 It is important that public bodies have effective internal governance and leadership arrangements to drive decarbonisation. Public bodies described various existing and new structures, including boards and dedicated senior staff groups. For example, all NHS bodies have an identified director or executive director to oversee decarbonisation. Responses to the call for evidence also acknowledged that clear structures are essential and need to be regularly reviewed to ensure they remain fit for purpose.

27 Public bodies recognised the importance of engaging all staff in the critical issue of decarbonisation, but they acknowledged that more needs to be done. Upskilling of staff through training was identified as key to supporting the delivery of the 2030 collective ambition. However, more needs to be done to ensure upskilling covers the whole staff base and not just senior leaders or those charged with governance.

28 **Exhibit 9** provides examples of what public bodies told us in relation to their governance and leadership arrangements for decarbonisation.

Exhibit 9: some comments from public bodies about their governance and leadership arrangements for decarbonisation

- ‘A climate and nature emergency officer group has been established to lead, facilitate and support the delivery of the action plan.’
- ‘The health board has established a sustainability and decarbonisation programme board led by the Executive Director Finance.’
- ‘The council has just appointed … a Climate Change Manager.’
- ‘We are building decarbonisation into the clinical model which will be operating in new hospital infrastructure going through business case stages.’
- ‘Some early adopter clinical departments are creating their own sustainability action plans.’
- ‘[We] will appoint a board director as decarbonisation lead (and senior responsible officer) and establish a steering group to oversee our decarbonisation programme.’
- ‘The Sustainable Group is chaired by the Executive Director of Strategy and attended by staff from across the health board, including clinicians and those networked into a wide range of partner forums.’
- ‘The council established its cross-party Climate Change and Ecological Emergency Working Group after declaring the climate and ecological emergency. The Working Group was supported by a team of officers.’

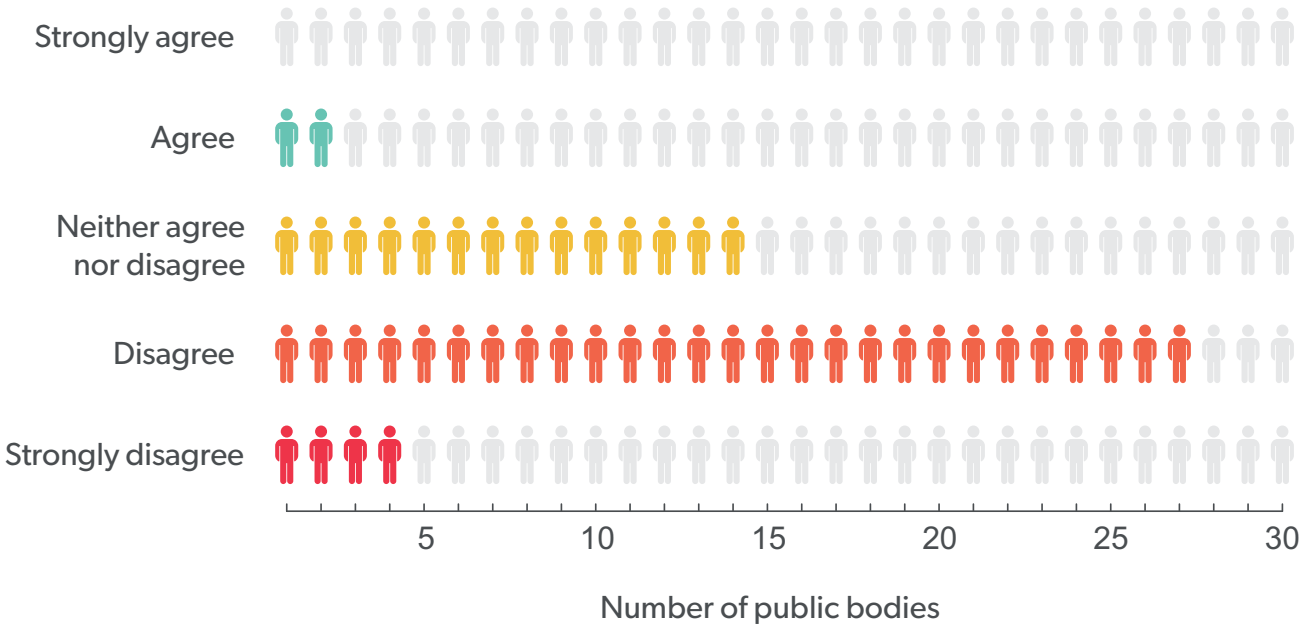
Source: Audit Wales call for evidence

“We are building decarbonisation into the clinical model”

Financial implications of decarbonisation

29 **Exhibit 10** shows that most public bodies have not fully assessed the financial implications of meeting the 2030 collective ambition. A few responses to the call for evidence included costings of specific recent or imminent projects but we did not see evidence of fully costed, long-term decarbonisation programmes. We are aware that some public bodies have since developed more detailed estimates for short to medium-term expenditure.

Exhibit 10: public bodies' responses to the statement, 'Our organisation has fully assessed the financial implications of meeting the 2030 carbon reduction targets'



Note: One public body did not respond to this question.
Source: Audit Wales call for evidence

30 In some cases, public bodies told us that they have not assessed the financial implications because they have not yet set out a clear set of actions and activities to achieve net zero. However, they were aware of the urgency and the need to increase the pace of implementing actions. Public bodies were very clear that decarbonisation at scale will require significant additional financial resources and that the absence of these funds will be a significant barrier to progress.

31 Public bodies need to plan their finances in such a way that they can deliver their decarbonisation strategies and action plans. This will require long-term planning because decarbonisation will need investment for many years. It will also require immediate expenditure because if the 2030 collective ambition is to be met, urgent action is essential. Public bodies told us significant long-term investment will be needed, particularly in relation to making their infrastructure fit for purpose to enable the decarbonisation of operations. However, public bodies expressed uncertainty over what additional funding would be available from the Welsh Government. They also pointed to the short-term nature of public sector funding and budget cycles making their longer-term financial planning more difficult.

32 The Welsh Government told us they are providing targeted funding for public bodies in certain areas but they also said they are unable to fund all activity required. The Welsh Government acknowledges that there will be additional costs in some areas and that funding will be provided to bridge some of those gaps, when moving to low carbon alternatives, for example, the increased cost of purchasing electric fleet rather than those powered by traditional fossil fuels. However, the Welsh Government said that as decarbonisation becomes increasingly mainstreamed into routine thinking, public bodies should not be focussed on additional funding, and they should move to a position where decarbonisation is funded through their existing budgets as a result of a strong business case.

33 **Exhibit 11** provides further examples of what public bodies told us in relation to the financial implications of decarbonisation.

Exhibit 11: some comments from public bodies about the financial implications of decarbonisation

- ‘The financial implications of decarbonisation have not been fully considered.’
- ‘We recognise that we have further work to do on this front.’
- ‘The council recognises that achieving its net zero ambition will have implications for its budget in the short and long term.’
- ‘Until the council formulates a detailed fully costed 2030 net zero delivery plan the council is unable to accurately assess the financial implications.’
- ‘It should be acknowledged that funding will be required to deliver the aim of net zero by 2030.’
- ‘There are no cost estimates for medium-term levels of expenditure.’
- ‘The cost of decarbonising our clinical operations has not been estimated.’

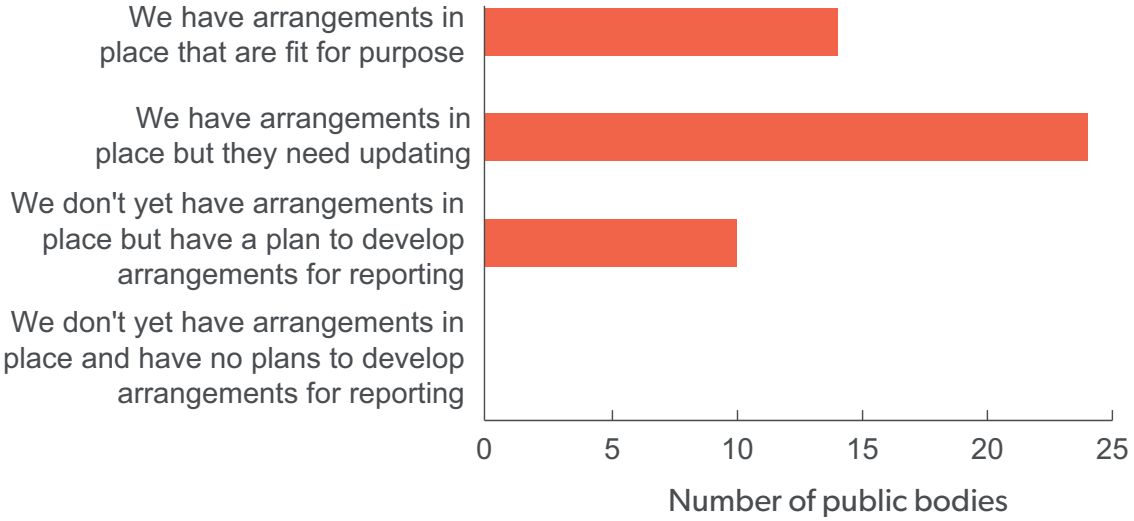
Source: Audit Wales call for evidence

“The council recognises that achieving its net zero ambition will have implications for its budget in the short and long term”

Reporting progress on decarbonisation

34 Public bodies need to understand where their emissions are coming from so they can check if they are making progress and prioritise their actions. We found that data issues are a major barrier to having a shared understanding of the problem and to taking strategic decisions about the solutions. **Exhibit 12** shows that 14 bodies indicated they had reporting arrangements that they felt were fit for purpose, 10 did not have arrangements in place, and 24 had arrangements that needed updating.

Exhibit 12: public bodies' responses to the question, 'Which of the following options best describes your organisation's arrangements for reporting on progress towards net zero carbon emissions?'



Source: Audit Wales call for evidence

35 Current monitoring and reporting tend to be done through reports or dashboards to cabinet, council, board, scrutiny committee or other groups. Some bodies report on decarbonisation as part of reporting progress on their corporate plans or wellbeing objectives. Some responses pointed to dedicated climate groups and other arrangements that have been set up specifically to monitor and report on decarbonisation activity.

36 Overall, the evidence suggests there is scope for improved reporting on decarbonisation. This finding aligns with a blog we published in February 2022 that called for clearer information on climate change actions to be included in public bodies' financial statements, to ensure greater transparency and accountability.

37 The Welsh Government has published a common reporting methodology (see **paragraph 5**) for public bodies to report their emissions through the Welsh Public Sector Net Zero Reporting Guide and net zero reporting spreadsheet. The Welsh Government asked public bodies to submit the first data by October 2021 for the 2020-21 financial year.

38 In responses to our call for evidence, public bodies generally recognised the usefulness of having a common reporting methodology but found aspects of the submission challenging and highlighted problems with the data collection in October 2021. Some responses pointed to concerns over calculation methods, particularly regarding supply chain. In relation to supply chain emissions, public bodies pointed to the fact that the calculation is based on the cost of the contract rather than the actual emissions generated by the product or service procured. Public bodies also called for further clarity of definitions to ensure consistent interpretation and reporting. Some responses also noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive.

39 Public bodies pointed to some other concerns about the common reporting methodology. Some respondents said the way in which emissions from land use is reported is too simplistic.

40 NHS bodies also raised concerns about duplication with already established reporting on carbon emissions such those required by the Estates and Facilities Performance Management System[7]. This created confusion in the first reporting year. NHS bodies wanted further clarity to avoid duplication between these reporting requirements.

7 The Estates and Facilities Performance Management System is a comprehensive set of estates and facilities data. The Welsh Government set up the system in 2002 to improve the management of the NHS estate. It allows NHS bodies to compare performance against other NHS bodies in Wales and England.

41 The Welsh Government recognises improvements are required in the existing reporting approach and has committed to learning from feedback and improving methods and systems where required. The Welsh Government commissioned consultants, to review the first submission of data from public bodies and, in June 2022, the Welsh Government published the consultancy report, Welsh Public Sector Net Zero: Baseline and recommendations in full. The report states that the figures include significant uncertainty, particularly in relation to supply chain emissions, which it said represented 87% of public sector emissions. Plus, the data has not been thoroughly audited. The figures also suggest emissions across Wales for the public sector reduced by 5% between 2019-20 and 2020-21.

42 As this is the first year of the reporting guide, it is a period of learning, and the calculation for reporting emissions will be further developed where required. Following feedback from public bodies, and the review of the data submissions from an external consultant, the Welsh Government published a revised reporting guide and tool in July 2022.

43 **Exhibit 13** provides examples of what public bodies told us in relation to the monitoring and reporting on decarbonisation.

Exhibit 13: some comments from public bodies about monitoring and reporting on decarbonisation

- ‘We followed the emissions reporting guidance as closely as possible.’
- ‘Two distinct areas need to be strengthened/clarified which are waste and supply chain.’
- ‘We appreciate the advantages of having a consistent format to aid our own and Welsh Government monitoring of progress.’
- ‘The supply chain emissions reporting method needs significant refinement in order to be considered accurate.’
- ‘Current data gathering and reporting functions require updating.’
- ‘We are developing the necessary reporting tools to meet the requirements of the Net Zero Carbon Reporting Guidance.’

Source: Audit Wales call for evidence

“We appreciate the advantages of having a consistent format to aid our own and Welsh Government monitoring of progress”

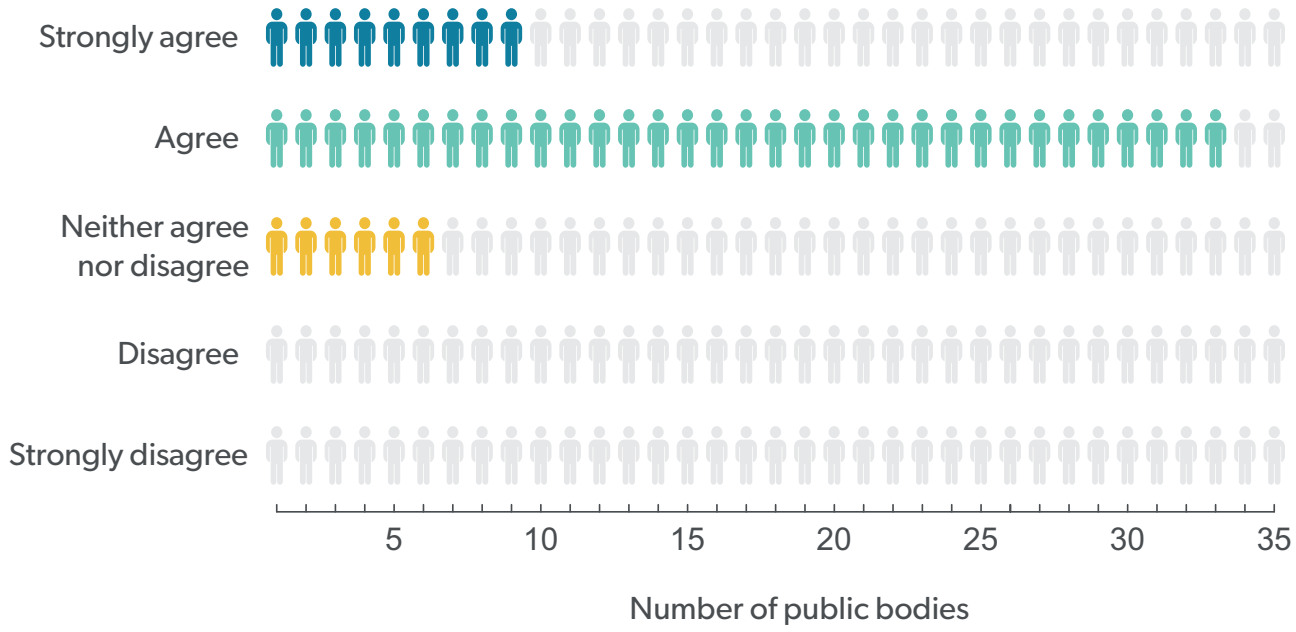
Collaboration and engagement with other bodies, staff, and citizens

44 To support collaboration and engagement at a national level, the Welsh Government published Climate Change: Welsh Government Engagement Approach 2022-26 in June 2021. The document refers to a Team Wales approach, where everyone in Wales plays a role in collective action on climate change. The engagement approach has two key objectives:

- to generate timely and effective engagement of stakeholders on matters of climate change; and
- to strengthen and grow the coalition of Team Wales to tackle the climate emergency.

45 **Exhibit 14** shows that public bodies feel they are working well with other organisations on decarbonisation. And **Exhibit 15** sets out comments made by public bodies about their collaborative efforts to date and aspirations for the future.

Exhibit 14: public bodies' responses to the statement, 'Our organisation is effectively collaborating with other bodies to achieve the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 15: some comments from public bodies about collaboration

- ‘Through the public services board (PSB) we have established a Climate Emergency Board which comprises existing PSB members, but also additional organisations including utility providers and our local university.’
- ‘As part of our Well-being Plan work, we are currently working collaboratively with our partners and are in the early stages of developing a Climate Strategy for the city.’
- ‘We are working closely with public sector partners through the North Wales Regional Leadership Board. We participate in the North Wales Decarbonisation Advisory Group.’
- ‘We have completed an informal analysis of who we need to work with, but we have not yet completed a formal analysis of partners.’
- ‘Collaboration between NHS organisations has been low, though is changing through Welsh Government setting up a Climate Change Programme Board.’
- ‘We have multiple representatives on the Decarbonisation Action Plan: Community of Experts. This will share learning and good practice across the health boards in Wales.’
- ‘We feel that a formal Welsh public sector decarbonisation working group would address some of the challenges faced by serving communities covered by multiple local authority agencies.’

Source: Audit Wales call for evidence

“We feel that a formal Welsh public sector decarbonisation working group would address some of the challenges”

46 Some bodies have set up their own local collaborative arrangements for decarbonisation, whereas other bodies are collaborating through Welsh Government or Welsh Local Government Association convened arrangements or through statutory fora such as public services boards. A significant proportion of bodies had also involved external experts in their decarbonisation efforts, such as the Carbon Trust.

47 Smaller bodies, such as the national parks and Welsh Government sponsored bodies, told us they have been collaborating well with each other. They said that due to their size, they are somewhat reliant on external expertise and advice in relation to decarbonisation.

48 Some public bodies acknowledged that their focus to date had been on establishing internal structures, rather than on external collaboration. And notwithstanding the responses shown in **Exhibit 14**, many public bodies agreed that collaboration and engagement needed to be strengthened.

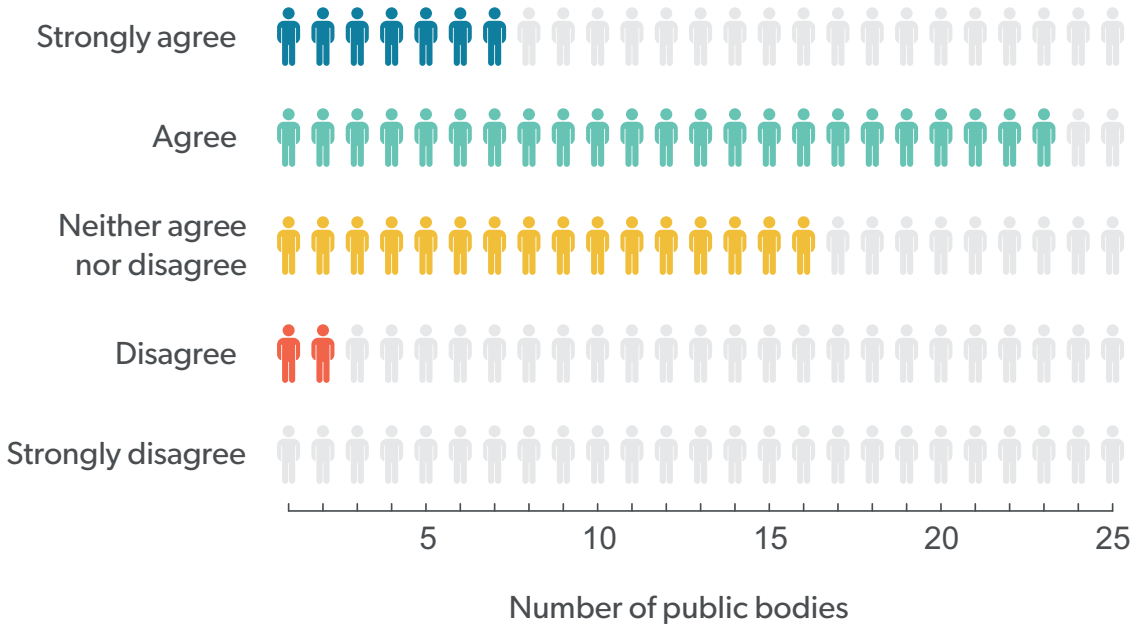
49 There is scope for stronger engagement and involvement with staff and the public. **Exhibit 16** shows mixed views from public bodies about the extent to which they are engaging and involving their staff. And **Exhibit 17** shows that only 15 of the 48 public bodies we contacted were confident that they were effectively engaging with the full diversity of the population. Some public bodies told us about engagement with the public through mechanisms such as online surveys, social media channels and community groups but they generally acknowledged that this engagement needs to improve. This is significant as both our 2019 report on fuel poverty[8] and the Decarbonisation of Homes in Wales Advisory Group[9] found there are some difficult trade-offs between social justice and carbon reduction goals. Engagement with the full diversity of the population should help public bodies in their efforts to make a just transition[10] towards net zero carbon emissions.

8 Auditor General for Wales, Fuel Poverty, October 2019

9 Decarbonising Homes in Wales Advisory Group, Better Homes, Better Wales, Better World: Decarbonising existing homes in Wales, July 2019

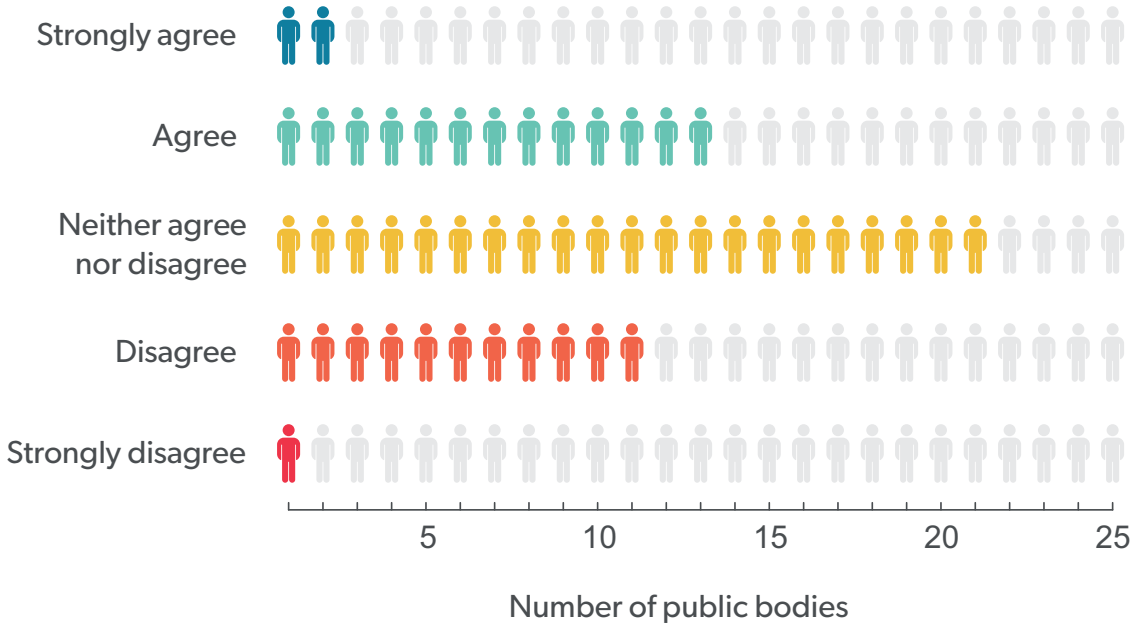
10 A 'just transition' means taking action on climate change and greening the economy in a way that is as fair and inclusive as possible to everyone concerned. Policy 1 in Net Zero Wales Carbon Budget 2 (2021-2025) sets out the Welsh Government's views on a just transition.

Exhibit 16: public bodies' responses to the statement, 'Our organisation is effectively engaging with and involving staff to achieve the 2030 carbon reduction targets'



Source: Audit Wales call for evidence

Exhibit 17: public bodies' responses to the statement, 'Our organisation is effectively engaging with the full diversity of our population to achieve the 2030 carbon reduction targets'

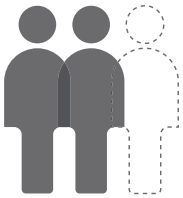


Source: Audit Wales call for evidence

Barriers, opportunities and interesting practices on decarbonisation

50 We asked public bodies about the barriers to achieving the 2030 collective ambition. **Exhibit 18** summarises the barriers they told us about that were largely common across the public sector, many of which are explored earlier in the report. One common theme was that decarbonisation is complex, requiring significant investment and that many of the easy wins had been achieved. However, public bodies were aware that the pace of activity needs to increase and there are reputational risks of not doing so.

Exhibit 18: summary of public bodies' views about barriers to meeting the 2030 collective ambition

Barriers	
Finance 	This was the most commonly mentioned barrier. Bodies pointed to the need for significant and sustained revenue and capital investment in the short and long term. They said there was a particular need for investment in improving infrastructure, estates, appliances and equipment that are not fit for carbon reduction. These matters are discussed further in **paragraphs 29 to 33**.
Staff capacity and skills gaps 	Public bodies told us existing staff capacity is stretched delivering public services. Decarbonisation is a complex area and public bodies feel they do not have the skills and expertise in this area. There is considerable competition for people with specialist expertise and knowledge. Financial constraints make it difficult for some bodies to bring in additional staff. In addition, as the private sector can offer higher salaries, public bodies are at a disadvantage in attracting staff.

Understanding the activities required

Public bodies are still building an understanding of the specific activities that are needed to decarbonise and how these should be prioritised. Public bodies feel that they need additional support and guidance on how to translate the strategic approach into action.

Culture, education and training

Embedding decarbonisation in day-to-day activities can represent a significant cultural shift. Some public bodies told us that decarbonising is complex and it may be difficult to change longstanding approaches to delivery.

Some bodies said there is the potential for staff apathy to having to undertake additional decarbonisation activities on top of the day job. Significant communication with staff will be required to obtain buy in and extensive training will also be needed to upskill staff to deliver.

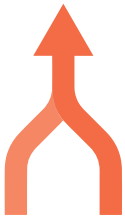
Technology and infrastructure

Many new technologies are expensive and public bodies are cautious about investing due the risks of the technology not being effective or becoming obsolete.

In other areas, such as the development of electric-powered ambulances and fire appliances, public bodies told us the technologies were not developing quickly enough and in some cases were prohibitively expensive.

There were also concerns about a lack of electric charging points and insufficient grid capacity to cope with the growing reliance on electricity.

Supply and demand issues are also a problem in relation to some new technologies, where technologies are sought-after but are limited in supply.

Data 	Public bodies recognised the usefulness of having a common methodology for reporting carbon emissions. However, some responses pointed to concerns over calculation methods, particularly regarding supply chain and land use, and called for further clarity of definitions to ensure consistency. Some responses noted that existing systems were not able to capture the required data, and had to be updated, or new systems had to be put into place. This was often time consuming and resource intensive. NHS bodies raised concerns about duplication with existing reporting arrangements on emissions.
Joined-up approach 	Some respondents told us that a wholesale change of thinking is required, with a more co-ordinated and joined-up approach across the public sector, driven by the Welsh Government. One example given related to the assessment of new and emerging technologies. Public bodies were concerned about investing in technologies that were quickly superseded or were not best practice, so a single public sector-wide decision over what is best would help mitigate this risk.
Third parties 	Third parties have a role to play in helping public bodies move towards the 2030 collective ambition. For example, emissions from partners in the procurement chain, and the high demand for limited specialist resources and newer technologies such as electric vehicles meaning they are often not available. The Office of the Future Generations Commissioner for Wales has recommended previously that public bodies should set out clearly how they have considered the carbon impact of their procurement decisions[11].

Source: Audit Wales call for evidence

11 Office of the Future Generations Commissioner, Procuring well-being in Wales, February 2021.

51 While public bodies identified a range of barriers to achieving the 2030 collective ambition, they also see some opportunities associated with decarbonisation (**Exhibit 19**) and shared with us some examples of interesting practices that they felt other bodies could potentially learn from (**Exhibit 20**).

Exhibit 19: some opportunities that public bodies told us about in relation to decarbonisation

Public bodies highlighted opportunities to:

- build on the profile of climate change from COP26 to take advantage of the raised public awareness and build relationships with local communities and other stakeholders;
- increase collaboration with other organisations, to share best practice in working towards decarbonisation and to develop local procurement approaches;
- increase the use of new and developing technologies, realise cost savings from renewable energies and consider the economic and job creation possibilities arising from new green industries;
- increase awareness of the urgency of decarbonisation with staff, executives, boards and members, and to revise governance and leadership arrangements to ensure decarbonisation is incorporated into everyday business and decision making; and
- build on flexible working practices that arose during the COVID-19 pandemic to further exploit digital technologies in service delivery and everyday working.

Source: Audit Wales call for evidence

Exhibit 20: some examples of interesting practices that other bodies could learn from

Cardiff and Vale University Health Board

The health board is involved in an initiative called Green Health Wales to build a community of healthcare professionals who can share experience with their colleagues across the country. Green Health Wales aims to empower the health and social care sector with the tools and knowledge to address the climate crisis.

The health board has not estimated the cost of net zero building infrastructure on the current estate configuration, however, specialists in 2021 estimated that in a new-build scenario of the University Hospital of Wales and the University Hospital Llandough, the cost of net zero building infrastructure could be between £89 million and £266 million.

Denbighshire County Council

The council established its cross-party Climate Change and Ecological Emergency Working Group after declaring the climate and ecological emergency. A key recommendation from the working group was to amend the council's constitution to include the need to have 'regard to tackle climate and ecological change' in the principles of decision making. The council has now formally committed to consider climate and ecological change when making all council decisions.

Swansea Bay University Health Board

The health board is developing a trajectory tool to measure the impact of different scenarios of financial input into decarbonisation measures. It will use the tool to monitor the efficacy of its decarbonisation measures.

A solar farm is directly connected to Morriston Hospital which supplies 30% of its electricity.

Blaenau Gwent County Borough Council

The council has been involved in establishing a mitigation steering group through the Blaenau Gwent Local Well-being Partnership, and residents' priorities have informed the group's work through the recommendations of the Blaenau Gwent Climate Assembly. The council, in its decarbonisation plan, has identified a number of transition pathways to follow in order to achieve net zero. Each transition pathway represents a coherent area of action with distinct, low carbon technologies, business models and infrastructure. These pathways have been developed to allow each to proceed at their own appropriate pace. Achievement of the pathways is supported by best practice readiness assessments adapted from tools developed by Place-Based Climate Action Network for Leeds Climate Commission.

Rhondda Cynon Taf County Borough Council

The council has established a 'Let's Talk' engagement website where members of the public can leave comments and ideas about a range of climate change matters.

Natural Resources Wales (NRW)

NRW's Carbon Positive Project, part funded by the Welsh Government to show leadership in how the public sector can measure and reduce its carbon impact, has informed the development of both the public sector route map and the net zero reporting guide. As part of the project, NRW is taking steps to not just reduce carbon emissions but enhance and protect carbon stored on the land it manages and share its experiences to encourage further decarbonisation in Wales.

Neath Port Talbot Council

The council is collaborating with a private company that specialises in the re-use of waste gases from industrial processes to enable conversion into biofuels. The plan is to deliver a pilot project within Neath Port Talbot which will utilise waste gases from the steel industry. It is anticipated that once fully operational, the plant will generate 30 million gallons of biofuels for use in the aviation industry each year.

The council's Lost Peatlands Project seeks to restore more than 540 hectares of historic landscape and habitat, including peat bogs and pools, heathland, grassland and native woodland.

Numerous public bodies

Several organisations gave us examples of:

- using the new construction or redevelopment of facilities to significantly improve their carbon footprint;
- procurement of low emission vehicles;
- installation of electric vehicle charging points;
- renewable energy generation on site;
- development of operational staff networks; and
- installation of energy efficient heating and lighting systems.

Source: Audit Wales call for evidence

Appendices

1 Audit approach and methods

1 Audit approach and methods

In November 2021, we issued a call for evidence to 48 public bodies, asking questions about their baseline position in achieving the 2030 collective ambition. Most public bodies responded in the period December 2021 to January 2022. We sent the call for evidence to the bodies covered by the Well-being of Future Generations (Wales) Act 2015 at the time. This included all principal councils, fire and rescue authorities, national park authorities, health boards and NHS trusts, and the larger Welsh Government sponsored bodies.

We also sent the call for evidence to the Welsh Ambulance Services NHS Trust, Digital Health and Care Wales, and Health Education and Improvement Wales to ensure we had a more complete picture across the NHS. We also sent the call for evidence to NHS Wales Shared Services Partnership (NWSSP), which is an independent mutual organisation, owned and directed by NHS Wales, that delivers a range of services for and on behalf of NHS Wales. NWSSP is hosted by and operates under the legal framework of Velindre University NHS Trust, which is itself covered by the Well-being of Future Generations (Wales) Act 2015.

We received responses from all bodies that were sent the call for evidence although in a small number of instances not all questions were answered. Where questions were not answered by all public bodies, this is set out in a note to each relevant graph.

To inform our work we held discussions with relevant stakeholders including the Welsh Government, the Office of the Future Generations Commissioner for Wales, representatives of NHS Wales and the Welsh Local Government Association. We also reviewed key documents, including policies and guidance, and other relevant information provided to us by the Welsh Government and other stakeholders.

We did not undertake a detailed review at each of the public bodies. While we have largely relied on what they reported through their call for evidence responses and any supporting documentation, we have also sought to triangulate our findings through discussions with stakeholders and evidence from our wider document and data review. We also shared and discussed our emerging findings at a public webinar held in May 2022. 109 people from outside Audit Wales attended the webinar, representing a range of public, private and third sector organisations.

As stated earlier in this report, the Auditor General has committed to a long-term programme of work on climate change. We have already reported on the decarbonisation efforts of fire and rescue authorities, we have begun to review council decarbonisation action plans and we are preparing a report on flood risk management. Following a recent consultation on our future work programme, we are considering our next steps in relation to auditing actions to decarbonise and to adapt to the changes already happening to our climate.

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AUDIT COMMITTEE

2022/23 INTERNAL AUDIT PROGRESS UPDATE

DATE OF MEETING	04/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
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	

1. SITUATION/BACKGROUND

Internal Audit provides 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 since the previous Audit Committee meeting.

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 Internal Audit reports to be considered for their implications regarding the governance, risk management and control framework within the Trust. Audit Committee to ensure that the recommendations contained therein 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.

2022/23 Internal Audit Progress and KPI Dashboard

Velindre University NHS Trust

20th September 2022

Contents

Executive Summary

Alert / Escalate

KPIs

KPI 4 (Management Response) is RAG rated red. It is reported at 50% (2/2 reports breached the KPI target). This is an improvement from the July 2022 reported position (0%).

Advise

Engagement

Engagement during audit fieldwork has started to improve, although delays have been encountered on two audits (Financial & Service Sustainability and Managing Attendance at Work). We will be undertaking learning exercises in both cases.

We attended the September EMB RUN meeting to further discuss mechanisms to improve engagement. We agreed to:

- provide an Internal Audit Progress and KPI Dashboard report as a consent item for the monthly EMB RUN meetings; and
- attend EMB RUN meetings on a quarterly basis.

At the meeting we also set out our timelines and approach for the 2023/24 annual internal audit planning cycle, which is due to commence in November 2022.

Assure

Progress

Progress is being made on the 2022/23 Internal Audit Plan:

- 4 final reports have been issued;
- 2 draft reports have been issued;
- 3 audits are in progress.

Changes to Annual Internal Audit Plan

There have been no changes to the 2022/23 Internal Audit Plan since the previous Audit Committee (July 2022).

KPIs

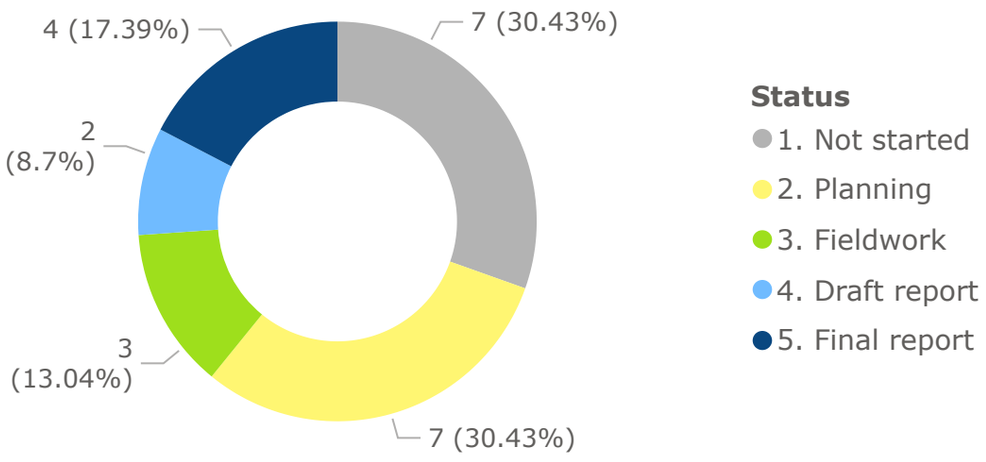
Except for KPI 4 (see alert section), all KPIs are rated green.

Other activities

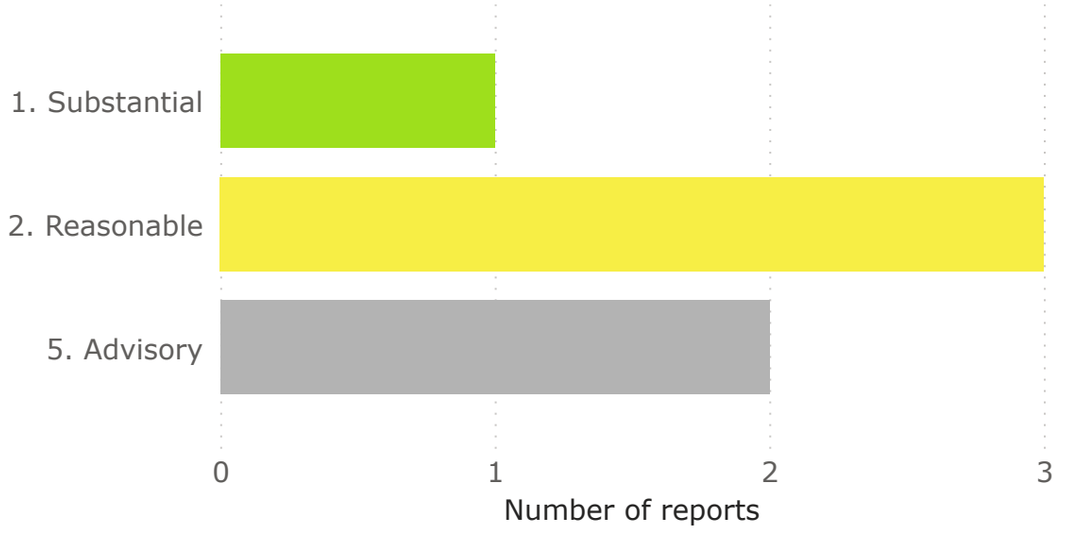
- Regular meetings with the Director of Finance and Director of Corporate Governance
- Planning meetings with various Executive Directors
- Attendance at Trust Board and Committee meetings
- Attendance at the Board Development session on assurance

Overview

2022/23 Audit Status



2022/23 Reports by Assurance Rating (Draft & Final)



Key Performance Indicators

KPI	RAG rating	KPI %	KPI Target	KPI Definition
KPI 1 - Annual Plan		100%	Apr-22	Timely approval of Annual Plan
KPI 2 - Month of Delivery		100%	80%	Review delivered in planned month
KPI 3 - Draft Report		100%	80%	Report turnaround: time from fieldwork completion to draft reporting (10 days)
KPI 4 - Management Response		50%	80%	Report turnaround: time taken for management response to draft report (15 days)
KPI 5 - Final Report		100%	80%	Report turnaround: time from management response to issue of final report (10 days)
KPI 6 - Planned Audit Committee		100%	80%	Report delivered to planned Audit Committee

Reports by Assurance Rating

Substantial Assurance Reports

Audit	Status	High	Medium	Low
Research & Development	5. Final report	0	0	0

Reasonable Assurance Reports

Audit	Status	High	Medium	Low
nVCC Enabling Works (deferred from 2021/22)	5. Final report	0	2	4
Divisional Review (Deep Dive)	4. Draft report	1	3	3
Finance & Service Sustainability	4. Draft report	0	5	4

Limited Assurance Reports

No limited assurance final reports have been issued

No Assurance Reports

No 'no assurance' final reports have been issued

Advisory Reviews

Audit	Status
Staff Wellbeing (Advisory)	5. Final report
nVCC EW Security Contract	5. Final report

2022/23 Internal Audit Plan Progress and KPI Performance by Audit

Audit	Planned Qtr	Actual Qtr	Status	Assurance rating	Assurance RAG	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6
nVCC Enabling Works (deferred from 2021/22)	2	2	5. Final report	2. Reasonable		●	●	◆	●	●
nVCC EW Security Contract	1	1	5. Final report	5. Advisory		●	●	◆	●	●
Research & Development	2	2	5. Final report	1. Substantial		●	●	●	●	●
Staff Wellbeing (Advisory)	2	2	5. Final report	5. Advisory		●	●	●	●	●
Divisional Review (Deep Dive)	2	2	4. Draft report	2. Reasonable		●	●			●
Finance & Service Sustainability	1	2	4. Draft report	2. Reasonable		●	●			●
Digital Health Record	3		3. Fieldwork							
Estates Assurance - Decarbonisation (VT)	2		3. Fieldwork							
nVCC MIM Contract Management	3		3. Fieldwork							
Capital Provision	3		2. Planning							
Clinical Audit (VT)	3		2. Planning							
Cyber Security (VT)	3		2. Planning							
nVCC Enabling Works (2022/23)	3		2. Planning							
nVCC MIM Design & Change Management	3		2. Planning							
Patient & Donor Experience	3		2. Planning							
Quality & Safety Framework	3		2. Planning							
Follow Up (VT)	4		1. Not started							
nVCC MIM Approvals	4		1. Not started							
nVCC MIM Planning	4		1. Not started							
nVCC MIM Procurement	4		1. Not started							
nVCC Validation of Management Actions	3		1. Not started							
Performance Management F/w	4		1. Not started							
Strategic Transformation Assurance	4		1. Not started							

Staff Wellbeing
Final Advisory Review Report
September 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:	VEL-2223-04
Report status:	Final
Fieldwork commencement:	18th July 2022
Fieldwork completion:	15th August 2022
Draft report issued:	22nd August 2022
Debrief meeting:	26th August 2022
Management response received:	13th September 2022
Final report issued:	15th September 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Sarah Morley, Executive Director of OD and Workforce
Distribution:	Susan Thomas, Deputy Director of OD and Workforce Claire Budgen, Head of Organisational Development
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

Increasingly healthcare and other organisations are recognising the importance of staff wellbeing in achieving organisational goals and objectives. Increasing rates of staff absence, often linked to poor levels of wellbeing, have the effect of reducing productivity which itself can lead to reduced levels in quality of care and patient safety and increased costs.

It is widely acknowledged that staff wellbeing is affected by a range of factors and, as such, there is no one identified single metric which provides a workplace wellbeing measure. Rather, organisations will look to levels and trends in factors such as sickness absence from occupational conditions, grievance reporting and wellbeing surveys to gauge the level of wellbeing in their workforce.

Through a programme combining assessments to identify where levels of staff wellbeing are low and the development of interventions to deliver improvements, the Trust is seeking to raise the wellbeing level of its workforce and thereby maximise workforce related productivity.

This advisory review seeks to assist the Trust in this. The scope and objectives are set out in Appendix One and work undertaken in Appendix Two.

We saw the following wellbeing related activity underway within the Trust:

- an agreed People Strategy with a theme around wellbeing;
- a well-developed Healthy & Engaged (H&E) Action Plan linked to the People Strategy objectives;
- formation of the Healthy & Engaged Steering Group (HESG) to oversee the H&E Action Plan and monitor effectiveness of interventions, with well-defined reporting lines/frequency to the Executive Management Board (EMB) and Quality, Safety and Performance Committee (QSP);
- reporting on workforce metrics often used by health organisations to identify wellbeing levels, e.g., absence levels, grievances, feedback from various surveys; and
- implementation of numerous interventions to support improvement in wellbeing in response to the impact of the Covid-19 pandemic and identified trends in absences related to psychological factors.

Areas we consider could be enhanced or strengthened include:

- exploring and developing robust means and measures by which the success or effectiveness of wellbeing interventions will be determined; and
- considering the contents of other standard wellbeing frameworks, models or research which may be beneficial.

Our recommendations are set out in Appendix Three.

1. Introduction

1.1 Velindre University NHS Trust (the 'Trust') has a legal obligation for the general health, safety and emotional well-being of its employees and promoting a healthy and supportive working environment.

1.2 The Trust places a high value on maintaining a healthy and safe working environment for all its employees and recognises its duty of care extends to their mental health as well as their physical health at work. Its recently developed People Strategy (approved by the Board in May 2022) includes a theme and supporting objectives / actions around 'People Wellbeing and Engagement' (theme 1).

1.3 The Trust has developed policies, procedures and initiatives to deliver against its obligations. These mechanisms are concerned with staff wellbeing and stress arising from the working environment. However, it also recognises that an employee's personal life may lead to stress and support and assistance is offered to help an employee whatever the cause of their stress.

1.4 Following the Covid-19 pandemic, the all-Wales review by Audit Wales 'Taking care of the carers' recommended a suite of priority areas that health care organisations should focus on to support staff well-being as the recovery period progresses. The Trust responded with a range of initiatives that it would implement aligned with these recommendations in addition to activity already underway in this area.

Key risks

1.5 The key risks considered in this review included:

a) negative impact on service delivery and patient care;
b) higher levels of staff absence or staff turnover with negative impact on productivity resulting in greater stress on the workforce; and
c) adverse effect on employees' health and wellbeing.

Advisory review

1.6 The overarching objective of the review was to consider the effectiveness of staff wellbeing support and initiatives utilised by the Trust, including throughout the Covid-19 pandemic, and to determine if improvements can be made through consideration of the approaches within other NHS organisations.

1.7 The review involved assessing Trust staff wellbeing development activities in the context of six related areas (see Appendices One and Two).

1.8 This is an advisory review therefore we have not provided an assurance rating. We have however identified learning and provided recommendations to strengthen and improve processes. Our recommendations are set out in Appendix Three.

2. Detailed Review Findings

Area examined 1: The metrics the Trust intends to capture and record to assess the level of staff-wellbeing across the workforce.

2.1 We sought to establish what metrics the Trust uses to monitor and report its level of organisational staff wellbeing and, by comparison with recognised models or standards, assess whether these are appropriate and effective.

2.2 There is no one identified single metric which provides a workplace wellbeing measure. Rather, organisations will look to levels and trends in factors such as sickness absence from occupational conditions, grievance reporting and wellbeing surveys to gauge the level of wellbeing in their workforce

2.3 The Trust captures and reports data for a range of staff related measures (staff turnover, training, PADR compliance, sickness absence, special leave, confidential counselling conversations etc.). Specifically, Trust officers interviewed cited the following as relevant to the wellbeing question and a means by which an organisational wellbeing level is informed:

- sickness absence (numbers and analysis);
- engagement sessions (what people say about wellbeing when asked); and
- staff surveys (responses to wellbeing related questions).

2.4 Going forward, we saw that the organisation's recently agreed People Strategy identifies the following short list of metrics that will be used to measure the success of the strategy deliverables in respect of people wellbeing and engagement:

- positive feedback from staff regarding wellbeing support;
- % of staff recommending the organisation as a good employer in staff survey;
- % sickness absence; and
- % of formal staff grievance cases.

2.5 Additionally, we understand the range and effectiveness of wellbeing interventions within the Trust will be of relevance to the question of the Trust's staff wellbeing level (see more on this later in area examined 4).

Conclusion:

2.6 The Trust captures and monitors a range of staff related activity to assess wellbeing levels. Going forward, the Trust will monitor and report a short list of metrics to measure delivery of the 2022 People Strategy wellbeing theme. Other wellbeing related factors the Trust could consider measuring and reporting are outlined in a later section of this report (see area examined 6).

Area examined 2: The mechanisms by which the Trust will regularly report and scrutinise these wellbeing metrics.

2.7 We sought to establish the mechanisms by which the Trust is to report on wellbeing measures at the corporate level as it develops further this area of activity (our 'Divisional Deep Dive on Managing Attendance At Work' will be reviewing monitoring at a divisional level). Our review took in all the captured and reported staff activity material that might, in broader terms, contribute to an organisational staff wellbeing measure.

2.8 We saw that workforce data (staff turnover, training, PADR compliance, sickness absence, special leave, confidential counselling conversations etc.) is regularly reported to QSP. We noted that commentaries from business leads accompanying graphs and data tables tend to focus on sickness absence trends and their underlying reasons.

2.9 Similar data as above is submitted to Welsh Government each month and to Health Education and Improvement Wales (HEIW) by the Trust and all NHS Wales organisations.

2.10 We noted the Trust conducts its own staff surveys from time to time in which wellbeing questions may be included and participates in the national NHS staff surveys (last conducted in 2020, next planned for late Autumn 2022).

2.11 The recently formed Trust Healthy and Engaged Steering Group (HESG) is responsible for managing, monitoring and reporting wellbeing related and other interventions which have been developed in response to the indicators seen in workforce data and emerging from staff surveys. The HESG will oversee implementation of the Healthy & Engaged Action Plan, which is linked to the People Strategy objectives. It will submit a quarterly highlight report to the EMB.

2.12 The HESG plays a significant role in progressing the various interventions and initiatives (e.g., providing Mental Health First Aiders, providing wellbeing resources and rooms) devised to address the identified factors which are adversely affecting staff wellbeing in the organisation.

Conclusion:

2.13 We noted the broader set of staff workforce data, including that linked to staff wellbeing, is reported through several different mechanisms. Information related to the progress of wellbeing interventions is monitored by the HESG which plays a significant role in progressing these.

Area examined 3: Wellbeing metrics used by other NHS organisations, to identify if there are further metrics the Trust could be utilising.

2.14 We sought to establish what metrics other NHS Wales organisations are using to monitor and report on their staff well-being levels and did so by conducting interviews with officers of six organisations.

2.15 We noted organisations (including the Trust) are similar in their approach to the reporting of staff activity. Workforce activity data collected through the shared ESR system is common to NHS Wales organisations which typically report the same range of metrics (staff turnover, training, PADR compliance, sickness absence, special leave, confidential counselling conversations etc.) internally and externally, although we did not in all cases obtain documentary evidence of this data from the other organisations who participated in the review.

2.16 NHS Wales organisations, the Trust included, periodically conduct their own surveys in which wellbeing questions feature. Several of the other organisations we spoke to pointed to commonly used generic wellbeing assessment frameworks, based around five or six core wellbeing themes, on which their own survey content may be based. This information can then be used by the organisations to identify and direct appropriate interventions to address the issues these surveys reveal.

2.17 Surveys are one source of employee voice and typically staff feedback will be gathered through other activities including wellbeing check-ins, staff networks and focus groups.

Conclusion:

2.18 In our review of other organisation's wellbeing assessment metrics, we did not identify any considered unique to these and which were not being used by the Trust. Generally, we saw a similar range of assessment / monitoring techniques in common usage – workforce data, staff surveys, pulse monitoring, wellbeing check-ins, etc. – across the NHS Wales organisations surveyed.

Area examined 4: The mechanisms the Trust has used to assess the effectiveness of the wellbeing initiatives implemented and action taken to further improve these.

2.19 We sought to establish the mechanisms adopted by Velindre for assessing the effectiveness of its wellbeing interventions.

2.20 We saw in the previous sections the way in which survey and assessment activities within the Trust give rise to interventions and noted the following generic effectiveness assessment mechanisms are being adopted:

Intervention method	Mechanisms to measure effectiveness
Individual counselling	Before and after surveys
Team counselling	Before and after surveys
Provision of on-line tools e.g. 'Work in confidence' confidential on-line counselling, Employee Assistance Programme (EAP)	Pulse surveys of service users Service usage metrics from provider billing
Wellbeing drop-in sessions	Feedback (questionnaire responses and free text comments)
Listening events with leadership and management teams	Feedback (questionnaire responses and free text comments)

2.21 Examples of current interventions and the method by which they currently are being, or are to be measured are recorded in the table below:

Interventions the Trust record in current documents	**How success of intervention will be measured**
Development of physical wellbeing spaces for staff	Room usage
Clinical Psychologist (CP) to support wellbeing	Usage of the services of the CP by staff
Range of mental, physical, financial wellbeing support for staff e.g. Menopause Cafes	Various, including surveys
Employee Assistance Programme/ Work in Confidence providing 24 hour counselling to staff and staff family	Data on the usage of the Employee Assistance Programme is analysed quarterly to identify themes or issues.
Introduction of mental health first aiders	Usage volume/ outcomes.
Counselling services offered via ENFYS	Usage volume.
Wellbeing Pop up events at VCC and WBS (early 2022)	Not stated, but number of attendees would be available.
introduction of an agile working group	Not stated
Work with HEIW in developing and publicising an All Wales Health and Wellbeing resource	Not stated
Mental Health Awareness for Managers Training	Not stated

2.22 We were advised that the HESG monitors progress of these and other interventions and in future will provide update reports to the EMB and QSPC.

2.23 However, we noted the HESG workplan in which interventions current and planned are listed does not specify effectiveness measures. It is not clear whether these have been determined for the interventions listed above, nor whether intervention effectiveness is to be included in the update reports to the EMB and QSP. We noted also that, in some cases, the effectiveness measures proposed do not provide the necessary information to determine intervention effectiveness. For example, usage volumes do not indicate whether an intervention has had a positive impact on wellbeing. See **recommendation 1** in Appendix Three.

2.24 We noted that measurement of the indicators that indirectly reflect the impact of combined wellbeing interventions and other staff engagement initiatives – KPIs around staff turnover, training, PADR compliance, sickness absence, special leave,

confidential counselling conversations, etc. – are included in the monthly Trust-wide WOD performance report to QSP.

Conclusion:

2.25 Options for the measurement of the effectiveness of wellbeing interventions are few and limited mainly to before and after surveys and staff feedback. That said, intervention effectiveness measurement is not, at present, prominent in Trust reporting and may not be sufficiently well defined to effectively assess the impact on wellbeing.

Area examined 5: Mechanisms used by other NHS organisations to assess the effectiveness of wellbeing initiatives, to identify if there are further mechanisms the Trust could be utilising.

2.26 Through interviews, we sought to establish the mechanisms used by other NHS Wales organisations to assess the effectiveness of their wellbeing initiatives and interventions. We did not obtain or review supporting documentation for any of the individual interventions given as examples.

2.27 We noted the Trust and the other organisations examined were using a similar range of metrics and indicators to gauge the level of improvements being achieved through interventions and initiatives, including the following:

- level of sickness absence from occupational conditions;
- number of referrals to Occupational Health due to work related conditions;
- number of employment relations cases;
- national staff survey results;
- periodic wellbeing survey results;
- internal pulse survey results;
- referrals from Occupational Health to the counselling service;
- evaluative feedback from leadership courses;
- feedback from individuals on how helpful the various interventions were;
- reports of usage from the external providers of services (e.g., 'Employee Assistance Programme' (EAP);
- case studies that follow through to outcomes; and
- use of industry standard questionnaires (e.g., WEMWBS for staff who've used services, attended courses, received counselling).

2.28 A number of these are common to all organisations interviewed, the Trust included, but the latter may wish to consider any that it is not currently using.

Conclusion:

2.29 In our review of other organisations' wellbeing intervention measuring and monitoring activity, we did not identify any effectiveness assessment methodologies unique to these. Generally, we saw a similar range of assessment / monitoring techniques in common usage – workforce data, staff surveys, pulse monitoring, wellbeing check-ins, etc. – across the health bodies surveyed.

Area examined 6: Where appropriate information is available, the impact of wellbeing initiatives in other NHS organisations on their staff wellbeing, to identify whether the Trust could be doing anything differently to improve effectiveness.

2.30 Through interviews, we sought to establish whether there were any other lessons that could be learned from the approaches adopted by the other NHS Wales organisations consulted to improve staff wellbeing. Earlier sections of this report have examined the metrics used by others to measure organisational wellbeing levels and the mechanisms used to assess their effectiveness.

2.31 We included in our discussion with other organisations an enquiry on key or notable interventions or solutions that they have adopted to address wellbeing issues. Notable interventions that came out of these discussions are listed below:

- providing access to confidential psychological support;
- providing the 'Work in Confidence' online confidential counselling platform;
- having wellbeing conversation with their staff as part of PADRs;
- development of agile working;
- developing a team-based working model;
- providing psychological therapies (e.g., Cognitive Behavioural Therapy for PTSD); and
- conducting structured discussion forums (e.g., 'Schwartz Rounds').

2.32 Again, a number of these are common to all organisations interviewed, the Trust included, but the latter may wish to consider any that it is not currently using.

2.33 We noted too from our research and discussions with other bodies, that wellbeing frameworks are emerging that consider additional factors such as 'presenteeism' and 'leaveism' (employees continuing to come to the workplace when sick or on leave respectively) where the impact of these harmful practices on the wellbeing of staff are being discussed. The Trust may wish to consider including these factors as it develops its model for the assessment of staff wellbeing going forward.

2.34 Through our discussions, we identified other useful wellbeing resources that could be considered by the Trust to develop this area further:

- What Works Wellbeing: an independent UK body for wellbeing evidence, policy and practice.
- NHS England Health and Wellbeing Programmes: includes a health and wellbeing framework and the concepts of 'Wellbeing Guardians' and 'Health and Wellbeing Champions'.

2.35 Much of what we have considered in this review relates to wellbeing interventions developed to address existing wellbeing concerns. Whilst such mechanisms can also be used to proactively prevent wellbeing from worsening, the Trust may also wish to consider wider actions which can help to prevent work-related wellbeing issues before they arise.

2.36 For example, the recent Kings Fund report – The courage of compassion – investigated how to transform workplaces so staff can 'thrive and flourish'. Whilst the report focused on nurses and midwives during the Covid-19 pandemic, the overarching recommendations are applicable to all staff groups regardless of the circumstances. The Trust may wish to explore the recommendations of this report, which we have summarised in Appendix Four.

Conclusion:

2.37 We noted a range of interventions adopted by other organisations which, where not already doing so, the Trust may consider examining further to ascertain whether its staff too could benefit. See **recommendation 2** in Appendix Three.

Appendix One: Terms of Reference

Scope and Objectives

The outline scope of the review was to consider the effectiveness of staff wellbeing support and initiatives utilised by the Trust, including throughout the Covid-19 pandemic, and to determine if improvements can be made through consideration of the approaches within other NHS organisations.

The review examined the following areas:

Capture of data and analysis of metrics

1. The metrics the Trust intends to capture and record to assess the level of staff-wellbeing across the workforce.
2. The mechanisms by which the Trust will regularly report and scrutinise these wellbeing metrics.
3. Wellbeing metrics used by other NHS organisations, to identify if there are further metrics the Trust could be utilising.

Effectiveness of wellbeing improvement initiatives

4. The mechanisms the Trust has used to assess the effectiveness of the wellbeing initiatives implemented and action taken to further improve these.
5. Mechanisms used by other NHS organisations to assess the effectiveness of wellbeing initiatives, to identify if there are further mechanisms the Trust could be utilising.
6. Where appropriate information was available, the impact of wellbeing initiatives in other NHS organisations on their staff wellbeing, to identify whether the Trust could be doing anything differently to improve effectiveness.

Associated Risks

The key risks linked to staff wellbeing in the organisation considered in this review were as follows:

a) Negative impact on service delivery and patient care;

b) Higher levels of staff absence or staff turnover with negative impact on productivity resulting in greater stress on the workforce; and

c) Adverse effect on employees' health and wellbeing.

Appendix Two: What we did

Our approach was to:

a. undertake interviews with executive directors and other key individuals;

b. undertake a high-level review of documentation related to wellbeing metrics and the Trust's assessment of the effectiveness of wellbeing initiatives; and

c. liaise with key individuals from other NHS organisations to understand their approach to capturing and analysing wellbeing metrics and assessing the effectiveness of wellbeing initiatives.

To achieve this, we undertook a range of review activity including the following:

Interviews with:

- Key Trust staff:
  - Director of OD and Workforce
  - Deputy Director of OD and Workforce
  - Head of Organisational Development
  - People Analytics Manager
  - Application Support Analyst
- WOD representatives from six other NHS Wales organisations

High-level review of:

- Mental Health, Wellbeing and Stress Management Policy
- Trust People Strategy
- Healthy & Engaged Steering Group documents
- Various wellbeing related documents from the six other NHS Wales organisations interviewed
- Audit Wales report 'Taking Care of the Carers'
- Various Trust Workforce reports to QSP
- Various wellbeing frameworks and studies

Appendix Three: Recommendations

Reference	Recommendation
Recommendation 1 (paragraph 2.23)	We recommend that the Trust should fully explore and develop the means and measures by which the success or effectiveness of wellbeing initiatives will be determined. This should be undertaken as part of the planning and approval process for initiatives, prior to implementation. The measures identified should provide the Trust with data that can be used to determine intervention effectiveness as well as intervention usage.
Recommendation 2 (paragraphs 2.31-2.36)	We identified several points that the Trust may wish to consider further to support improvements in staff wellbeing: • wellbeing interventions implemented in other NHS Wales organisations that may not yet have been considered by the Trust – set out in paragraph 2.31; • the inclusion of additional factors in identifying the level of wellbeing within the Trust, e.g., presenteeism and leaveism and their impact on wellbeing; • consideration of useful wellbeing resources used by other NHS Wales organisations, e.g., What Works Wellbeing and NHS England Health and Wellbeing Programmes; and • wider consideration of preventative actions, such as the recommendations set out in the Kings Fund report, The courage of compassion (recommendations summarised in Appendix Four of this report).

Appendix Four: Kings Fund – The courage of compassion

The recent Kings Fund report – The courage of compassion – investigated how to transform workplaces so staff can 'thrive and flourish'. Whilst the report focused on nurses and midwives during the Covid-19 pandemic, the overarching recommendation are applicable to all staff groups regardless of the circumstances. We have summarised the recommendations of the report below.

Key recommendation 1: Authority, empowerment and influence

Introduce mechanisms for staff to shape the cultures and processes of their organisations and influence decisions about how care is structured and delivered.

Key recommendation 2: Justice and fairness

Nurture and sustain just, fair and psychologically safe cultures and ensure equity, proactive and positive approaches to diversity and universal inclusion.

Key recommendation 3: Work conditions and working schedules

Introduce minimum standards for facilities and working conditions for staff in all health and care organisations.

Key recommendation 4: Teamworking

Develop and support effective multidisciplinary teamworking for all staff across health and care services.

Key recommendation 5: Culture and leadership

Ensure health and care environments have compassionate leadership and nurturing cultures that enable both care and staff support to be high-quality, continually improving and compassionate.

Key recommendation 6: Workload

Tackle chronic excessive work demands, which exceed the capacity of staff to sustainably lead and deliver safe, high-quality care and which damage their health and wellbeing.

Key recommendation 7: Management and supervision

Ensure all staff have the effective support, professional reflection, mentorship and supervision needed to thrive in their roles.

Key recommendation 8: Learning, education and development

Ensure the right systems, frameworks and processes are in place for staff learning, education and development throughout their careers. These must also promote fair and equitable outcomes.

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Finance & Service Sustainability: Budgetary Control & Savings Plans

Final Internal Audit Report

October 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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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 the arrangements in place within Velindre University NHS Trust (the Trust) to ensure sustainability of services.

Our 2022/23 review focused on the fundamental processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans.

Overview

The Trust's budgetary control and savings plan processes are generally adequately designed.

We identified several areas where improvement is needed to comply, or demonstrate compliance, with the Standing Orders / Standing Financial Instructions and Budgetary Control FCP. Specific areas requiring management attention are set out in the key recommendations table below.

Our full recommendations are set out 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	Financial Control Procedures (FCPs), including Delegation of Budgets	Reasonable
2	Budget Holder Reporting	Reasonable
3	Budget Monitoring, Escalation & Recovery	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Priority
3.1	Distribution / Acknowledgement of Budget Sub-Delegation Letters	1/2	Operation	Medium
4.1	Timeliness of Budget Holder Reporting	2/3	Operation	Medium
5.1	Plans to Support Realisation of Savings	2	Operation	Medium
6.1	Evidencing Budget Monitoring / Actions to Address Variances	3	Operation	Medium

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

1. Introduction

1.1 Financial and service sustainability is a key area of focus for NHS Wales organisations. We incorporate this area into our annual internal audit plans for the Trust, covering different aspects of governance and control each year.

1.2 Our 2022/23 review focused on the fundamental processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans.

1.3 Future audits in this area will incorporate consideration of medium to longer term financial planning. This will include financial planning to support:

- funding for the Trust's new ten-year Strategy (Destination 2032); and
- the revenue aspects of the Transforming Cancer Services / Velindre Futures transformation programmes.

1.4 The Trust was not in a position for us to formally audit these areas as anticipated at the time of our 2022/23 audit fieldwork.

Key risks

1.5 The risks considered in this review were:

- non-compliance with financial control procedures (FCPs);
- ineffective financial planning and monitoring;
- lack of timely corrective action for unsustainable services; and
- lack of financial scrutiny in decision-making.

Limitations of scope

1.6 Governance of capital funding for the new Velindre Cancer Centre (nVCC, including Enabling Works) is captured in the nVCC Integrated Audit & Assurance Plan. Therefore, it was excluded from this review.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	-	4	4	8
Total	-	4	4	8

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

Audit objective 1: appropriate FCPs are in place for financial management and budgetary control, including delegation of budgets

2.3 The Budgetary Control FCP (the BC FCP) has been recently updated by the Finance team and is due to be approved by the Audit Committee in January 2023.

2.4 We identified that the BC FCP was not readily available to budget holders (BHs), although we note that BHs can request the BC FCP and/or contact their Finance Business Partners (FBPs) as needed should support be required. Additionally, we were informed that targeted and non-targeted BH training is provided (out of scope for this review). See matter arising 1 in Appendix A.

Annual Budget Approval

2.5 The Trust's Standing Orders / Standing Financial Instructions (SO/SFIs) state that the annual budget should be approved by the Board.

2.6 As part of the 2022/23 IMTP, the Board approved the budget deficit reconciliation, which set out the brought forward deficit, budgeted changes in income and expenditure and the carried forward break-even position. The Board did not approve the total income or expenditure figures for the 2022/23 budget. This is consistent with the approach taken in previous years.

2.7 We note that there is inconsistency across NHS Wales organisations in the approach to implementing this aspect of the SO/SFIs. We reviewed the March 2022 Board minutes for nine other organisations, noting five organisations approved the total budgeted income and expenditure figures and four took the same approach as the Trust. Further analysis is shown in figure 1 below.

Approval of total budgeted income and expenditure figures		Approval of deficit reconciliation showing changes in budgeted income / expenditure
Approval of total budgeted figures	Of which includes breakdown of delegation to Directors / Divisions	
5	2	4

Figure 1: analysis of approach to budget approval across NHS Wales

2.8 Whilst the Board did not approve the budgeted income and expenditure figures, our review of Board papers confirmed the Board regularly views this information via the financial performance reports.

2.9 See matter arising 2 in Appendix A.

Budget Delegation to Executive Directors

2.10 We reviewed the 2022/23 budget delegation letters from the Chief Executive to the Chief Operating Officer (divisional budgets), Medical Director (Research & Development budget) and Director of Strategic Transformation, Planning & Digital

(TCS Project Management Office budget). All letters had been returned as acknowledged.

Conclusion:

2.11 We identified two low priority recommendations relating to availability of the BC FCPs and budget approval. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: service areas have sustainable budget plans, with effective monitoring and scrutiny in place; savings plans / arrangements are identified if required to produce a balanced budget

Budget Sub-delegation

2.12 We identified that, except for the sub-delegation from the Chief Executive to the Divisional Directors, budgets were not sub-delegated in writing. Therefore, BHs were not formally asked to acknowledge their budget allocation or their responsibilities as BHs. This is not in line with the sub-delegation requirements set out in the budget delegation letters. See matter arising 3 in Appendix A.

BH Reporting

2.13 BH reports are issued monthly to all BHs. More senior BHs also receive a quarterly, more detailed and in-depth financial performance report. We tested a sample of 25 different BH reports from across the Trust, as set out in figure 2.

	Monthly reports (all 2022/23)	Quarterly reports
Corporate BHs	2 months for 2 BHs	1 report from Q1 2022/23*
Velindre Cancer Centre (VCC) BHs	2 months for 2 BHs	5 reports from Q1 2022/23 (VCC senior BHs did not receive quarterly reports prior to 2022/23)
Welsh Blood Service (WBS) BHs	2 months for 3 BHs	6 reports from across Q3 2021/22 and Q1 2022/23
Total	14 reports for 7 BHs	11 reports for 11 senior BHs

** This report was also one of the month 3 monthly report from our monthly report sample, so is not included in the quarterly report total*

Figure 2: analysis of BH reports reviewed

2.14 Our testing confirmed that the reports contain appropriate information to support budget monitoring activities.

2.15 We noted that BH report content and distribution methods are different between the divisions and FBP. However, we were informed that the Finance team had already identified this and is looking to bring consistency into the reporting process, including the use of automated reporting (e.g., QlikView or Power BI). Therefore, we have not raised a matter for reporting here.

2.16 BH reports are not always issued in a timely manner. For the reports reviewed in our testing (25 individual BH reports per paragraph 2.13 and 6 divisional financial reports per paragraph 2.28), the average timeframe to produce and make reports available to BHs was 16-18 calendar days from the month or quarter end. The

longest timeframe was 34 calendar days from quarter end, although we note this report was produced for a quarterly review meeting, with individuals BH reports already having been distributed. Further analysis is provided in figure 3. See matter arising 4 in Appendix A.

	Calendar days to produce BH reports		Calendar days to make BH reports available	
	From month / quarter end	From close-down*	From month / quarter end	From close-down*
Average time frame	16	8	18	9
Shortest time frame	5	0	9	0
Longest time fame	27	20	34	24

** Close-down is the fifth working day of the month*

Figure 3: analysis of timeframes for production and issue of BH reports (monthly, quarterly and divisional reports)

Savings Plans

2.17 The 2022/23 financial plan contained eleven savings plans totalling £1.3m. Of the eleven, four schemes totalling £500k were classified as non-recurring.

2.18 We selected five savings plans for testing. Whilst we saw evidence of increasing focus and discussion around savings plans at a divisional management team level, we identified that there is limited evidence of:

- detailed discussions on the development of individual savings plans; and
- implementation plans with financial and non-financial actions to support realisation of the savings, as required by the budget delegation letters. Particularly, we tested five savings plans, of which three required implementation plans (the other two were achieved at the outset through budgets, so no plans required). However, only one of the three had a formal action plan in place.

2.19 Without implementation plans, it is difficult to assess whether appropriate action is being taken to realise the anticipated savings. See matter arising 5 in Appendix A.

2.20 RAG-rated financial performance of savings plans is reported to Board and divisional management teams in the financial performance reports. Through review of related papers and minutes, we confirmed that financial performance of the five plans tested above is being reported to the Board.

2.21 One of the five plans tested was RAG rated amber at the time of our fieldwork (the other four were rated green). We were informed that non-recurring opportunities have been identified to offset the potential shortfall (£50k), but there remains a recurring gap to be covered. However, this change to the plan has not been formally documented or approved. See matter arising 5 in Appendix A.

Conclusion:

2.22 We identified three medium priority findings relating to budget sub-delegation, timeliness of BH reporting and savings plans. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: where financial sustainability is not achieved, there is a process of escalation (consistent with the FCP); underlying reasons are investigated, and timely mitigating action is taken

Individual BH Monitoring

2.23 BHs and FBPs should meet monthly to discuss budget variances and agree actions to address adverse variances. However, the meetings are not clearly evidenced (e.g., through notes or action logs) and actions (including responsible individual(s) and timescales) are not formally documented.

2.24 We were informed that some BH meetings had been postponed or not held due to BHs and FBPs being unable to find time to meet. We identified that there is no mechanism to track whether BH meetings take place in a timely manner.

2.25 Whilst BH meetings are not minuted, there is some evidence of variance monitoring and identifying of actions, particularly:

- Board and divisional financial performance reports include narrative on significant variances and mitigating actions; and
- some of the individual BH reports contained notes against individual variances, which sometimes identified actions – in our testing of 25 monthly/quarterly BH reports (per paragraph 2.13), we identified that eight included comments and actions against variances.

2.26 See matter arising 6 in Appendix A.

Divisional Monitoring

2.27 The divisional management teams should receive written monthly financial reports.

2.28 We reviewed a sample of three months financial performance reports and related divisional minutes, identifying that:

Welsh Blood Service – Senior Management Team (SMT)
Due to the timing of the monthly SMT meetings vs the timeframes for producing the WBS finance report, the WBS SMT receives a verbal finance update at its monthly meeting. The report is provided to SMT later in the month. See matter arising 4 in Appendix A.

Velindre Cancer Centre – Senior Leadership Team (SLT)

We were informed that, due to pandemic pressures in the Finance team, VCC SLT did not always receive a written finance report during the pandemic. Verbal financial performance updates should have been provided at SLT meetings. We identified that there was no evidence of financial performance being presented / discussed at the February or March 2022 meetings. However, we were informed by the Finance team that verbal updates were provided an SLT away day during that period.

Through review of the VCC financial reports for months 2 to 4 of 2022/23, we identified that monthly reporting has now returned to business as usual.

We were also informed that VCC SLT had identified the need for more structure in financial reporting at its meetings, so it has incorporated:

- a verbal financial update on the part 1 (early month) standing agenda; and
- the formal financial report on the part 2 (mid-late month) standing agenda.

We confirmed this is now the case through review of the agenda, papers and minutes for the June 2022 SLT meeting.

These issues with VCC SLT financial reporting / monitoring will be considered in the assurance rating for this objective. However, as they had been resolved by the time of our audit, we have not raised a matter for reporting here.

Conclusion:

2.29 We identified one medium priority recommendation relating to evidencing budget monitoring and one low priority recommendation regarding the timing of divisional finance reports. Therefore, we have provided **reasonable assurance** over this objective.

Appendix A: Management Action Plan

Matter arising 1: Availability of the BC FCP (Operation)	Potential Impact / Risk
The BC FCP is not readily available to BHs. It is accessible by the Finance team but is not on the Trust's intranet. We note that BHs can request the BC FCP and/or receive support from their FBPs should the need arise. Additionally, we were informed that targeted and non-targeted BH training is provided (out of scope for this review).	BHs may not be aware of their budgetary responsibilities. Non-compliance with the BC BCP. Poor financial control resulting in overspending.

Recommendations	Priority
1.1 The BC FCP should be made available to all BHs. BHs should be made aware of its location.	Low

Management response	Target Date	Responsible Officer
1.1 Recommendation accepted with the FCP already been made available on the Trust Intranet site. BHs will be informed of its location.	31.10.2022	Head of Financial Planning & Reporting / Head of Business Partnering

Matter arising 2: Budget Approval (Operation)	Potential Impact / Risk
The Trust's SO/SFIs state that the annual budget should be approved by the Board. For the 2022/23 budget (as in previous years), the Board approved a deficit reconciliation showing changes in income and expenditure, rather than the total income and expenditure figures. We note there is inconsistency across NHS Wales application of the SO/SFIs. Of the nine other organisations reviewed, five approved total budgeted income and expenditure figures and four followed the same approach as the Trust (figure 1 in paragraph 2.7 sets out further analysis). Whilst the Board did not approve the budgeted income and expenditure figures, we note that it views this information regularly via the financial performance reports.	Insufficient information to support formal budget approval.

Recommendations	Priority
2.1 The Trust Board should formally consider if it receives sufficient information to approve the annual budget and meet the requirement of the SO/SFIs.	Low

Management response	Target Date	Responsible Officer
2.1 Prior to the development of the 2022-23 budget submission to Trust Board Management will review the SO/SFI requirements with regards to Budget Setting (Section 5.1), taking into account the Responsibilities and Delegation outlined in Section 2.	30.04.2023	Director of Finance

Matter arising 3: Distribution / Acknowledgement of Budget Sub-Delegation Letters (Operation)	Potential Impact / Risk
We reviewed the 2022/23 budget delegation process, identifying that, except for the sub-delegation from the COO to the Divisional Directors, budgets were not sub-delegated in writing beyond the above Directors. Therefore, BHs were not formally asked to acknowledge their budget allocation or their responsibilities as BHs, although we were informed that the month 1 budget packs are shared with BHs and there is opportunity for BHs to discuss anything they do not agree with.	BHs may not be aware of their budgetary responsibilities. Non-compliance with the BC BCP. Poor financial control resulting in overspending.

Recommendations	Priority
3.1 Budget sub-delegation letters should be formally issued and acknowledged by all BHs, in line with the sub-delegation requirements of the budget delegation letters.	Medium
3.2 The Trust should consider including timeframes for the issue and acknowledgement of delegation letters within the BC FCP.	Low

Management response	Target Date	Responsible Officer
3.1 The BC FCP requires both Directors via chief Executive and Divisional Directors via the Chief Operating Officer to formally acknowledge the delegation with letters issued. There is flexibility for further sub-delegation with budget packs issued to BHs. Formal acknowledgement of sub-delegation to all BH's however will be incorporated as a requirement from next year.	30.04.2023	Head of Business Partnering / Head of Financial Planning & Reporting
3.2 Management will review and update the FCP to include timescales for DECL letters being sent and expected acknowledgement of receipt and acceptance in line with Budgetary Delegation expectations set in Section 5.2 of the SO/SFIs.	30.01.2022	Head of Financial Planning & Reporting

Matter arising 4: Timelines of Budget Holder Reporting (Operation)	Potential Impact / Risk
BH reports are not always issued in a timely manner. The average time for producing and making available the BH reports we tested (25 individual BH reports and 6 divisional financial performance reports) was 16-18 calendar days from the month end (eight to nine days from close-down). The longest time taken was 34 calendar days from quarter end (24 days from close-down), although we note this report was produced for the quarterly review meeting, with individual BH reports already having been distributed. Figure 3 (paragraph 2.17) provides further details. Due to the timing of the monthly WBS SMT meetings vs the timeframes for producing the WBS finance report, the WBS SMT receives a verbal finance update at its monthly meeting. The report is provided to SMT later in the month. VCC has recently formally added the written finance report to its part 2 (mid-late month) agenda.	Adverse variances not detected and acted upon in a timely manner. Poor financial control resulting in overspending.

Recommendations	Priority
4.1 The Trust should ensure BH information is issued in a timely manner. Inclusion of reporting and BH meeting timeframes in the month-end financial timetable may support this.	Medium
4.2 The Finance Team should liaise with the divisions to ensure the divisional management team meetings receive and consider written finance reports.	Low

Management response	Target Date	Responsible Officer
4.1 Management acknowledges some occurrences of delayed reporting due to temporary resource issues, however regular reports and meetings do take place. Timeframes to be included and adhered to within monthly timetable, with formal confirmation and records of completion.	31.10.2022	Head of Business Partnering
4.2 Verbal updates have been provided on occasion due to timing issues. Management will ensure that written reports are available to Divisional Teams and will be retained in the records of SMT meetings.	31.10.2022	Head of Business Partnering

Matter arising 5: Plans to Support Realisation of Savings (Operation)	Potential Impact / Risk
We selected five savings plans for testing. Whilst we saw evidence of increasing focus and discussion around savings plans at a divisional management team level, we identified that there is limited evidence of: • detailed discussions on the development of individual savings plans; and • implementation plans with financial and non-financial actions to support realisation of the savings, as required by the budget delegation letters. Particularly, we tested five savings plans, of which three required implementation plans (the other two were achieved at the outset through budgets, so no plans required). However, only one of the three had a formal action plan in place. Without implementation plans, it is difficult to assess whether appropriate action is being taken to realise savings, although we confirmed that financial performance of savings plans is reported to Board and divisional management teams. One of the five plans tested was RAG rated amber at the time of our fieldwork. We were informed that non-recurring opportunities have been identified to offset the potential shortfall (£50k), but there remains a recurring gap to be covered. However, this change to the plan has not been formally documented or approved.	Anticipated savings may not be realised. Challenge to achieving a balanced position due to non-achievement of savings.

Recommendations	Priority
5.1 The Trust should develop clear implementation plans (or an appropriate alternative dependent upon the savings plan) for its savings plans. The implementation plans should: • cover financial and non-financial actions, including timescales and responsible individuals; and • be monitored at an appropriate forum (plan dependent) within the Trust. Significant changes to savings plans should be formally approved at an appropriate level within the Trust, and the related implementation plan updated accordingly.	Medium

Management response	Target Date	Responsible Officer
5.1 Accountable leads and associated actions plans to be reported at monthly Divisional SMT's and / or Executives with a review of actions required to deliver the plans on time. Assurance to the Trust Board will continue to be provided via established financial reporting mechanisms, whereby the Finance Report includes details of any corrective actions required as a result of savings plans reviews at Divisional or Corporate level.	31.10.2022	Head of Business Partnering /Head of Financial Planning &Reporting

Matter arising 6: Evidencing Budget Monitoring / Actions to Address Variances (Operation)	Potential Impact / Risk
We identified that: • BH meetings are not clearly evidenced (e.g., through notes or action logs); and • action plans to address adverse variances (including responsible individual(s) and deadlines) are not formally documented. We note that there is some evidence of variance monitoring and actions in some BH reports (8/25 tested) and narrative on variances is included in the Board and divisional financial reports. We were informed that some BH meetings had been postponed or not held due to BHs and FBPs being unable to find time to meet. We identified that there is no mechanism to track whether BH meetings take place in a timely manner.	Adverse variances not detected and acted upon in a timely manner. Poor financial control resulting in overspending.

Recommendations	Priority
6.1 The Finance team should: • ensure BH meetings are evidenced with notes/action logs; • track whether BHs and FBPs are meeting in a timely manner (see also recommendation 4.1); and • ensure actions to address adverse variances are clearly identified and trackable, including responsible individuals and timescales. We can provide the Finance team with example templates used elsewhere for BH meeting notes / actions if required.	Medium

Management response	Target Date	Responsible Officer
6.1 Management notes that Budget Holder and FBP capacity has occasionally been limited during the COVID recovery period due to operational pressures on the service. Management will schedule and formally record meeting attendance and note reasons for non-compliance. Notes and actions are taken with examples provided during the audit. Actions and escalations will be formally logged in a consistent manner across all Divisions. Enhancement and consistency of budget reporting to be picked up as part of Divisional team review/ PADR.	31.10.2022	Head of Business Partnering / Head of Financial Planning & Reporting

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Research and Development
Final Internal Audit Report

September 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

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Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Rhian Gard, Principal Auditor
Executive sign-off:	Jacinta Abraham, Medical Director
Distribution:	Edwin Massey, Deputy Medical Director Sarah Townsend, Head of Research & Development (Trust) Peter Richardson, Head of Quality & Assurance (WBS)
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.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 prepared for the sole use of 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

To provide assurance that there are effective systems, processes and governance in place around the Velindre University NHS Trust (the Trust) research and development (R&D) function, including partnership working.

We focused on R&D falling under the Health and Care Research Wales definition of NHS research.

Overview of key findings

No matters were identified for reporting during our review.

Full details of our findings can be seen in section 2.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance trend:

2017/18 (follow-up)
Reasonable assurance

2017/18 (full scope)
Limited assurance

Assurance summary[1]

Assurance objectives		Assurance
1	Procedures, Processes and Strategy	Reasonable
2	Governance Framework	Substantial
3	R&D Organisational Arrangements	Substantial
4	R&D Projects	Substantial

The Trust's new Strategy – Destination 2032 – contains a strategic goal of being "a beacon for research, development and innovation" in the Trust's stated areas of priority. Significant effort has been made to transform R&D within the Trust in support of this goal, including:

- developing and implementing effective R&D procedures, including clearly defined roles and responsibilities;
- developing and implementing an effective R&D governance framework;
- good partnership working and engagement with stakeholders across many different organisations; and
- well-regulated and managed R&D projects which are monitored robustly.

The positive outcome of our review is a result of the focus and work undertaken by the Trust, in particular the Medical Director, Head of Research and Development, Head of Innovation and research and development staff throughout the Trust.

[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 sought to provide the Trust with assurance regarding the effective management of R&D within the Trust, focusing on NHS research.

1.2 Research and development are essential for the advancement of healthcare and wealth creation through the development of intellectual property. All NHS R&D in Wales is overseen by Health and Care Research Wales (HCRW).

1.3 The Trust's R&D function is a corporate function. It takes a lead in ensuring that research falling under the HCRW definition of NHS research is conducted and managed to high scientific, ethical and financial standards. Additionally, it provides support for the non-NHS research led by the Welsh Blood Service (WBS).

1.4 The key risks considered in this review were:

- the R&D function is not meeting the Trust's or HCRW's strategic objectives;
- financial and reputational risk to the Trust if research projects are taking place without proper permission and authorisation;
- a lack of governance arrangements resulting in poorly governed research; and
- insufficient resource, training, knowledge and competency arrangements within the Trust resulting in poor quality R&D.

2. Detailed Audit Findings

Audit objective 1: The trust has robust procedures, processes, including an appropriate strategy, which adheres to the principles of good practice in the management and conduct of Health and Social Care research set out by HCRW.

2.1 The Trust has two R&D strategies, one for each division, aligned to the Trust Strategy and reflecting the differing nature of NHS and non-NHS research.

2.2 The Trust has a suite of R&D Standing Operating Procedures (SOPs). As part of the audit, we reviewed nine SOPs across the Trust's R&D function and WBS, a key management approval document and the WBS R&D Quality Manual.

2.3 Whilst we identified some SOPs were overdue for review, the underlying processes remain the same. We were informed that the review was intentionally delayed due to Covid-19 pressures and was underway during our audit (no matter arising has been included due to the review being underway, but the finding impacts the assurance rating for this objective). The R&D function is also writing a Quality Manual.

Conclusion:

2.4 Noting the above, we have provided **reasonable assurance** over this objective.

Audit objective 2: The trust has an appropriate governance framework in place for the management of the R&D function and within the Divisions in the Trust.

2.5 The Trust has a robust R&D governance framework and reporting structure. We reviewed relevant agendas, papers and minutes over the last twelve months and could see detailed R&D reporting going to several forums (including QSPC, SDC, RD&I Sub Committee, RD&I Operational Management group, divisional meetings and Board).

2.6 There appears to be some duplication in reporting. However, the Trust is aware of this, and work is ongoing to develop a streamlined integrated R&D performance report with clear alignment to the strategies and IMTP.

2.7 There is strong stakeholder engagement and partnership working taking place throughout the Trust itself and with other NHS organisations and academia. This is evidenced by the awards won by the Trust for joint research projects.

Conclusion:

2.8 Noting the above, we have provided **substantial assurance** over this objective.

Audit objective 3: There are appropriate organisational arrangements in place for the management of the R&D function and within the Divisions in the Trust.

2.9 As part of the audit, we reviewed the organisational chart for the Trust's R&D function and the committee reporting structure and can confirm there is an appropriate level of scrutiny and challenge over R&D through the various forums it is reported to. We can confirm this from our review of Committee, group and Board minutes of the forums mentioned previously. Representatives from the R&D function and WBS regularly attend R&D forums to ensure there is joined up working and on-going communication between the two teams. This will be further enhanced by the appointment of the Head of Innovation for the Trust who will work closely with the Head of R&D in the Trust R&D function.

2.10 We were informed that the R&D function is in the process of undertaking a workforce review to identify the effectiveness of working arrangements and any improvements needed. The WBS R&D team works closely with the WBS Quality Assurance function to ensure good management of research and innovation.

Conclusion:

2.11 Noting the above, we have provided **substantial assurance** over this objective.

Audit objective 4: All R&D Projects in the Trust are appropriately peer and risk reviewed, approved and comply with research governance standards and statutory requirements.

2.12 At the time of our audit, there were 299 research projects registered on the HCRW/Trust portfolio management system and 12 non-NHS studies in WBS. We tested a sample of 23 NHS research projects across both divisions (22 for VCC and 1 for WBS).

2.13 As part of the testing, we reviewed evidence to demonstrate key aspects of the project approval process had been followed. We did not identify any exceptions in our testing.

Conclusion:

2.14 Noting the above, we have provided **substantial assurance** over this objective.

Appendix A: Assurance opinion rating

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.

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New Velindre Cancer Centre Development: Enabling Works

Final Internal Audit Report

September 2022

Velindre University NHS Trust

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

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Executive sign-off:	Steve Ham, Chief Executive Officer
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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.

Executive Summary

Purpose

The audit sought to determine the adequacy of arrangements in place at the Enabling Works project, forming part of the wider new Velindre Cancer Centre (nVCC) project; and considered the period from May 2021 to June 2022.

Overview

Reasonable assurance has been determined in this area.

Robust arrangements were in place to support project activity, including management of the FBC development process, operation of working groups (including planning and design/construction activities), contractual arrangements and stakeholder engagement.

Appropriate scrutiny had been applied to those contracts where variation to value was required; and this process needs to be maintained as the project progresses to effectively manage within the approved funding envelope.

Matters requiring management attention are within the detail of the report, including those requiring consideration at future projects / the wider TCS programme (recognising the opportunity for implementation at the Enabling Works project has passed).

Whilst some of the matters are currently assessed as low priority, they are not unimportant, and the risk assessment would change if not addressed by management.

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	Business Case Development	Reasonable
2	Governance	Reasonable
3	Appointment & Contracting	Substantial
4	Financial Reporting	Substantial
5	Planning Applications	Reasonable
6	Stakeholder Engagement	Reasonable

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

Project Performance – against key delivery objectives

Time

Minor delays noted during the FBC development and approval process but not deemed to significantly impact anticipated completion (July 2023), or the wider nVCC delivery programme.

This will continue to be monitored as planning approvals are sought and related works are completed e.g., utilities and Asda.

Cost

Whilst the value of required works at some contracts has increased from the original award, this has been managed within existing approvals with the project reported to be progressing within budget at the time of review.

Quality

No issues to report. Noting the early stage of construction activities, at the time of the audit, performance of the contractor and advisers will be reviewed as part of the agreed Integrated Audit Plan for 2022/23

Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
2.1	The Project Board should receive an update on the Gateway 3 recommendations.	1	Operation	Low
3.1	The Project Initiation Document should be updated for the delivery of the construction phase.	2	Operation	Low
4.1	The risk register should be enhanced to reflect the risks to the Trust in delivering the Enabling Works if MIM procurement is not successfully concluded.	2	Operation	Low
5.1	Single Tender Actions should be reported accordingly to Audit Committee.	3	Operation	Low

Future Assurance Matters[2]		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Project Boards should receive assurance on the progress of business case development.	1	Operation	Medium
1.2	Project Boards should be appropriately involved in the endorsement of business cases.	1	Operation	Medium

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

1. Introduction

1.1 This audit formed a part of the 2021/22 Integrated Audit Plan and has sought to determine the adequacy of arrangements in place at the Enabling Works project, forming part of the wider new Velindre Cancer Centre (nVCC) project.

1.2 The audit covered the period from May 2021 to June 2022, which incorporated the development of the Full Business Case, site clearance works and preparation for commencement of the main works.

1.3 The key risks considered in the review were:

- The business case was not produced in a timely manner or was inadequate to define the case for change.
- Governance arrangements do not support effective decision making, contributing to poor project management and the failure to achieve project objectives.
- Contractual documentation does not protect the interests of the Trust and / or inhibits the achievement of the key objectives of the project.
- Project costs have not been adequately controlled leading to failure to achieve project objectives.
- Site related issues have not been appropriately addressed; and
- Stakeholders have not been appropriately informed, leading to challenge and risk of delay to the wider project programme.

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

Business Case Development: Assessment of the adequacy of arrangements to develop the component elements of the business case including resource, structures, monitoring and reporting; and assurance that scrutiny comments have been adequately addressed.

2.1 A development plan for the FBC, setting out key targets for the five individual elements of the business case (Strategic, Economic, Commercial, Financial and Management) and the overall business case, was presented to the Project Board in June 2021.

2.2 The development process was coordinated by the Assistant Project Director (Commercials & Finance), with support from Senior Project Managers and the wider project team (including external advisers). An activities log was utilised to coordinate the supporting activities required to facilitate the completion of each individual case to the pre-determined deadlines.

2.3 The key deadline was for approval by Trust Board – this was received on 30 September 2021, although this was a delay to the targeted date of 7 September.

2.4 The Delegations Framework requires endorsement and approval at the various reporting stages including Project Board, Programme Delivery Board and Scrutiny Committee. This was evident for the latter two, however, due to slippage against target delivery dates, the FBC was not completed in time for its scheduled submission, for endorsement, to the Project Board on 15 September (against the original planned date of 31 August) (**MA1**).

2.5 Further, through attendance at Project Board, it was noted that updates on progress against the FBC development plan, or potential risks to the achievement of agreed targets for completion and approval were not received (**MA1**).

2.6 Following submission of the FBC to Welsh Government, a Gateway 3 review was undertaken in November 2021, with an Amber/Green rating determined. Whilst the Project Board was updated as to the outcome of the review, a subsequent update has not been evidenced, to provide assurance that the agreed recommendations were appropriately discharged (**MA2**).

2.7 In addition to the above, FBC scrutiny comments were received and addressed, with WG approval given on 18 January 2022.

2.8 Noting the above, **reasonable assurance** has been determined in this area.

Governance Arrangements: Assurance that governance arrangements have been adequately defined and enacted; and that roles and responsibilities have been clearly defined and updated as the project / programme progresses.

2.9 The Enabling Works project is one of the seven projects that form part of the overarching Transforming Cancer Services (TCS) Programme.

2.10 Governance arrangements are largely shared with the nVCC project, including the allocation of key roles and the lines of reporting. These arrangements have recently been audited with a conclusion of substantial assurance (*MIM Governance, issued February 2022*).

2.11 A dedicated Project Board operates for the Enabling Works project, with the same membership as that for the nVCC Project Board (with both project boards meeting on the same day).

2.12 A Project Initiation Document (PID), and terms of reference for the Project Board, were in place. However, the PID required updating for the current project phase (**MA3**).

2.13 Project Board meetings, for the period July 2021 to May 2022, were held monthly; except for February and March 2022 due to the focus on the nVCC competitive

dialogue process. The Programme Delivery Board continued to meet during the period, with reporting and decision-making taking place, as required, at that forum.

2.14 The Project Board was observed to operate as required by its terms of reference, with each meeting achieving quoracy. Meeting agendas comprised of suitably detailed papers on key matters to inform scrutiny and decision-making (however, ref ***para 2.5***, **MA1**).

2.15 Whilst quorate, it was noted that the Project Director was absent from three of the eight meetings reviewed. However, the Project Board has acknowledged the issue of competing priorities, with attention given to protestor action, on those occasions.

2.16 The robust reporting of project risks was observed, through the above governance structure. On review of the risk register, noting the next phase of the programme, risks associated with the progression of the MIM and impact of the delivery of the Enabling Works project should be enhanced (**MA4**).

2.17 Working Groups were operating as defined in the PID, as follows:

- Construction Delivery Team.
- Asda Technical Group; and
- Planning Group.

2.18 Each group had an appropriate membership (including Trust project team members, external advisers and third-party partners/contractors as required), with regular meetings taking place to manage delivery. Working Group activity was managed centrally via the Critical Milestones Log, bringing together key targets and issues from each working group.

2.19 Noting the above, **reasonable assurance** has been determined in this area.

Appointment and Contracting: Assurance that the process to appoint the preferred contractor (Design & Build) and advisers accorded with local and national requirements; that appropriate contractual arrangements have been put in place; and that adequate monitoring / reporting of outputs against plans and agreed fee schedules is demonstrated.

2.20 The following contracts in place at the Enabling Works project were selected for audit review:

Contract	Contract Value	Procurement Method
Project Management & Design services[1]	£788,468	Framework (competition)
Site Clearance: Vegetation	£119,869	Single Tender Action

Site Clearance: Trees	£325,561	Single Tender Action
Design & Build	£9,247,518	Framework (competition)
Utilities installation[2]	£2,006,986	Single Tender Action
Filming Services	£7,700	Quotation exercise

[1]The procurement and award of this contract was previously reviewed in the nVCC 2020/21 Advisers audit (report issued April 2021: reasonable assurance). The current audit has focused on the execution of the formal contract, which took place during this period of review.

[2]The contract for these works had not been finalised at the time of review. Therefore, only the Single Tender Action authorisation was reviewed.

2.21 Appropriate controls were evidenced at the contracts reviewed, including:

- Procurement in accordance with the Trust's Standing Financial Instructions and UK Procurement Regulations, including the appropriate authorisation of Single Tender Actions, where required.
- Appropriate contracts in place in each case; with expert advice sought on the contract option and formulation of the Design & Build contract (including calculation of delay damages).
- Contracts appropriately authorised in line with the Trust's delegated limits; and
- Contracts in place prior to duties commencing; except for the Design & Build and Project Management contracts. In these cases, it is recognised that contracts could not be formally entered into until Welsh Government approval of the FBC was received. Instead, letters of intent were utilised, clearly defining the scope of duties and financial value of the instruction. Upon approval of the FBC, the contracts were addressed in a timely manner. As noted in a previously issued report [*nVCC 2020/21 Advisers audit (report issued April 2021: reasonable assurance)*], letters of intent should only be utilised in exceptional circumstances.

2.22 However, one of the Single Tender Actions reviewed had not been reported to Audit Committee in accordance with the required process (**MA5**).

2.23 Monthly contract management reports have been presented to the nVCC Project Board (noting they cover both nVCC and Enabling Works arrangements), detailing status and fee expenditure against approved contract values. Where the value of required works has increased from the original award, advice has been obtained from NWSSP: Procurement Services to ensure the processes have been compliant with applicable procurement regulations, and approval being sought from Trust Board to vary the contract arrangements, providing confirmation the variation is within budget – a factor which management need to apply reasonable scrutiny as the project progresses.

2.24 At the current juncture of the Enabling Works project, **substantial assurance** has been determined in this area, noting that further work on contract management will be undertaken as part of the 2022/23 audit plan.

Financial reporting: Assurance that the budget is adequately supported by formal approvals; regular cost and cashflow reporting requirements are adequately defined; reporting is sufficiently robust and timely to support effective scrutiny and that cost reports clearly outline assumptions and/or limitations.

2.25 The FBC was approved by WG, with a total funding envelope of £28.1m confirmed (ref ***para 2.7***).

2.26 The cost and cash flow reporting arrangements for the Enabling Works project are aligned with reporting at the main nVCC project; and were reviewed at the *2021/22 Financial Reporting audit (issued June 2022: substantial assurance)* with recommendations made to enhance reporting to Welsh Government.

2.27 **Substantial assurance** has therefore been determined in this area.

Planning Applications: Assurance that a strategy is in place to monitor and progress any known planning conditions (i.e., licence arrangements); that appropriate planning approvals have been sought; and that professional advice (including legal advice), where applicable, has been obtained to support the process where applicable.

2.28 The development of the nVCC site includes a number of complex planning and licence requirements, which require active management by the project team to ensure applications are granted and conditions are discharged in a timely manner.

2.29 A specialist planning adviser has been appointed to work with the Trust in the delivery of the Enabling Works, to advise and assist with the management of the required permissions. Specialist legal advice has also been obtained where required.

2.30 A robust process for the management and oversight of planning requirements was evidenced, including fortnightly meetings with the advisers, and regular reporting of progress, issues, and risks to the Project Board. Key decisions affecting the project have been reported to and approved at Trust Board level.

2.31 Recognising the complexity of requirements, including the need for timely linkage with Cardiff City Council (CCC) and their planning processes, at the date of reporting the Trust was in the process of developing a Planning Performance Agreement (PPA) with CCC.

2.32 The PPA encompasses both the Enabling Works and wider nVCC requirements and aims to enable CCC, and the Trust, to agree the processes and programme for preparing, assessing, and determining planning application(s), subject to

appropriate timescales that have been agreed. These will be regularly reviewed by the parties involved, including reporting to the Project Board.

2.33 Whilst recognising the robust arrangements operating to manage the complex planning requirements, as expected with the project programme, a number of permissions remain to be secured/discharged. The reliance on external decision-making parties means progression in line with the determined programme is not entirely within the control of the project team. This has been appropriately reflected at the project risk register and is therefore monitored and reported via the risk management process. Noting any delays in this area may significantly impact the Enabling Works (and wider nVCC) timetable, **reasonable assurance** has been determined in this area. Assurance would increase once all required permissions are in place.

Stakeholder Engagement: Assurance that there has been appropriate engagement with key stakeholders both internal and external to the Trust.

2.34 The project's stakeholders have been appropriately identified and documented within the FBC and PID.

2.35 The Communications & Engagement plan included within the FBC provided a detailed analysis of stakeholders, including their level of interest in, and influence on the project. This document also presented the project's Engagement strategy and plan (however, ref ***para. 2.38***).

2.36 Communications and Engagement updates have been routinely presented at all stages of the governance framework for the period reviewed, addressing engagement activity within the period (across the range of identified stakeholders including the public / local community), progress towards previously agreed targets and future plans.

2.37 The November 2021 Gateway 3 review (ref ***para 2.6***) made a recommendation regarding stakeholder engagement, as follows:

"With the project facing ongoing opposition and given the compressed delivery timeline for the project, the project communications and engagement strategy should be reviewed to ensure it is suitable to support the commencement of site preparations. Alongside, a comprehensive plan should be developed to align with the key milestones for this phase and to identify the activities and the resources required to deliver these."

2.38 Whilst specific communications plans have subsequently been presented to the Project Board (e.g., in relation to the injunction process), the recommended exercise for the overall project has not yet been evidenced (see **MA2**).

2.39 Noting the above, **reasonable assurance** has been determined in this area.

Appendix A: Management Action Plan

<table>
<tr><th colspan="2">Matter Arising 1: Project Board oversight & endorsement of the FBC (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">The Project Board terms of reference states (at section 4.3):

"the purpose of the Project Board is to ensure the effective management of….the delivery of the Business Cases for the nVCC and the Enabling Works..."

Additionally, the nVCC Delegations Framework sets out the route for FBC approval, which includes endorsement at Project Board ahead of endorsement by the Programme Delivery Board and approval at Trust Board. Whilst the latter was achieved, with some slippage from the agreed targets (see table), the former was not evidenced (Project Board papers reviewed from May to August 2022).
<table>
<tr><th>FBC governance milestones</th><th>Target date</th><th>Date achieved</th></tr>
<tr><td>Project Board endorsement</td><td>31 August 2021</td><td>Neither the component cases, nor the full FBC, were presented to the Project Board for review, scrutiny, and endorsement</td></tr>
<tr><td>Programme Delivery Board endorsement</td><td>31 August 2021</td><td>16 September 2021</td></tr>
<tr><td>TCS Scrutiny Committee assurance</td><td>31 August 2021</td><td>21 September 2021</td></tr>
<tr><td>Trust Board approval</td><td>7 September 2021</td><td>30 September 2021</td></tr>
</table></td><td>Potential risk of:

• Non-compliance with delegated responsibilities.

• Insufficient scrutiny and agreement of key documents prior to submission for formal approval.</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>1.1</td><td>Future Assurance

Project Boards should receive routine assurance on the progress of business case development, against agreed targets, and detail of the component cases and full FBC for appropriate scrutiny / endorsement.</td><td>Medium</td></tr>
</table>

1.2	***Future Assurance*** Project Boards should be appropriately involved in the endorsement of business cases, in accordance with agreed delegations frameworks / project plans.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed. The Project will ensure that routine progress reports will be provided to the Project Board(s) to provide assurance on the business case development. The nVCC Project will be completing the nVCC FBC by Winter 2023 and so from October 2022, will provide a progress report to the monthly nVCC Project Board.	From October 2022 to February 2023	Project Director at applicable projects
1.2	Agreed. The Project Team and Business Case Lead always endeavours to involve the Project Board in endorsing the business case where timings allow. The key priority is to ensure the achievement of Trust Board approval dates. Project Plans always include a date for Project Board to endorse the business case.	At future projects	Project Director at applicable projects

Matter Arising 2: Gateway Review Recommendations (Operation)	**Impact**

The OGC Gateway 3 review "*Investment Decision"* was undertaken in November 2021 and determined an Amber/Green rating (defined as: "*successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery").*

The report made the following five recommendations, however, there was no evidence of status update (ref 3 – 5) being reported to an appropriate forum:

Ref	Recommendation	Target completion date	Audit observation
1	*The Project Director should review all identified benefits for the EW and nVCC projects to ensure any opportunities to enhance the current benefits profiles are maximised.*	*For FBC submission*	*Actioned: reviewed ahead of FBC submission to WG*
2	*The SRO should ensure the scrutiny process is concluded without delay and the FBC is submitted to the Infrastructure Investment Board (IIB) as planned.*	*For FBC submission*	*Actioned: FBC was submitted to the IIB on 25 November 2021.*
3	*Project Director to ensure the communications and engagement capability is fully aligned to project needs and is resourced to ensure strategic oversight, horizon scanning and day to day activities can be completed.*	*End December 2021*	*Management confirmed additional resource was appointed (Project Support Officer) as well as Senior Project Managers being a key link on all communication matters.*
4	*The SRO should satisfy himself that the governance mechanisms demonstrate best practice.*	*End December 2021*	*No evidence available to confirm this had been addressed.*
5	*The SRO to discuss the replacement of the Project sponsor at Welsh Government with the newly appointed CEO of NHS Wales/DG Health and Social Services.*	*As soon as feasible*	*Management confirmed this was undertaken noting it took some time for the replacement WG Project Sponsor to take up their role.*

Potential risk of:

- Failure to address identified areas for improvement in a timely manner.
- The Project Board does not receive sufficient information to fulfil its scrutiny role.

Recommendations			Priority
2.1	For completion, the Project Board should receive an update on the status of the Gateway 3 recommendations.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed. The EW Project will provide an update report at the EW Project Board in September 2022, confirming that all actions have been completed.	September 2022	Assistant Project Director

Matter Arising 3: Project Initiation Document (Operation)			**Impact**
The current version of the Project Initiation Document (PID) (version 11) was last updated in March 2021. It was therefore out of date in terms of current timescales and detail regarding the construction phase. The Project Manager advised the document was due to be reviewed shortly. The PID should be updated at key project junctures to ensure it remains a "live" project tool for project team members.			Potential risk of: • The PID cannot act as a useful "live" document to inform project team members.
Recommendations			**Priority**
3.1	The PID should be updated for the delivery of the construction phase.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed. The Project will update the PID for the delivery of the construction phase. This will be presented to the EW Project Board in October 2022.	October 2022	Senior Project Manager

Matter Arising 4: Risk Register (Operation)			**Impact**
A combined Programme risk register is maintained, across the seven TCS projects (including Enabling Works and nVCC). Risk R225 (impacting both the EW and nVCC projects) references cancellation of the project as both a reputational and political risk, owing to stakeholder decision making processes. This has not been expanded to reflect the potential risks in the nVCC MIM procurement process, which may impact the Enabling Works project. For example, should the MIM process fail to secure an Economic Operator and the nVCC project cannot progress as planned; the Enabling Works will have been delivered to no benefit. Whilst the financial risk of this would largely be borne by Welsh Government, it would pose a significant reputational risk to the Trust.			Potential risk of: • Potential risks are not appropriately identified and monitored.
Recommendations			**Priority**
4.1	As part of the forthcoming scheduled review of the risk register (for the current juncture of the project), it should be enhanced to reflect the risks to the Trust in delivering the Enabling Works, if the MIM procurement is not successfully concluded.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed. The risk register will be reviewed to reflect the risk to the Trust. This will be presented o the EW Project Board in September 2022.	September 2022	Assistant Project Director

Matter Arising 5: Single Tender Action reporting to Audit Committee (Operation)	**Impact**
All Single Tender Actions (STAs) are reported to Audit Committee by the Executive Director of Finance, via the Procurement Compliance Report. The report provides assurance that Standing Financial Instructions have been complied with during the reportable period and enables the Committee to scrutinise the detail of individual awards, should it wish. A sample of contracts in place at the project were reviewed (ref para 2.30), with three having been awarded via STA. Of the three STAs reviewed, two fell into the period reported to the May 2022 Committee. However, only one was observed in the report (vegetation clearance, £120k). The STA for the tree clearance works (£325k), was not included. The reporting of the third STA (for the utilities award), was not yet due at the time of review.	Potential risk of: • Formal Committee processes not applied. • Scrutiny function reduced.

Recommendations		**Priority**
5.1	Single Tender Actions should be reported to Audit Committee in a timely manner.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Agreed. The reporting of STAs is a corporate finance function but the Project will ensure that all relevant STAs are reported to the Audit Committee. This will be recorded on the Contracts Register. The Project will ensure that the Tree Clearance STA is reported to the next Audit Committee.	Tree clearance STA: to the next Audit Committee Ongoing for future STAs	Assistant Project Director in conjunction with Director of Finance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

NHS WALES
Velindre University NHS Trust

Counter Fraud Progress Report
20/06/2022 - 09/09/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Velindre NHS Trust in relation to the second period of reporting for the year 2022-2023. The report covers the period from 20 th June 2022 to 9th September 2022.

The report's format has been adopted in order to update the Audit Committee about counter fraud referrals, investigations, activity and operational issues.

At 9th September 2022, 45 days of Counter Fraud work have been completed against the agreed 110 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness training, and investigating referrals in relation to fraud and financial crime.

This report builds upon the period 1 report that was delivered to Audit Committee on 19 th July 2022 and detailed the work covered to 20th June 2022.

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

TYPE	Days P1	Days P2	Days P3	Days P4
Proactive	15	15 (30)		
Reactive	9	6 (15)		

2. Progress

Staffing

A member of the team has, during this period, applied for a new role within the Counter Fraud Service Wales regional team. They were successful in their application and as a result they will be leaving the Cardiff and Vale Team in early September. Recruiting a new team member will be undertaken as soon as is practicable but it is anticipated that there will, as a result, be a temporary reduction in staffing resource during reporting period 3 of this financial year.
One other member of the team has now received formal notification of their Accreditation as a Counter Fraud Specialist (ACFS) and has subsequently been nominated to the Counter Fraud Authority as a support Local Counter Fraud Specialist for Velindre NHS Trust.

Activity

Infrastructure/Annual Plan

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

a. The maintenance of a comprehensive activity database which is already assisting in maintaining a detailed and accurate record of work undertaken.
b. Review of the Counter Fraud Bribery and Corruption Policy – Velindre NHS Trust have their own Counter Fraud Bribery and Corruption Policy. This requires updating and is currently being reviewed.
c. Review of CF digital presence – Fully functional, modern, Counter Fraud Intranet site has now been developed and is operational. This is hosted by the Cardiff and Vale University Health Board Share point site but is available to all members of Velindre staff via the link below. This link is publicised and

signposted via the Velindre intranet site and through ongoing publications and messaging such newsletters bulletins and surveys.

(Link to the site for reference : Counter Fraud - Home (sharepoint.com))

d. Counter Fraud e-Learning arrangements – as previously reported work is underway with the LED team at CAVUHB to develop a modern fit for purpose learning site on the All Wales Learning @ Wales Platform. Development of this platform continues and whilst it was aimed that this will be up and running at this point this has been delayed. The reason for the delay is beyond the control of Cardiff and Vale Counter Fraud Team as it awaits the new All Wales eLearning package to be finalised and distributed by the Counter Fraud Service Wales. When complete this will be available to all Velindre NHS Trust staff as a, Counter Fraud, education, learning and awareness tool. It will be signposted internally within the organisation in order that staff can access at the click of a button.

e. New Counter Fraud posters have been designed, developed and printed in high volume by the print team at Cardiff and Vale University Health Board and have now been delivered. The aim is for them to be placed in impactive locations at organisation sites in order to improve awareness and presence. This will be supported by visits from Counter Fraud staff who will be present at sites that will be publicised with the aim of engaging in-person with staff and public. This has historically been an impactive method of engagement and awareness and aims to further an anti-fraud culture throughout the organisation.

Fraud Prevention Notices and IBURN notices

During this reporting period two Fraud Prevention Notices (FPN) have been issued by the NHS Counter Fraud Authority. These have both been issued in relation ongoing attempts Cyber enabled Mandate fraud.

During this reporting period one Counter Fraud Authority intelligence bulletin (IBURN) has been issued. This was issued also in relation to Cyber enabled Mandate fraud.

These documents reinforce the high-risk impact factors that NHS organisations face in relation to this type crime. The documents have been cascaded accordingly as per the dissemination list.

Investigation into the subject matter with NHS Wales shared services partnership Accounts Payable and Supplier Maintenance Teams, and with the Cyber Security team at Digital Health and Care Wales has resulted in the findings that the organisation has **not** had any interaction with the malicious sites and or 'rogue' suppliers that are the subject of these bulletins.

These documents are classified as Official Restricted and as a result the information contained these notices can only be shared with those staff identified in the Handling Information.

Local Alerts/Bulletins

During this reporting period there has been one fraud alert issued. This was issued in relation to a phishing attack directed at overseas nurses. (Appendix 1)

Awareness Sessions

During this reporting period no further awareness sessions have been delivered to Velindre staff.

Efforts underway to roll out further sessions throughout the organisation.

Newsletters

During the reporting period one newsletter has been produced, published and communicated to all staffing groups. (Appendix 2)

Referrals/Enquiries

During this reporting period no referrals have been received in relation to Velindre NHS Trust.

Investigations

At the beginning of this reporting period (20/06/2022) there were two investigations open at Velindre NHS Trust.

These have both now been formally closed.

The first related to an Abuse of Position in relation to charity work by a senior member of staff. No further action was taken in respect of criminal offences. The staff member received a disciplinary sanction by way of a first formal warning following a disciplinary panel hearing.

The second investigation involved a suspected overseas patient receiving cancer treatment funded by the NHS. This matter was formally investigated with the support of external partners from the Passport Office and Borders Agency. The findings of this investigation were that the subject could be deemed ordinarily resident and therefore no offences disclosed and no further action required.

Other

NA

Appendix 1

13 July 2022

Fraud Alert – Scam Text to Overseas Nurses

It has been brought to our attention from a neighbouring Health Board that there have been a number of scam messages being sent to overseas nurses.

The messages are being sent as Text Messages or WhatsApp messages purporting to be from **"Criminal Court Birmingham"**, are showing as having the following number **"0121 681330"** and shows a **"Gov UK"** Logo.

The messages are convincing in appearance, contain genuine information about the recipient and state that the hospital have made an error with tax payments and demanding a payment of £1,500 to avoid arrest and prosecution. A number of members of staff have fallen victim to this.

These are not genuine messages!

If there was an error in tax HMRC would contact you directly via post or alterations would be made by payroll

The Criminal Courts are not involved with tax payments and would not make contact regarding tax matters

Do not make payment if you receive this message

If you have already received one of these messages and made payment please report the matter immediately!

There was a similar incident in 2021 where scammers were using "courts phone numbers" in a tax scam, further details and information from HMCTS can be found HERE.

Counter Fraud Enquiry Form (LINK)

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

Counter Fraud SharePoint Intranet (LINK)

Access our SharePoint Intranet site for further information, useful links and recent news.

CounterFraudEnquiries.CAV@wales.nhs.uk

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Tel: 029218 36265
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Counter Fraud Manager

Nigel Price
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Local Counter Fraud Specialist

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

Appendix 2 (Front)

Counter Fraud Newsletter

July 2022

CAVUHB | Velindre | HEIW | PHW | DHCW

Local Counter Fraud Specialists (LCFS)

Welcome to the July 2022 edition of the Counter Fraud Newsletter

Over the past two months we have set up a new **Counter Fraud Intranet Page** it can be accessed via the link above or the QR code. It is hosted on the Cardiff and Vale SharePoint Platform however is accessible to anyone in NHS Wales.

On the site you will find out more information about your counter fraud team, NHS Fraud, how to report fraud, how to request awareness sessions and useful links. You will also find information about recent cases and investigations. We look forward to your visit.

Topic of the month: Overpayments

Background:

An overpayment case will generally occur when a member of staff leaves the organisation and a termination form is not completed or is completed incorrectly. This results in the now ex-employee continuing to get paid their normal wage when they are no longer working for the organisation. Overpayments can also occur in a number of other situations such as sickness, maternity leave, change in hours etc.

Overpayments result in financial loss to the NHS as the person in receipt of payments is not entitled to the money. Any loss to the NHS has an impact on the service that can be delivered and as a result patient care.

Your responsibilities:

Whilst overpayments are a result of a systematic failing by the organisation it is the subsequent action of the employee that dictates how the matter will be dealt with. It is imperative that you are aware of the Overpayments Policy and your responsibilities. If you do receive an overpayment or suspected over-payment you should contact your manager or the payroll department at the earliest opportunity for it to be looked into.

Outcome:

In an overpayment case where the employee/ex-employee has made contact with the organisation (as soon as possible) then it would be resolved by repaying the money over an agreed time scale.

Counter Fraud Department:

However, if there is a prolonged overpayment / there is suspected to be an element of dishonesty involved / no contact is received from the employee/ex-employee then the matter is referred to the Counter Fraud Team for initial assessment. This can result in a formal investigation and the possibility of being charged with a criminal offence and going to court. Pease turn over to read about a recent case!

Remember: be honest, if you are aware you are being overpaid, tell someone!

Appendix 2

(Rear)

ABUHB — Nurse convicted of Theft at Merthyr Magistrates Court — Overpayment of Salary

As a result of the work of the Local Counter Fraud Team at Aneurin Bevan University Health Board, a former employee has been convicted of Theft at Merthyr Magistrates Court as a result of dishonestly retaining salary overpayments. They are due to appear at Merthyr Crown Court later in July for sentencing.

The former nurse at ABUHB left their position at the health board in November 2020, however, due to a system error continued to be paid until the error was discovered in July 2021. The value of the overpayment was in the region of £21,000.

A subsequent investigation by the Local Counter Fraud Team discovered no attempts had been made by the former employee to contact payroll or management in relation to overpayment. Furthermore it was discovered all of the money had been spent and the nurse was in alternative employment during the time of the overpayment.

This case underpins the importance of staff members alerting payroll/managers to incidents of overpayments in a timely manner.

Cardiff based Pharmacy worker sentenced at Cardiff Crown Court for Fraud

A prescriptions clerk at a Cardiff Pharmacy has been convicted of Fraud and sentenced to 20 weeks in prison (suspended for 2 years), to complete 15 days of Rehabilitation Activity Requirements and to pay a victim surcharge.

The prescriptions clerk became addicted to co-codamol having taken the medication due to suffering chronic pain. Having become addicted to the medication the clerk used their position to create false prescriptions in other peoples names with the intention of taking those medications themselves. The matter came to light after concerns were raised due to one of the medications she was prescribing being out of stock.

A subsequent referral and investigation by the Counter Fraud Team at Cardiff and Vale found there to be 199 false prescriptions over a period of 4 years, with a value of the medication totalling over £1700.

NHS fraud. Spot it. Report it. Together we stop it.

Local Counter Fraud Team

The counter fraud department has a **new online reporting tool** which can be accessed from the link or by scanning the QR Code below. There is also a new generic email inbox which can be used to contact the Fraud Department. Any information provided is treated **confidentially**.

Counter Fraud Enquiry Form (link)

CounterFraudEnquiries.CAV@wales.nhs.uk

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Counter Fraud Manager

Nigel Price
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AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	04/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ann Marie Stockdale, Head of Outpatient, Medical Records and Private Patient Services
PRESENTED BY	Lisa Miller, Head of Operational Services and Delivery Ann Marie Stockdale, Head of Outpatient, Medical Records and Private Patient Services
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Management Group	26/09/2022	Noted

ACRONYMS	
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

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

1.2 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 are at full establishment, with two administrators taking up position on the 4th July 2022. Training was provided against departmental processes, ways of working and internal systems for a four week period. As a result of this, there were no bills raised during July 2022. A significant increase totaling £428,860 is reported for August 2022 reducing any impact in both billing timelines and financial income (Appendix 1)

2.2 The decrease in July 2022 billing is reflected in the increase in 'Days Sales Outstanding' indicator. This has been offset by the increase in billing during August and will be reflected in the October up-date.

2.3 The Team have completed submission of April 2022 and May 2022 invoices. Work on June 2022 invoicing will commenced 19th September 2022.

2.4 The reduction in the invoicing timeline has been maintained, with steps being taken to reduce this further. Healthcode was implanted on the 15th September 2022 which will require Insurance Companies to adhere to a payment timeline of 30 days for all electronic billing, which is a reduction from 90 day timeline for paper billing. The 30 day timeline is achieved by the system efficiency associated with electronic validation.

2.5 A report will be submitted to the Private Patient Management Group detailing the position against aged debt recovery. A final position will then be submitted to the Executive Director of Finance for consideration and approval of next steps.

2.6 As an audit action, financial key performance indicators have been developed for consideration and agreement. These are as follows:-

Key Performance Indicators (Targets to be agreed)	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022
% Debts Payable by Insurance Companies	95.1%	95.6%	94.7%	94.3%	96.9%

% Debts Not Payable by Insurance Companies	4.9%	4.4%	5.3%	5.7%	3.1%
% Debts aged 30 days or less	0.2%	28.0%	12.3%	0.0%	47.0%
% Debts aged 31-180 days	52.3%	24.2%	33.1%	38.2%	17.1%
% Debts aged 181-365 days	27.0%	23.3%	27.3%	28.2%	16.5%
% Debts aged 1 year +	20.5%	24.5%	27.3%	33.6%	19.4%

Following feedback from the Audit Committee, an additional indicator has been added. The indicator calculation is derived from the total private patient value divided by the amount of income raised in the last twelve months (rolling year) times 365 days. The position is as follows:

Key Performance Indicator	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**
Days Sales Outstanding	83	91	78	79	122

The increase in the 122 day position is reflected as a result of the reduction in billing during July 2022, offset by the increase in billing August 2022.

Key Performance Indicators (Targets to be agreed)	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**
Debts recovered in month compared with total debt end of month	63.3%	20.1%	25.0%	6.8%	0.1%

2.5 The full report (Appendix 1) continues to demonstrate a significant shift in debt between months particularly by insurance companies. It is anticipated that this position will shift over the forthcoming months with the introduction of electronic billing in parallel to the team now fully established.

2.6 The present percentage of debts less than 180 days is 64.1%, which when compared to average of Apr-Sep 2021 of 45%, reflects a highly significant shift towards “recent” rather than “aged” debt, improving the likelihood of receipt and demonstrable benefit of processes embedded. This is influenced by the high proportion and value of invoices raised during August period, reflective of the factors raised earlier within this paper.

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

2.7 The total value of total aged debt is exaggerated in August period at £912,403 due to the catch up in raised invoicing, £428,860 in month. Adjusting for the average monthly income raised, the total debt raised still represents a significant increase in total average monthly income, at approximately £200,000 above normal levels. The increased proportion of debt from Insurance Companies creates a higher probability of debt recovery.

2.8 As above, the Private Patient Team has been reduced significantly for approximately fifteen months. Training has been completed as part of the induction process, with increasing focus on reducing the billing times, rigorous follow-up with Insurance Companies with the aim to improving the time from invoice to payment.

2.9 The Private Patient Team have commenced focus on recovery of debt greater than 180 days.

2.10 Additional financial support is being targeted, in terms of commercial and contract management, processing and business support.

3.0 IMPACT ASSESSMENT

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

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

4.1 The Committee is asked to REVIEW and APPROVE the financial key performance indicators.

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

Appendix 1 – Aged Debt Report

Spreadsheet attached.

PP Aged Debt
Position August 202

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

Key Performance Indicators (Targets to be agreed)	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022
% Debts Payable by Insurance Companies	95.1%	95.4%	96.0%	95.1%	95.6%	94.7%	94.3%	96.9%
% Debts Not Payable by Insurance Companies	4.9%	4.6%	4.0%	4.9%	4.4%	5.3%	5.7%	3.1%
% Debts aged 30 days or less	33.6%	17.0%	44.5%	0.2%	28.0%	12.3%	0.0%	47.0%
% Debts aged 31-180 days	33.4%	49.7%	25.6%	52.3%	24.2%	33.1%	38.2%	17.1%
% Debts aged 181-365 days	10.8%	13.0%	15.3%	27.0%	23.3%	27.3%	28.2%	16.5%
% Debts aged 1 year +	22.2%	20.2%	14.7%	20.5%	24.5%	27.3%	33.6%	19.4%
Days sales outstanding			126	83	91	78	79	122

Movement between Months (brackets indicate increase in debts)

Key Performance Indicators (Targets to be agreed)	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022
Debts recovered in month compared with total debt end of month	7.9%	17.2%	63.3%	20.1%	25.0%	6.8%	0.1%

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 days)	194,349	108,522	389,682	932	163,241	63,800	0	428,860
31-60 days	44,949	151,954	89,972	141,409	328	89,335	48,263	0
61-90 days	40,168	43,327	46,511	61,064	36,376	328	80,645	48,263
91-180 days	107,874	121,265	87,415	78,248	104,269	81,331	55,854	107,641
181-365 days	62,635	82,974	133,660	145,049	135,991	141,214	136,686	150,957
1 year +	128,476	128,824	128,579	110,099	142,493	141,203	162,844	176,682
Total	**578,452**	**636,867**	**875,819**	**536,803**	**582,698**	**517,211**	**484,293**	**912,403**

All debts	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 days)	85,827	(281,159)	388,750	(162,309)	99,441	63,800	(428,860)
31-60 days	(107,005)	61,982	(51,437)	141,081	(89,007)	41,071	48,263
61-90 days	(3,159)	(3,184)	(14,554)	24,688	36,048	(80,317)	32,382
91-180 days	(13,390)	33,850	9,167	(26,020)	22,938	25,477	(51,787)
181-365 days	(20,339)	(50,686)	(11,389)	9,058	(5,223)	4,528	(14,270)
1 year +	(348)	245	18,480	(32,394)	1,290	(21,642)	(13,838)
Total	**(58,415)**	**(238,952)**	**339,017**	**(45,896)**	**65,488**	**32,918**	**(428,110)**

Insured								
Within maturity (0-30 days)	191,500	102,991	380,725	0	163,241	63,800	0	427,667
31-60 days	43,477	151,397	85,044	141,409	0	89,335	48,263	0
61-90 days	40,018	42,025	46,511	57,174	36,376	0	80,645	48,263
91-180 days	100,720	116,223	82,333	77,550	99,891	76,538	50,733	106,410
181-365 days	62,479	82,648	133,334	139,831	130,889	135,664	131,137	141,686
1 year +	111,925	112,273	112,895	94,390	126,653	124,508	146,149	159,817
Total	550,120	607,558	840,842	510,355	557,051	489,845	456,927	883,844

Insured	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 days)	88,509	(277,733)	380,725	(163,241)	99,441	63,800	(427,667)
31-60 days	(107,920)	66,353	(56,365)	141,409	(89,335)	41,071	48,263
61-90 days	(2,007)	(4,486)	(10,664)	20,798	36,376	(80,645)	32,382
91-180 days	(15,502)	33,890	4,783	(22,340)	23,353	25,805	(55,677)
181-365 days	(20,169)	(50,686)	(6,497)	8,942	(4,775)	4,528	(10,550)
1 year +	(348)	(622)	18,505	(32,263)	2,145	(21,642)	(13,668)
Total	(57,437)	(233,285)	330,487	(46,695)	67,206	32,918	(426,917)

Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)								
Within maturity (0-30 days)	2,849	5,531	8,957	932	0	0	0	1,193
31-60 days	1,472	557	4,928	0	328	0	0	0
61-90 days	150	1,302	0	3,890	0	328	0	0
91-180 days	7,154	5,042	5,082	698	4,378	4,793	5,121	1,231
181-365 days	156	326	326	5,218	5,102	5,550	5,550	9,270
1 year +	16,551	16,551	15,684	15,709	15,840	16,695	16,695	16,865
Total	28,332	29,309	34,977	26,447	25,648	27,366	27,366	28,559

Within maturity (0-30 days)	(2,682)	(3,426)	8,025	932	0	0	(1,193)
31-60 days	915	(4,371)	4,928	(328)	328	0	0
61-90 days	(1,152)	1,302	(3,890)	3,890	(328)	328	0
91-180 days	2,112	(40)	4,384	(3,680)	(415)	(328)	3,890
181-365 days	(170)	0	(4,892)	116	(448)	0	(3,720)
1 year +	0	867	(25)	(131)	(855)	0	(170)
Total	(977)	(5,668)	8,530	799	(1,718)	0	(1,193)

Self payer								
Within maturity (0-30 days)	0	0	809	0	0	0	0	1,930
31-60 days	380	0	0	0	0	0	0	0
61-90 days	150	210	0	0	0	0	0	0
91-180 days	260	410	450	360	150	903	903	903
181-365 days	0	170	170	430	470	580	580	410
1 year +	1,098	1,098	231	256	231	1,086	1,086	1,256
Total	1,888	1,888	1,660	1,046	851	2,569	2,569	4,499

Self payer							
Within maturity (0-30 days)	0	(809)	809	0	0	0	(1,930)
31-60 days	380	0	0	0	0	0	0
61-90 days	(60)	210	0	0	0	0	0
91-180 days	(150)	(40)	90	210	(753)	0	0
181-365 days	(170)	0	(260)	(40)	(110)	0	170
1 year +	0	867	(25)	25	(855)	0	(170)
Total	0	228	614	195	(1,718)	0	(1,930)

Top Up								
Within maturity (0-30 days)	0	5,531	8,148	932	0	0	0	0
31-60 days	338	0	4,928	0	328	0	0	0
61-90 days	0	338	0	3,890	0	328	0	0
91-180 days	6,894	4,632	4,632	338	4,228	3,890	4,218	328
181-365 days	156	156	156	4,788	4,632	4,970	4,970	8,860
1 year +	15,453	15,453	15,453	15,453	15,609	15,609	15,609	15,609
Total	22,841	26,110	33,317	25,401	24,797	24,797	24,797	24,797

Top Up							
Within maturity (0-30 days)	(5,531)	(2,617)	7,216	932	0	0	0
31-60 days	338	(4,928)	4,928	(328)	328	0	0
61-90 days	(338)	338	(3,890)	3,890	(328)	328	0
91-180 days	2,262	0	4,294	(3,890)	338	(328)	3,890
181-365 days	0	0	(4,632)	156	(338)	0	(3,890)
1 year +	0	0	0	(156)	0	0	0
Total	(3,269)	(7,207)	7,916	604	(0)	0	(0)

Overseas								
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0
31-60 days	754	557	0	0	0	0	0	0
61-90 days	0	754	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	3,603	1,311	0	0	0	0	0	0

Overseas							
Within maturity (0-30 days)	2,849	0	0	0	0	0	0
31-60 days	197	557	0	0	0	0	0
61-90 days	(754)	754	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0
Total	2,292	1,311	0	0	0	0	0