Led by Claire Bowden, Head of Financial Operations

4.0.0   EXTERNAL AUDIT

Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales

4.1.0   Progress Reports

Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales

4.1.1   Structured Assessment 2021 (phase 2) final report (and management response incorporated)

Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales

      4.1.1a Covering paper Structured Assessment Nov 2021.docx

      4.1.1b 2579A2021-22_Velindre_Phase_2_Structured Assessment_2021.pdf

4.1.2   Audit Wales Audit Committee Update

Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales

      4.1.2a Covering paper AW Audit Committee Update Dec 2021.docx

      4.1.2b VUNHST Audit Position Statement 2022 01 Jan.pdf

4.1.3   Update on the Audit Wales Approach to the Audit of Inventories for 2021-22

Led by Steve Wyndham, Audit Wales

      4.1.3 Audit Wales Inventories briefing paper January 2022 Audit Ctte.docx

5.0.0   INTERNAL AUDIT

Led by James Quance, Head of Internal Audit/Audit & Assurance and Emma Rees (NWSSP - Audit and Assurance Services)

5.1.0   2021/22 Internal Audit Plan progress update

Led by James Quance, Head of Internal Audit, NWSSP (Audit and Assurance Services)

      5.1.0 VUNHST 2122 - Internal Audit Update Report - Jan-22.docx

5.2.0   Receipt of Individual Reports

Led by James Quance, Head of Internal Audit, NWSSP (Audit and Assurance Services)

5.2.1   Advisory Review Report: Use of Technology - Fit for the Future

Led by Martyn Lewis, ICT Audit Manager, NWSSP (Audit and Assurance Services)

      5.2.1 VT 2122 11 use of digital tech final Internal Audit Report.pdf

5.2.2   Internal Audit Report: Board Committee Effectiveness

Led by Emma Rees, Audit Manager, NWSSP (Audit and Assurance Services)

      5.2.2 VT 2122-02 - Final Internal Audit Report - Board Committee Effectiveness - Trust issue.pdf

5.2.3   Internal Audit Report: Trust Assurance Framework

Led by Emma Rees, Audit Manager, NWSSP (Audit and Assurance Services)

      5.2.3a VT 2122-01 - Final Internal Audit Report - Trust Assurance Framework - for Trust issue.pdf

      5.2.3b VT TAF - PAQ.docx

6.0.0   COUNTER FRAUD

6.1.0   Counter Fraud Annual Report 2020/21

Led by Nigel Price, Local Counter Fraud Specialist

      6.1.0a Counter Fraud Annual Report Cover Sheet.doc

      6.1.0b Annual Report - Velindre NHS Trust - 2020-21.doc

6.2.0   Counter Fraud Progress Report for the period 1st October 2021 to 30th December 2021

Led by Nigel Price, Local Counter Fraud Specialist

      6.2.0a Counter Fraud Progress Report Cover Sheet.doc

      6.2.0b Velindre NHS Trust Audit Committee LCFS Update 14.10.2021.doc

7.0.0   ADMINISTRATION

7.1.0   Production of Audit Committee Annual Report

Led by Claire Bowden, Head of Financial Operations and Martin Veale, Chair of the Audit Committee

      7.1.0a Covering Paper AC Annual Report December 2021.docx

      7.1.0b Audit Committee Annual Report Jan - Dec 2021 final.docx

8.0.0   FINANCE

8.1.0   Receipt of Finance Technical updates

Led by Claire Bowden, Head of Financial Operations

      8.1.0 Technical update January 2022.docx

9.0.0   HIGHLIGHT REPORT TO THE TRUST BOARD

10.0.0   MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

11.0.0	ANY OTHER BUSINESS
	By prior approval of the Chair of the Committee
12.0.0	DATE AND TIME OF THE NEXT MEETING
	Tuesday 03 May 2022 at 10:00am
13.0.0	CLOSE

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 8 October 2020 Meeting			
01/2021 4.1.0	**Audit Action Tracker** **VCC Control and Governance** The Datix form is complete and going through the divisions. An update will be presented to the Board next week, This is to be concluded by the end of March 2021. It is a very difficult time to undertake training programmes on this. Gareth Jones recognises the challenges that Covid has presented and undermines the efficacy of DATIX; one of the fundamental objectives was that staff could have access to it; however, he does appreciate that training cannot be done during this time. If we perceive that the training is important then it moves up the priority list. **** Action: Lauren Fear to speak to Cath O'Brien and Paul Wilkins.**	**ACTION:** Lauren Fear/Cath O'Brien/Paul Wilkins	**UPDATE MARCH 2021** Training needs analysis progressing with both divisions. On track to complete by end of March 2021 and then take through Datix Project Board and update to July Committee. **Action on-going** **UPDATE JUNE 2021** Action remains open until training approach has been finalised and delivered with Divisional and Corporate Teams – July 2021 **Action: on-going** **UPDATE JULY 2021** This is on the agenda for this meeting. Actions will be picked up in this discussion. **UPDATE OCTOBER 2021** Training to be completed by end November	LF/ COB/ PW

				UPDATE JANUARY 2022 Was agreed in November meeting to roll out the training by end of January 2022. To reflect current service pressures propose this is extended to March 2022 as requiring staff to undertake this training by end of January would not be appropriate.	
	Actions from 22 March 2021 Meeting				
03/2021 4.2.0	Mark Osland commented on the **Processes and Procedures Workstream** within Appendix 2. It may be marked as green but it is not actually closed. The independent root review started this week and the Trust has commissioned an independent consultant to come in and look at the Velindre Private Patient function's processes and procedures, regulatory processes, the chasing of debts and relationships with insurance companies. They will report back in two to three weeks, which should show what actions the Trust need to take. The Chair requested that this should be kept on the agenda to see how it is progressing. **Action: Mark Osland to confirm that the Independent Consultant's findings will be available for the July 2021 Committee meeting.**	**ACTION:** Mark Osland/Anne-Marie Stockdale		**UPDATE JUNE 2021** Report not available until the end of June 2021. This needs to be agreed and checked for accuracy and an action plan produced. Consequently, the report will be presented in detail at the October Audit Committee. **Action: on-going** **UPDATE 08.07.2021 MO** Draft report is due to be released. This will be on the main agenda for October 2021.	MO/AMS
	14/10/2021 UPDATE – **Action – Matthew Bunce to review the revised Private Patient Report once received from the Independent Consultants and circulate to Audit**	**ACTION:** Matthew Bunce		**UPDATE 05.01.22 MB** Updated Draft report received from Independent Consultants at the end of Nov '21. Work is ongoing	

	Committee prior to the January 2022 meeting.		to review and agree the findings and actions with clinical and operational leads	
03/2021 10.1.0	**Response by Shared Services to the Future Generation Commissioners report on 'Procuring Well-Being in Wales** **Action: Responses to be brought back to the Audit Committee meeting in October 2021** **14/10/2021 UPDATE –** ****Action Christine Thorne to update report and circulate outside of Committee.**	**ACTION:** Christine Thorne	**Action: on-going**	CT
07/2021 3.1.0	**Legislative & Regulatory Compliance Register** **ACTION: Lauren Fear and Mark Osland to discuss the inclusion of procurement compliance in this document.**	**ACTION:** Lauren Fear and Mark Osland	**Report to be reviewed in January 2022 Audit Committee** **UPDATE JANUARY 2022** The work to finalise updating the register was not able to be completed in late December 2021 due to service and corporate resourcing pressures. This work will continue in background, for presentation to Audit Committee in April 2022.	LF/MO
07/2021 3.5.0	**Private Patients' Debts** Gareth Jones requested a breakdown analysis of the dates of the debts, in order for us to be aware if there are any debts we cannot collect due the age of them.		**UPDATE JANUARY 2022** Claire Bowden supplied a breakdown of the age of the debts on 21/10/2021. Ann Marie	

	ACTION: Break down the debt in terms of a date analysis to ascertain if there are old debts we cannot claim due to the length of time they have been outstanding.	ACTION: Ann Marie Stockdale	Stockdale confirmed the PP team has identified debts that can be written off (small sums), and debts that they have been unable to collect (eg drug top up costs patient deceased) but not debts that they cannot collect purely based on age.	AMS
	Actions from 14 October 2021 Meeting			
10/2021 2.1.1	**Draft Minutes from the Audit Committee meeting held on 08 July 2021** The Committee **NOTED** the following changes to be made: • Changes to be made from Audit Wales to Shared Services throughout Minutes. • Apologies Ann-Marie Harkin should be Claire James. • Typos to be amended. • Item 3.1 - Final paragraph change from procurement recommendations to procurement regulations. **ACTION: Make above changes to minutes.**	**ACTION:** Alison Hedges		AH
10/2021 4.1.0	**Trust Risk Register** Lauren Fear clarified in response to the Committee that Version 14 is a new module of Datix, and those fields are what's abstracted directly from Datix, and the issue 14 spreadsheet, 1st page, the column that has the explanation of risk, the last one on that page 'Performances Service Sustainability', will be altered.	**ACTION:** Lauren Fear	**UPDATE JANUARY 2022** Complete	LF

	ACTION: Lauren Fear to amend version 14, page 1 of the Trust Risk Register.			
10/2021 4.2.0	**Trust Assurance Framework** Gareth Jones highlighted some amendments to be made in Appendix B paragraph page 9, Assurance Ratings, 3.4 – 'Executive Leads must provide an assessment on the level of assurance reached risk', this is then repeated in 3.6. Item 3.6 should read 'must provide an assessment on the controlled effectiveness'. **ACTION: Lauren Fear to amend Appendix B, Page 9, Assurance Ratings item 3.6 to read 'must provide an assessment on the controlled effectiveness'.** **ACTION: Lauren Fear to circulate an update on the Trust Assurance Framework to Audit Committee in early September 2021.**	**ACTION:** Lauren Fear **ACTION:** Lauren Fear	**UPDATE JANUARY 2022** Complete	LF
10/2021 4.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** The Committee noted there was inconsistency between item 4.3.0 and 4.4.0. It was requested by the Committee that document's be reviewed outside of the Committee and correct versions are circulated. **ACTION – Alison Hedges and Lauren Fear to review Action Trackers and recirculate outside of the Audit Committee.**	**ACTION:** Alison Hedges / Lauren Fear	**UPDATE JANUARY 2022** Complete	AH / LF
10/2021 4.5.0	**Update on review of Private Patients debts (Verbal Update)** Matthew Bunce as mentioned will do piece of work on age debt and can have a discussion		**UPDATE 05.01.22 MB**	

	with Martin Veale and Gareth Jones and share the information with the committee when ready. Gareth Jones raised concerns to the Committee that age debt analysis should be relatively available and was worried about bad publicity and wants to avoid that. Martin Veale noted a meeting will be scheduled with Matthew Bunce this year. This will be firmly on agenda with written update for the January 2022 meeting. **ACTION: Meeting to be arranged between Martin Veale and Matthew Bunce to discuss Private patient debts.**	**ACTION:** Matthew Bunce		MB
10/2021 7.2.0	**Counter Fraud Staffing** **ACTION: Matthew Bunce, Nigel Price and Andy Butler to have a conversation about resources more widely in figures in this report 110 for Velindre Trust and 75 for Shared Services, whether those numbers are appropriate and what that might look like going forward.**	**ACTION:** Matthew Bunce		MB

MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE

VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS

THURSDAY 14 OCTOBER 2021 AT 10:00AM

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

1.0.0	Standard Business	Action
	Led by Martin Veale, Chair, and Independent Member	
1.1.0	**Apologies** Led by Martin Veale, Chair, and Independent Member Apologies were received from: • Cath O'Brien, Chief Operating Officer • Steve Wyndham, Audit Wales • Craig Greenstock, Counter Fraud	
1.2.0	**In Attendance** Led by Martin Veale, Chair, and Independent Member Attendance was **NOTED** as above. Martin Veale welcomed Matthew Bunce to the Committee as the new Executive Director of Finance. Martin Veale also gave a welcome to Felicity Quance, Senior Audit Manager, attending her first 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	
	03/2021 4.2.0 Private Patient Report – Matthew Bunce noted to the Committee, he recently received a draft report from the external company who is reviewing our private patient service. Following discussion with the Executive Team, a period of 2 weeks has been requested to produce the final report, which will include a piece of work around the recommendations, and an action plan on strategy and operational matters. The report will be brought to the Audit Committee in January 2022. Martin Veale requested the final report be circulated to Committee members before January 2022 meeting. ****Action – Matthew Bunce to share Private Patient Report with Audit Committee prior to the January 2022 meeting.**	**Matthew Bunce**
	03/2021 10.1.0 - Response by Shared Services to the Future Generation Commissioners report on 'Procuring Well-Being in Wales' Christine Thorne noted to the Committee that a response was provided to Mark Osland on 21 May 2021. Christine Thorne to discuss the details actions with Matthew Bunce. The terms of delivery of Executive training will also be addressed. Martin Veale requested this be circulated outside of the Committee to close this action. ****Action Christine Thorne to update report and circulate outside of Committee.**	**Christine Thorne**
	07/2021 3.1.0 Legislative & Regulatory Compliance Register The Committee **NOTED** that this will be reviewed at the January 2022 meeting.	
	07/2021 3.5.0 Private Patients' Debts Martin Veale highlighted the breakdown analysis that Gareth Jones sought hasn't been received. The committee **AGREED** this will be picked up in item 4.5.0 on the Agenda. Matthew Bunce advised he will complete a piece of work on the private element of age debt analysis for all our debts. Matthew Bunce also assured the Committee there is still focus effort on chasing debts. Claire Bowden noted the recovery of Private Patient debts raised before October 2016 remains the responsibility of the Corporate Finance team and, are down to just a couple of thousand now; with the remainder likely to be written off due to their age and improbable likelihood of recovery. Collection of the debts raised post October 2016 are the responsibility of the Private Patient team but regular updates are received in terms of the debts that they're seeking to collect. Claire Bowden reassured the Committee that advice is given to the Private Patients team as requested on any issues and Matt is fully informed of any potential issues. The Audit Committee **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 Audit Committee meeting held on 08 July 2021** Led by Martin Veale, Chair, and Independent Member	

	The Committee **NOTED** the following changes to be made: • Changes to be made in some places from Audit Wales to Shared Services. • Apologies Ann-Marie Harkin should be Clare James. • Typos to be amended. • Item 3.1 - Final paragraph change from procurement recommendations to procurement regulations. **Action: Make above changes to minutes.** The AUDIT Committee **AGREED,** apart from the above amendments, the notes from the meeting held on the 08 July 2021 were an accurate record.	**Alison Hedges**
	Christine Thorne left the Committee at 10.10am	
2.2.0	**For Noting** Led by Martin Veale, Chair, and Independent Member	
2.2.1	**Governance Lessons that can be Learnt from the Response to COVID-19** Led by Lauren Fear, Director of Corporate Governance This item was **NOTED** by the Audit Committee.	
2.2.2	**Transfer of assets & liabilities to Digital Health & Care Wales** Led by Claire Bowden, Head of Financial Operations Martin Veale raised the question to the Committee of legacy issues i.e. is the Trust is still liable for past events from NWIS? Claire Bowden noted to the Committee the memorandum of understanding between both Directors of Finance in terms of how we would manage financial transactions pre and post transfer, in which any issues were outlined and anything that could create a big impact was specifically referred to. It was noted to the Committee that debts raised when NWIS was part of the Trust, are Trust debts and the same applies to creditors. This item was **NOTED** by the Audit Committee.	
2.2.3	**Lessons learned from completing the Statutory Accounts Remotely** Led by Claire Bowden, Head of Financial Operations Gareth Jones questioned why the year end stocktake issue wasn't mentioned in this paper, or the separate paper referring to Governance Lessons learned during the pandemic. In respect of this paper, Claire Bowden noted to the Committee that this paper was about completing the accounts and supporting an audit remotely from the point of view of the members of the Trust finance team that are primarily involved in doing so: the scope of the audit wasn't taken into account. Claire added that even if this had been included, there would still not have been reference to the stocktake as the members of staff directly involved in the preparation of the accounts & the audit are not involved in the divisional stocktakes. Lauren Fear highlighted that this is being referred to in the final page of the Governance Lessons, that stocktaking will be manged differently going into this year's audit. Martin Veale noted The Audit Wales Paper. Conversations are happening and we will get a briefing in our January 2022 meeting when things are in place. This item was **NOTED** by the Audit Committee.	
2.2.4	**Procurement Compliance Report** Led by Matthew Bunce, Executive Director of Finance This item was **NOTED** by the Audit Committee.	

2.2.5	**Public Sector Payment Policy (PSPP) Performance Update** Led by Matthew Bunce, Executive Director of Finance This item was **NOTED** by the Audit Committee.	
3.0.0	**Clinical Audit Annual Report** Led by Jacinta Abraham, Medical Director	
	Martin Veale welcomed Jacinta Abraham to present the Clinical Audit Annual Report to the Committee. Jacinta Abraham noted the report has been presented at the Quality, Safety & Performance Committee and received endorsement in July 2021 and is now seeking endorsement from the Audit Committee prior to taking to Trust Board in November. Jacinta Abraham highlighted the ambition for clinical audit to be strengthened through the Quality and Safety Framework and The National Clinical Framework. Jacinta Abraham and Nicola Williams are working on a Quality at the Centre of our Service Report and the Plan for Financial Year 2021-2022, which will be going to Quality and Safety Committee in January 2022, and to Audit Committee following this. Martin Veale raised the issue of media coverage regarding aspects of patient health that haven't been picked up through video consultations. Jacinta Abraham noted a clinical audit is taking place to assess the safety element of delivery of remote consultation and these challenges and issues that are being looked at within this piece of work. The report was **NOTED** and **ENDORSED** by the Audit Committee.	
	Jacinta Abraham left the Committee at 10:35am.	
4.0.0	INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING	
4.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance Martin Veale welcomed Lauren Fear to present the Trust Risk Register to the Committee. Lauren Fear highlighted the report was received at Board the end of September 2021 and going forward there will be the visibility of the trust risk register in this way at both Audit Committee and Board Meetings. Martin Veale noted the section marked 'our journey' and liked the reference between risk appetite and reporting. Lauren Fear clarified in response to the Committee that Version 14 is a new module of Datix, and those fields are what's abstracted directly from Datix, and the issue 14 spreadsheet, 1st page, the column that has the explanation of risk, the last one on that page 'Performances Service Sustainability', will be altered.	

	Lauren Fear noted to the Committee that in the cycle over the last few months, the 25s, 20s and 16s scored risks were being focussed on andfor all those, the owners have been through, and the quality is much better. In this current cycle there is a focus on scores of 15.		

Gareth Jones raised the question to the Committee where a couple of scores where higher than original, whether there could be further review to ensure appropriate visibility of any potential issues.

Martin Veale asked about those risks with an impact of 5.

Lauren Fear confirmed everything that is animpact of 5 is included in the reporting and the 2 points will be built into the November Board report and clearly in the cover paper.

The Trust Risk Register (Version 12 and Version 14), the actions status of individual risks and next steps were **NOTED** by the Audit Committee.

Project plan is in place to manage the transition from Vs 12 to Vs 14 of Datix was **NOTED** by the Audit Committee.

Incorporate the feedback on the Risk Register report into subsequent reports.

Lauren Fear

4.2.0

Trust Assurance Framework
Led by Lauren Fear, Director of Corporate Governance

Martin Veale welcomed Lauren Fear to present the Trust assurance Framework to the Committee and noted this has been to Board already.

Lauren Fear noted to the Committee that this item will be placed back on the Peer Group Agenda, to compare more, and highlighted that Katrina Febry has been helpful in sharing some good examples from elsewhere.

Gareth Jones highlighted some amendments to be made in Appendix B paragraph page 9, Assurance Ratings, 3.4 – 'Executive Leads must provide an assessment on the level of assurance reached risk', this is then repeated in 3.6. Item 3.6 should read 'must provide an assessment on the control effectiveness'.

Katrina Febry noted to the Committee, there is a lot of development of Board Assurance Frameworks currently underway across Wales and there is a real opportunity to get together and see what needs to be reset and how good practice can be shared across each of the bodies.

	** The progress to date and the first iteration of the Trust Assurance Framework included at *Appendix A* was **NOTED** by the Audit Committee. Next steps in the development pathway to support full operationalisation of the Trust Assurance Framework were **NOTED** by the Audit Committee.		
4.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** Led by Matthew Bunce, Executive Director of Finance Martin Veale welcomed Matthew Bunce to present the Actions Trackers to the Committee and highlighted the Action Trackers were showing less red than seen for a while in a good place. Matthew Bunce presented the Action Trackers to the Committee and noted the significant reduced number of 7 red, with then 3 orange, 36 green and 22 yellow. The Committee noted there was inconsistency between item 4.3.0 and 4.4.0. It was requested by the Committee that documents be reviewed outside of the Committee and correct versions are circulated. ****Action – Alison Hedges and Lauren Fear to review Action Trackers and recircultae outside of the Audit Committee.**	**Alison Hedges/ Lauren Fear**	
4.4.0	**Audit Action Tracker - All Remaining Outstanding Recommendations** Led by Matthew Bunce, Executive Director of Finance **Red Actions:** **Governance Arrangements 2020** **11 – Information Governance and updating the policies** Matthew Bunce noted the new IG person is due to start 01 December 2021. One of their first pieces of work will be to review the policies and reflect this action. Requested an extension to December 2021. **Risk Management 2019** **A Training Needs Assessment (TNA)** Lauren Fear requested an extension to 30 November 2021. Specifically, for the training which is also covered in the process for updates in the Risk Register paper. As plans aren't firmly in place on how to do the board version. the Committee recommended and approved an extension to 31 January 2022. Update for next Board paper. A review of the arrangements in place for the provision of Risk Management advice has been completed on that item. **VCC Control & Governance 2019** **Management should ensure Therapies Department given access to DATIX training** The Committee noted this has still not been completed and the dates on the action don't reflect that this action is marked urgent, with a note to review in May 2022. ****Action Matthew Bunce to speak to Kate Baker to get an update on this action and clarify if it is urgent.**	**Matthew Bunce**	

	VCC **RL Datix (Once for Wales System)** The Committee noted the change in completion date from April then changed to September 2021, but September update doesn't note this new date. Steve Ham noted this is all done Management response and Datix sections complete. Risk Management training to do, but Lauren Fear outstanding deals with this. Action needs to just be formally closed by Nicola Williams. ****Action Nicola Williams to update and formally close this action.** **nVCC Gov Finance** **Project Initiative Document** Lauren Fear confirmed this is a version control issue and this action is in fact complete and should be green. The Audit Committee **AGREED** to **CLOSE** all Green Actions and **AGREED** to all **EXTENTIONS.**	**Nicola Williams**	
4.5.0	**Update on review of Private Patients debts (Verbal Update)** Led by Lisa Millar It was noted to the Chair and Committee at this point that AnnMarie Stockdale thought she had sent apologies and stated that an up-date report would be difficult at this point, as several comments still need to be collated, and requested this be deferred to the next meeting. Lauren Fear highlighted to the Committee the External Commissioners Report and analysis into the age debt. Matthew Bunce as mentioned will do piece of work on age debt and can have a discussion with Martin Veale and Gareth Jones and share the information with the committee when ready. Gareth Jones raised concerns to the Committee that age debt analysis should be relatively available and was worried about bad publicity and wants to avoid that. Martin Veale noted a meeting will be scheduled with Matthew Bunce this year. This will be firmly on agenda with written update for the January 2022 meeting. ****Action: Meeting to be arranged between Martin Veale and Matthew Bunce to discuss Private patient debts.**	**Matthew Bunce**	
5.0.0	**EXTERNAL AUDIT** Led by Katrina Febry, Audit Lead (Performance), Audit Wales and Clare James, Audit Wales		
5.1.0	**Progress Reports** Led by Katrina Febry and Clare James, Audit Wales		
5.1.1	**FINANCIAL AUDIT REPORT 2020/2021** Led by Katrina Febry and Clare James, Audit Wales Martin Veale welcomed Katrina Febry and Clare James to present the Financial Audit Report to the Committee. Clare James presented to the Committee a report that sets out the recommendations from this year and noted the 2 recommendations set out in the report.		

	Clare James noted to the Committee that all of these have been accepted by management and highlighted that last years' recommendations have been implemented. The Audit Committee **REVIEWED** and **NOTED** the report.	
5.1.2	**Audit Position Statement 2021 – Velindre University NHS Trust** Led by Katrina Febry and Clare James Martin Vale welcomed Katrina Febry and Clare James to present the Audit Position Statement 2021 to the Committee. Clare James highlighted that next month a Charitable Funds audit will commence and an audit of the DHCW S1 and S2 forms is planned for December 2021. Clare James noted that there have been discussions with Andy Butler and Neil Frow in Shared Services on early work and stocktaking for this year, with a view to bringing an update paper to the January 2022 Shared Services Committee, which can be brought to the Audit Committee if required following this. Katrina Febry then presented the second part of structured assessment to the Committee and noted that the report was shared within the Trust last week and is awaiting comments and approval. Katrina Febry highlighted to the Committee that Audit Wales is not where it would like to be in terms of Quality Governance and delivery of the report, there have been staff issues, but is on the radar as next piece of work to be focussed on, but timing of this will link in with the quality framework within the trust. Katrina Febry noted to the Committee that the topic for this years' workplan piece of work, hasn't been confirmed. This will be picked up in a conversation with Steve Ham, Lauren Fear and Matthew Bunce outside of the Committee to see what a useful focus would be. Martin Veale noted to the Committee, the piece that touched on briefly, on the 'signing off annual accounts' the page on 'environmental impact and C02, paper waste and travel and raised concern that this isn't reflected quite accurately due to people working from home. Clare James responded that climate change has increased on agendas for future topics and have been looking to do in the future more cross sector areas, helping to bring good practice across different sectors, as well as different areas and will take those comments back. Katrina Febry responded that the Trust will be receiving a call for evidence on climate change shortly, looking at this across the whole of the public sector. The Audit Committee **REVIEWED** and **NOTED** the report.	
	Break for 10 Minutes	
6.0.0	**INTERNAL AUDIT** Led by James Quance, Head of Internal Audit/Audit & Assurance and Emma Rees (NWSSP - Audit and Assurance Services)	
6.1.0	**Internal Audit 2021/22 Progress Update Report** Led by James Quance, Head of Internal Audit Martin Veale welcomed James Quance to present the Internal Audit Progress Update Report to the Committee.	

	James Quance noted to the Committee this report highlights progress of the 2021/22 Audit plan and provides an overview of other activity undertaken since the previous meeting. James Quance highlighted to the Committee they have followed up the points raised in the financial systems report from last year which flagged issues around private patients' debts which led to that being included. The Audit Committee **NOTED** this report.	
6.2.0	**Receipt of Individual Reports** Led by James Quance, Head of Internal Audit James Quance introduced the Team that would be presenting today: Martyn Lewis - Leads on IT work across the Piece and leads all the audit work throughout wales. Emma Rees- Leading core work in the plan for Velindre going forward. Felicity Quance - Leads the Capitol and Estates work and reports through to Huw Richards who heads up the national work around Capital and Estates. Martyn Veale welcomed the Team to the Committee to present their relevant reports.	
6.2.1	**CaNISC Replacement Internal Audit Report** Led by Martyn Lewis, ICT Audit Manager Martyn Lewis noted to the Committee that the overall objective of this report was to make sure there is arrangements is place for the management of the CaNISC replacement to enable successful implementation. Martyn Lewis highlighted the key findings where final delivery of the functionality has been delayed and work ongoing before implementation, need further agreement on a national basis. Martyn Lewis noted this is a well-run project, with a lot of the issues being wider than just within the Velindre or indeed the Trust. Martin Veale noted that the reports improved hugely and that the summary and Executive pages and the Matters Arising list is a great addition. The Audit Committee **NOTED** this report.	
6.2.2	**Waste Management Internal Audit Report** Led by Felicity Quance, Senior Audit Manager. Felicity Quance noted the Waste Management Audit looked at the Trust compliance with Waste Management Legislation and Guidance, looking at clinical and general waste across both the Velindre Cancer Centre and Welsh Blood Services, taking into consideration the pressures that were caused by Covid, from a financial and operational risk perspective. Reviewing areas of	

	internal management and coordination and looking at the contractual arrangements in place, for the management of waste within the Trust. Operational management was confirmed through site visits. Felicity Quance noted a reasonable assurance rating, with no significant matters arising. . This Audit Committee **NOTED** this report.	
6.2.3	**Infection Prevention & Control internal audit report** Led by Emma Rees, Audit Manager Emma Rees noted to the Committee that this report doesn't have a matters arising table and the executive summary, as whilst there's 4 medium priority findings, they weren't considered significant or concerning. Emma Rees highlighted to the Committee that the IPC review was looked at in adherence with the Trust policies and procedures and linked in with the health and care standards with focus on divisional activities as well as the corporate IPC Team. This report showed reasonable assurance. Th Audit Committee **NOTED** the report.	
6.2.4	**Divisional Review – Incident Management Internal Audit Report** Led by Emma Rees, Audit Manager Emma Rees noted to the Committee that this report looked in depth at specific subject areas to enable comparison across divisions rather than separating Velindre Cancer Centre and Welsh Blood Service and looked at policies and procedures and whether incidents and risks were being effectively managed, and both came out with reasonable assurance. Findings included ensuring policies were in date, ensuring incidents has been recorded on a timely basis, quality audits, incidents can be recorded on Datix and quality audits, consistency, trend monitoring improvements could be made and ensuring learning is shared more widely across organisations. This report showed reasonable assurance The Audit Committee **NOTED** the report.	
6.2.5	**Divisional Review – Risk Management Internal Audit Report** Led by Emma Rees, Audit Manager Emma Rees noted to the Committee that this report has a similar picture to incident management. This report showed reasonable assurance, with no significant concerns, with 4 Medium priority findings. Lauren Fear noted have run a regular meeting between team and divisional leads for several months, and this work has informed that planning and helped phase and prioritise. Worked on scoring also and are tweaking the final version of Datix 14 to allow that information to be clear for Welsh Blood Service purposes. This Audit Committee **NOTED** this report.	
7.0.0	**COUNTER FRAUD**	
7.1.0	**Counter Fraud Progress Report** Led by Nigel Price	

	Martin Veale welcomed Nigel Price to present his Counter Fraud Process Report to the Committee.	
	Nigel Price noted to the Committee the points which were completed 70.5 days of counter fraud work for VCC, taken up with various national exercises post covid and the usual Fraud awareness presentations and investigations. During this reporting period 2 investigations have been closed and one remains open. The subject has been interviewed under caution and the next phase is to prepare a case file to be submitted to the Crown prosecution service, and an update will be provided at the next Audit Committee. Priority matches for VCC have all been investigated for this period and are closed with no fraud discovered.	
	Martin Veale highlighted that it would be useful to have a view of across Wales of the work we do which would be helpful in terms of assurance. Nigel Price agreed to cover in next audit report and noted there is a discussion going on with Shared Services to take on board more work for the NFI reporting. Peter Stephenson is going to be having discussion with Information Governance Mangers about how information is going to be dealt with under GPDR restrictions and other elements of handling personal data.	
	The Audit Committee **RECEIVED** and **DISCUSSED** the Counter Fraud Progress Report for the period 1st July 2021 to 30th September 2021.	
7.2.0	**Counter Fraud Staffing** Led by Nigel Price Nigel Price presented the Counter Fraud Highlight report to the Committee, stating due to sickness and admin staff leaving post and recent new of resignation, staffing is down to 50%. Advert gone out for Investigator to give more capacity for investigations and the vacancy closed yesterday and a Band 8 job is under review with HR, hoping to be up to full capacity of staff by end of year. It was highlighted to the Committee that access to Graham Dainty's team is available when cases emerge, and 3 cases have been referred them and there is also support from Counter Fraud managers from neighbouring HBs. Martin Veale noted that Andy Butler revealed that they are looking to recruit more counter fraud services directly within the shared services.	
8.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	The Chair and Committee **NOTED** there was no other business.	
9.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting 11 January 2022.	
10.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 11 January 2022 at 10:00am via Microsoft Teams	
11.0.0	**CLOSE**	

| | The Committee was asked to adopt the following resolution:

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT 29th September 2021 – 1st December 2021 (Reporting Deadlines)

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Christine Thorne, Head of Procurement
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
N/A	(DD/MM/YYYY)	Choose an item.

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

1.   SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with an update in relation to procurement activity undertaken during the period 29th September 2021 – 1st December 2021 and in accordance with reference 1.2 (Schedule 2.1.2 Procurement and Contracts Code for Building and Engineering Works) of the Standing Financial Instructions.

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

SFI Reference	Description	Items
3.5	Single Quotation Actions	0
4.2	Single Tender Actions	4
5.3	Single Tenders for consideration following a call for an OJEU Competition	0
10.8	Contract Extensions	0
14.2	Award of additional funding outside the terms of the contract (executed via Contract Change Note (CCN) or Variation of Terms)	2

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Optional Appraisal/Analysis

Not applicable.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	All policies are equality impact assessed prior to approval.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As indicated in Appendices 1.1 (Summary Information) 1.2 (Further Matters)

4. RECOMMENDATION

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

Velindre University NHS Trust - Audit Committee Report – January 2022

Appendix 1.1 – Summary Information

Trust	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
VEL	Welsh Blood Service	WBS-STA-836	18/08/21 – 31/12/23	Single Tender Action	Provision of historical and technical information. Including reviewing documents and assisting with responses to the Welsh Infected Blood inquiry.	GKAIT Ltd	£54,000	Specialist scientific knowledge and experience in relation to the WBS and wider UK Blood Services.	Endorsed	No further actions required.	Repeat submission reported in November 2019
VEL	Velindre Cancer Centre	VCC-STA-837	01/07/21 – 31/03/22	Single Tender Action	Provision of an Independent healthcare facilitator	Wilderspin Consulting Ltd	£25,000	Co-authored the independent Nuffield Trust advice published in December 2020 therefore specialist experience and knowledge.	Endorsed	No further actions required.	First Submission
VEL	Welsh Blood Service	WBS-STA-851	01/10/21 – 31/03/22	Single Tender Action	Clinical rooms for stem cell collection	Nuffield Health	£ 35,000	No other Facility able to provide service due to validation requirements.	Endorsed	Further STA required due to delays with establishment of clinical area in VCC.	Repeat Submission reported in October 2021

VEL	Welsh Blood Service	WBS-STA-860	01/12/21	Single Quotation Action	Purchase of 12 Blood donor chairs	Renfrew Group International	£ 42,592	Standardisation and compatible with existing chairs.	Endorsed	No further actions.	First Submission

Velindre University NHS Trust - Audit Committee Report – January 2022

Appendix 1.2 - Further Matters

Trust	Division	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
VEL	Velindre Cancer Centre	VEL-VCC-FN-118	19/07/21 to 31/03/22	File Note	Supply of a Temporary marquee to provide comfort to patients during the COVID-19 Pandemic and support the vaccination process.	County Marquees LTD	£112,044	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.	Competition not sought in accordance with SFI'S	Formal Tender Exercise required	Repeat Submission reported in January 2021
VEL	Welsh Blood Service	VEL-WBS-FN-114	16/07/21 to 13/12/22	File Note	Various venues for Blood collection.	Various	£130,723	Due to increase number of collection services due to social distancing.	Extended in excess of SFI allowable limits	Formal STA Procurement exercise required due to limitations on venue availability.	First Submission

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AUDIT COMMITTEE

AMENDMENT TO STANDING ORDERS – SCHEDULE 3

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	01/11/2021	Endorsed for Committee Approval
Charitable Funds Committee	04/11/2021	Endorsed for Board Approval
Strategic Development Committee	08/11/2021	Endorsed for Board Approval

Quality, Safety & Performance Committee	18/11/2021	Endorsed for Board Approval

ACRONYMS	
SO	Standing Orders
ToR	Terms of Reference

1. SITUATION

1.1 The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

1.3 The purpose of this report is to outline the required changed to the Trust Standing Orders – Schedule 3, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the:
   - Charitable Funds Committee;
   - Strategic Development Committee;
   - Quality, Safety & Performance Committee, and
   - Audit Committee

The Audit Committee is asked to **ENDORSE for Board Approval** the revised Standing Orders – Schedule 3 for the updated Terms of Reference and Operating arrangements for each of the above Trust Board Committees, included in *Appendices 1 - 4.*

2. BACKGROUND

2.1 In September 2020, the Trust Board approved a new Board Committee model resulting in the move from a top line nine-committee model to a five-committee model effective from November 2020.

2.2 The new Board Committee model introduced a host of key changes to the operating arrangements including the establishment of two new committees, namely the Quality, Safety & Performance Committee and the Strategic Development Committee. In parallel, it invoked the dissolution of the Quality & Safety Committee, Planning & Performance Committee, Digital & Information Governance Committee and Workforce &

Organisational Development Committee, which no longer operate as separate Committees of the Board.

2.3   The revised Board Committee model necessitated a review of all Board Committee Terms of Reference and Operating Arrangements together with the development of new Terms of Reference and Operating Arrangements for the newly established Quality, Safety & Performance Committee and the Strategic Development Committee.

2.4   As such, this review represents the first Annual Review of the Terms of Reference and Operating Arrangements for both the Quality, Safety & Performance Committee and the Strategic Development Committee.

2.5   Also included for endorsement are the updated Terms of Reference and Operating Arrangements of the Charitable Funds Committee and Audit Committee whose normal Annual Review cycle has fallen within this period and as such are also included here for endorsement.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

3.1   Summary of Amendments

The revised Terms of Reference and Operating Arrangements are set out in **Appendices *1 - 4***, and include the following key changes which are summarised below:

Terms of Reference & Operating Arrangements	Summary of Amendments
Quality, Safety & Performance Committee	**Section 2:** - **Purpose** has been strengthened to reflect the Committee's role in respect of scrutiny and assurance of all relevant **statutory** and **regulatory** requirements that sit within the Quality, Safety & Performance remit - Amalgamation of **advice** and **assurance** remit and responsibilities to remove duplication and aid read across **Section 3:** - Addition of Committee's role in promoting and adopting a **triangulated** approach to advise and assurance for the Board - Addition of Committee's remit in ensuring a robust Quality Management System is

Terms of Reference & Operating Arrangements	Summary of Amendments

	in place across the Trust and meeting the requirements outlined in the Wales Quality Framework
	- Inclusion of the Committee's role in considering the implications for patient / donor experience / outcomes, planning and finance
	- Removal of items of business from the Committee's remit that fall within the agreed remit of either the Executive Management Board / Strategic Development Committee and / Audit Committee, namely:
	   ○ Commitment of Expenditure over the Chief Executive's Limit (*overseen by EMB*)
	   ○ Trust Capital Programme & Expenditure (*overseen by EMB & Strategic Development Committee)*
	   ○ Trust Assurance Framework (*overseen by Strategic Development Committee and Audit Committee*)
	- Strengthened the Committee's role in respect of ensuring there is an ethos of learning and improvement and its role in ensuring the Health & Care Standards (2015) are applied and met
	- Addition of the wider governance and accountability reporting arrangements in place at a local and divisional level that feed upwards into the Committee
	Section 4:
	- Attendance, addition of Deputy Director of Planning and Performance, removal of Claims Manager and updating job titles as appropriate

Strategic Development Committee	**Section 3:** - 3.4 Sub-Committees, removal of wording *'as illustrated below'* in ref. to the organigram provided **Section 4:**

Terms of Reference & Operating Arrangements	Summary of Amendments
	- 4.2 Attendees, removal of Assistant Director of Planning, Associate Director of Organisational Development and Workforce, Associate Director of Digital, Assistant Director of Communications & Engagement. Addition of Chief Digital Officer **Section 6:** - 6.1 Relationships, inclusion of Committee's role in relation to staff, patients and donors not previously captured
Charitable Funds Committee	**Section 5:** - 5.1 Authority, update of Executive Director of Finance job title - 5.4 Sub-Committees, update of the Charitable Funds Sub-Committee arrangements with regards to the Velindre Charity Senior Leadership Group which has been reconstituted and revised
Audit Committee	**Section 2:** - 2.3 Details of the arrangements in place for NWSSP Audit Committee included. **Section 4:** - 4.4 Acronym OD included in full i.e. Organisational Development.

3.2 Publication of revised Standing Orders – Schedule 4

Subject to the necessary approvals being in place as outlined above the revised Standing Orders – Schedule 3 will subsequently be uploaded to both the Trust Intranet and Internet sites.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is a correlation between governance behaviours in an organisation and the

	level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	
	Not Required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

- The Audit Committee is asked to **ENDORSE for Board Approval** the amendments to the Trust Board Standing Orders – Schedule 3 as outlined in section **3** of this report, and included in *Appendices 1-4.*

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	
Next Review due:	October 2022

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:
  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects of workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021);

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align Service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes/outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively;

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high quality care ;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2   The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to co-operate with any reasonable request made by the Committee), and any other Committee, Sub-Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.3   Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and the Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at *Annex 1*. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at *Annex 2*.

The two sub-committees have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:
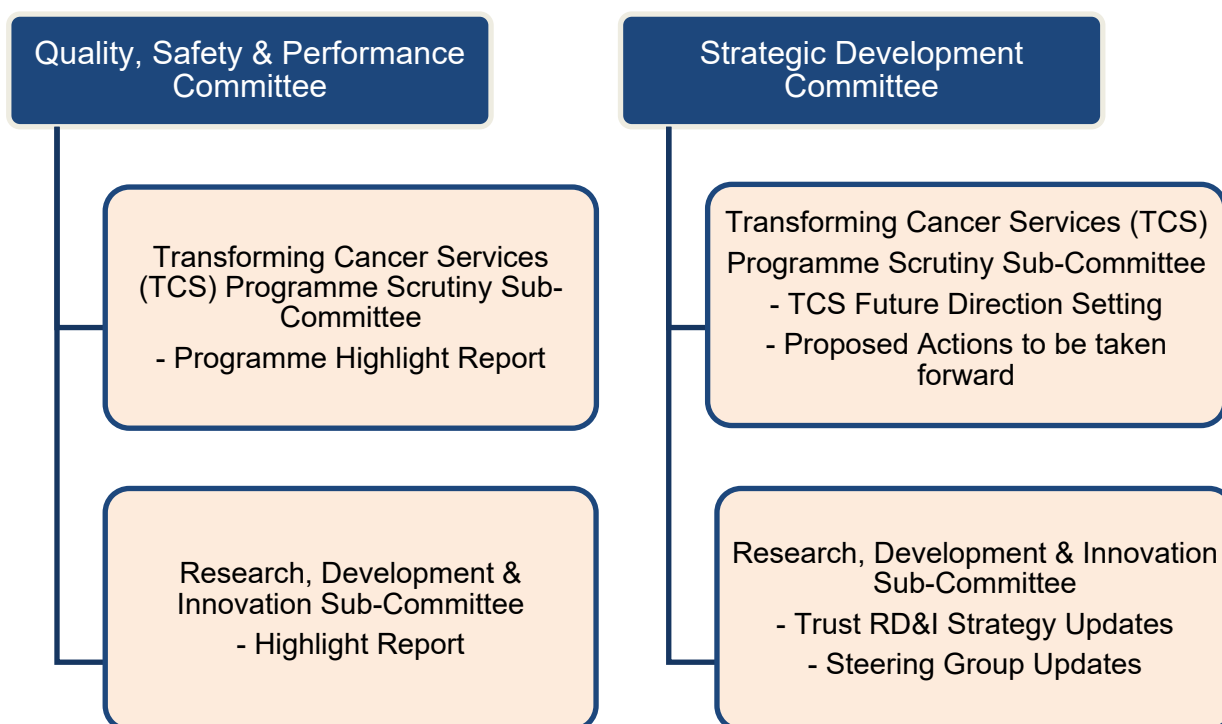
Quality, Safety & Performance Committee	Strategic Development Committee
Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - Programme Highlight Report	Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - TCS Future Direction Setting - Proposed Actions to be taken forward
Research, Development & Innovation Sub-Committee - Highlight Report	Research, Development & Innovation Sub-Committee - Trust RD&I Strategy Updates - Steering Group Updates

Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee also feeds into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

Members

4.1 A minimum of two (2) members, comprising:

	Chair	Independent member of the Board (Non-Executive Director)
		One independent member of the Board (Non-Executive Directors)
		The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- WBS & VCC Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance & Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning & Performance
- Deputy Director of Nursing, Quality & Patient Experience
- Chief Digital Officer (*also cyber/data outtages/performance*)
- Quality & Safety Manager
- Head of Corporate Governance

4.3 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting. The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

Secretariat

4.4   Secretary - as determined by the Director of Corporate Governance & Chief of Staff

Member Appointments

4.5   The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6   Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.7   The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5.   COMMITTEE MEETINGS

Quorum

5.1   At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

5.2   Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

5.3   The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.   RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1   Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

6.2   The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3   The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4   The Committee will consider the assurance provided through the work of the Board's other

Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5   The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7.   REPORTING AND ASSURANCE ARRANGEMENTS

7.1   The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2   The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8.   APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
Cross reference with the Trust Standing Orders.

9.   REVIEW

9.1   Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10.   CHAIR'S ACTION ON URGENT MATTERS

10.1   There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2   Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Statutory, Public

Trust Board

Committees

Quality, Safety & Performance Committee (Bi-Monthly)	Strategic Development Committee (Bi-Monthly)	Audit Committee (Quarterly)	Remuneration Committee (Bi-Monthly)	Charitable Funds Committee (Quarterly)	Audit Committee (NWSSP) (Quarterly)
Quality & Safety Compliance & Standards Commissioning Arrangements Risk Management Trust Assurance Framework Annual Plan / IMTP Monitoring Listening & Learning Workforce Digital Delivery Information Governance	Strategy for Commissioning Innovation TCS future direction setting & other Major Programmes Trust Strategies Development of IMTP Partnerships (Academia / Industry / Third Sector) Digital Developments Organisational Development	Governance & Risk Accounts Internal Audit External Audit Counter Fraud Audit Tracker	Executives Objectives Executive Performance Anonymous Correspondence Voluntary Early Release Scheme (VERS)	Governance & Risk Strategy & Performance Financial Reporting Investment Fundraising Activity Advanced Radiotherapy Programme Board	Partnership Committee between NHS Wales Shared Services Partnership and Velindre University NHS Trust

Sub Committee: TCS Scrutiny
- Programme Highlight Report
- Risks & Issues
- Close Out Report

Sub Committee: TCS Scrutiny
- TCS Future Direction Setting
- Proposed Actions to be taken forward

Sub Committee: R,D & I
- Highlight Report
- Progress against Trust R, D & I Annual Operational Plan

Sub Committee: R,D & I
- Trust R, D & I Strategy Updates
- Steering Group Updates

Sub Committee: R,D & I
- Alignment to Strategy & Funding

Sub Committee: Investment Performance Review

Forums & Advisory Groups:
Local Partnership Forum & Advisory Groups / Advisory Consultants Appointment Committee / Academic Partnership Board / Integrated Governance

Mission: Partnering people to live well
Vision: *By 2025 we will have helped more people to live longer, better lives and be the organisation others come to learn from*

MANAGEMENT GROUP HIERACRCHY

TRUST BOARD

- STRATEGIC DEVELOPMENT COMMITTEE
- QUALITY, SAFETY & PERFORMANCE COMMITTEE
- CHARITABLE FUNDS COMMITTEE
- REMUNERATION COMMITTEE
- AUDIT COMMITTEE
- NWSSP AUDIT COMMITTEE

- TRANSFORMING CANCER SERVICES SCRUTINY
- RESEARCH, DEVELOPMENT & INNOVATION COMMITTEE
- INVESTMENT PERFORMANCE REVIEW SUB–COMMITTEE

TRANSFORMING CANCER SERVICES PROGRAMME BOARD

EXECUTIVE MANAGEMENT BOARD

- WELSH BLOOD SERVICE SENIOR MANAGEMENT TEAM (SMT)
- INFECTION PREVENTION & CONTROL MANAGEMENT BOARD
- WELSH LANGUAGE DEVELOPMENT GROUP
- EDUCATION STEERING GROUP
- ESTATES STATUTORY COMPLIANCE GROUP
- HEALTH AND SAFETY GROUP
- SAFEGUARDING AND PUBLIC PROTECTION MANAGEMENT BOARD
- VELINDRE CANCER CENTRE STRATEGIC LEADERSHIP (SLT) PARTS 1 & 2

DIVISIONAL INFECTION PREVENTION & CONTROL GROUPS

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GO TO PAGE 2

WBS SMT

- Education and Training Panel
- Business Planning Group (BPG)
  - Change Review Panel (CHIRP)
- Capital and Procurement Planning Group (CPPG)
- Regulatory Assurance and Governance Group (RAG)
  - Patient Clinical Governance
    - Change Notification Implementation Group
  - Donor Clinical Governance
    - Apheresis Quality Monitoring Group
  - WBMDR Clinical Governance
  - Infection Prevention and Control Group
- Research, Development and Innovation Group (RD&I)
- Cynefin Group (formerly Estates and Facilities Management Group)
  - Time Limited Projects/ Programmes
- Welsh Language Task and Finish Group
- WBS Local Partnership Forum (LPF)
- O&G Meetings Collections General Services WT&L Laboratory Services
- Time Limited Projects/ Programmes
- Demand Planning Group
  - Daily Resilience Group

Note: WBS also feed into Trust specific Project Groups

VCC SLT PART 1

- VCC Quality & Safety Management Group
- Radiation Services Directorate
- VCC Medicine Management Group
  - VCC Controlled Drugs Oversight Group

VCC SLT PART 2

- Velindre Futures
- Business Planning Group Part 1
- Business Planning Group Part 2 – Change Board
- SACT & Medicine Management Directorate
- Medical Directorate
- Operational Service & Delivery Directorate
- Integrated Services Directorate

Strategic Development Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	
Next Review due:	October 2022

1.	INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Strategic Development Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2.	PURPOSE

2.1 The purpose of the Strategic Development Committee "the Committee" is to provide:

- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:

  - strategic direction
  - strategic planning and related matters
  - organisational development
  - digital services, estates and other enabler services
  - sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act
  - investment in accordance with Value-based healthcare

- **Assurance** to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3.	DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:

- Oversee the development of the Trust's strategies and plans which set out how plans the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

- Regularly review whether the Trust is developing a strategic approach, which provides it with the greatest opportunity to fulfil its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle.

- Review the arrangements and contents of key plans to ensure alignment with the Trusts strategic goals and objectives, including the Trust's Integrated Medium Term Plan (IMTP) in accordance with above.

- Review the Trust's Capital Plan to ensure alignment with key Trust strategies, plans (IMTP) and sustainable development principles.

- Review Trust developments involving significant investment or modernisation.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

3.2   To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.

Authority

3.2   The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

- To approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.3 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.4 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee:
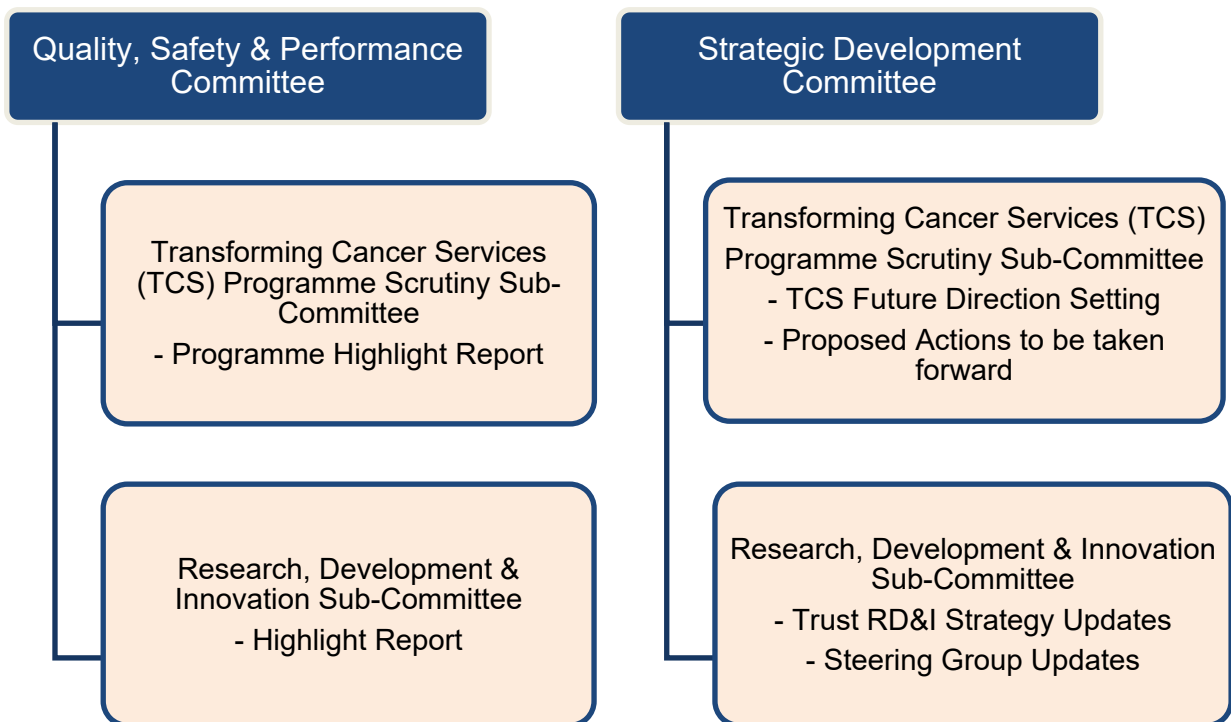
Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4.	MEMBERSHIP

Members

4.1   A minimum of two (2) members comprising:

Chair   Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2   **Attendees:**

- Chief Executive Officer
- Director of Strategic, Transformation, Estates, Planning & Digital
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director
- Chief Operating Officer
- Divisional Directors
- Director of Corporate Governance
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Commercial and Strategic Partnerships
- Chief Digital Officer

The Committee welcomes attendance at Committee meetings by staff from within the organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.3   **Secretariat**

As determined by the Director of Corporate Governance.

4.4   **Member Appointments**

The membership of the Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills

and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.5 Support to Committee Members

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 Quorum

At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 Frequency of Meetings

Meetings shall be held bi-monthly, consistent with the Trust's annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its staff, patients, donors and citizens through the effective governance of the Organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4 The Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.

- Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.

7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
Cross reference with the Trust Standing Orders.

9. REVIEW

9.1   These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1   There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2   Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	
Next Review due:	October 2022

1.	INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2.	CONSTITUTION

2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.

2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3.	SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

4.	DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE

4.1 The Executive Director of Finance has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance are:

- Administration of all existing Charitable Funds.

- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.

- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.

- Responsibility for the management of investment of funds held on trust.

- Ensure appropriate banking services are available to the Trust.

- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5.	AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.

- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment

Manager. In exercising this power the Committee must ensure that:

a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.

b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.

c) The performance of the person or persons exercising the delegated power is regularly reviewed.

d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2012.

e) Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise

if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

5.3   Approve policies relevant to the business of the Committee as delegated by the Board.

5.4   **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the *'Charitable Funds Investment Performance Review Sub Committee'*, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

The Charitable Funds Committee is also supported by the Velindre Charity Senior Leadership Group, whose purpose on behalf of the Board of Trustees is to support the development of the strategic direction, take forward strategic delivery and operational management of all Charitable Funds held within the Trust.

In addition, the Trust Research, Development & Innovation Sub-Committee has been established to act as the 'front door' for all RD&I business at Board level. The RD&I Sub Committee will feed into the Charitable Funds Committee for alignment with strategy and funding.

6.	MEMBERSHIP

Members

6.1   A minimum of four members, comprising:

- Chair, Independent member of the Board (Non-Executive Director)
  Independent Member of the Board (Non-Executive Director)The Trust's Chief Executive and Executive Director of Finance (one of which at any one meeting may be represented by a Nominated Representative in their absence)

Attendees

6.2   In attendance   The Committee may require the attendance for advice, support and information routinely at meetings from:

- Charity Director
- Chief Operating Officer
- Director Velindre Cancer Centre (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Charitable Funds Accountant
- Deputy Director of Finance
- Head of Fundraising
- Head of Corporate Governance (Charity Governance Lead)
- Head of Communications

By invitation,   The Committee Chair may invite:

- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

6.3   Secretary   As determined by the Director of Corporate Governance

Member Appointments

6.4   The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

6.5   Applicable to Independent Members only. Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

6.6   In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

6.7   The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational Development & Workforce.

7.   COMMITTEE MEETINGS

Quorum

7.1   At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

7.2   Meetings shall be held every three months and otherwise as the Committee Chairs deems necessary - consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

7.3   The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8.   RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1   The Committee will only consider Research and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

8.2   The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

8.3   The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and

- appropriate sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4   The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9.   REPORTING AND ASSURANCE ARRANGEMENTS

9.1   The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.

9.2   The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

9.3   The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10.   APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1   The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
Cross reference with the Trust Standing Orders.

11.   REVIEW

11.1   These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

12.   CHAIR'S ACTION ON URGENT MATTERS

12.1   There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2   Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	December 2021
Approved:	
Next Review Due:	November 2022

1. INTRODUCTION

1.1   The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2   In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3   These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1   The purpose of the Audit Committee ("the Committee") is to:

- *Advise* and *assure* the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2   Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3   A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1   With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

- the organisation's ability to achieve its objectives,

- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3　In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4　This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5　To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's

review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6   The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7   The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8   The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair   Independent member of the Board (Non-Executive Director)

Two independent members of the Board (Non-Executive Directors)

[one member should be a member of the Quality, Safety & Performance Committee]

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2   In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.*)
Executive Director of Finance
Director of Corporate Governance
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation   The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.1   Secretary   As determined by the Director of Corporate Governance

Member Appointments

4.2   The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.3   Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.4   The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1   At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2   Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

5.3   The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1   Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2   The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3   The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4   The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5   The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7.	**REPORTING AND ASSURANCE ARRANGEMENTS**

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8.	**APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS**

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
Cross reference with the Trust Standing Orders.

9.	**REVIEW**

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10.	**CHAIR'S ACTION ON URGENT MATTERS**

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In

these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

AUDIT COMMITTEE

TRUST RISK REGISTER – PUBLIC VERSION OF REPORT FOR ONWARD REPORTING TO COMMITTEES AND TRUST BOARD

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Lenisha Wright, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
EMB	04.01.22	Noted

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

1. SITUATION AND BACKGROUND

The purpose of this report is to present Audit Committee with information on the status of organisational Risks recorded in the Trust Risk Register, as part of the ongoing management and mitigation of risks. The Trust Risk Register includes risks that meet the Trust Board risk appetite criteria for reporting, which for most risk categories are risks >=12 and risks with an impact of 5. As discussed previously with Audit Committee, we want to report on risks that are up to date in as transparent a way as possible. Therefore, risks in the Trust Risk Register were drawn in December. Further insight and analysis from SLT for VCC and SMT for WBS will be included in versions of the paper for QSP Committee and Board.

Risk information for this cover paper includes risks level 20, 16, 15, and 12, and risks with impact of five are highlighted in this cover report, in accordance with the risk appetite levels. To note that no level 25 risks have been recorded in the Trust Risk Register.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Executive Management Board, Trust Board and Committees. Risks on the Trust Risk Register presented in this report have been reviewed at Divisional Senior Team meetings on scheduled meeting dates.

Audit Committee is requested to note and support the continued work being undertaken on the management of risks in the organisation which includes the ongoing validation, authentication and mitigation of risks. Audit Committee is requested to scrutinise data in the risk registers including, risk ratings, review dates and identified controls. Audit Committee is requested to note the following work that is currently progressing.

- Implementation of the board approved risk process, risk appetite and risk framework;
- Establishing a new risk process;
- Risk mitigation from version 12 to version 14 of Datix;
- User set up and access to the new system (Vs 14);
- Training for staff.

3. THE TRUST RISK REGISTER

Risks are recorded in two registers currently, version 12 and version 14 of Datix. Trust Risk Registers for Corporate, VCC and TCS are recorded in Vs 14 of Datix, and Risks for WBS is currently recorded in version 12 of Datix. Work is currently progressing with regard to updates on the Risk form in version 14 as well as the development of a paper based Risk form to align requirements ensuring the new process is fit for purpose for all Divisions within the Trust. Following the completion of this process, all risks will be recorded on one risk register, in version 14 of the Datix system.

3.1. Covid Related Risks

The risk profile has changed significantly within weeks in many respects, including: staffing levels; supply and access to testing; nosocomial transmission and so on. The risk profile extracted from December Datix position prior to Christmas, therefore does not yet reflect many of these fast moving changes. The risk profile is being worked on to provide as relevant as possible information to Quality, Safety and Performance Committee on 17th, and Trust Board on 27th January.

3.2. Total Risks

There are a total of **152** risks recorded in Datix Trust Risk Registers, 51 in version 12 and 101 in version 14. This compares to 119 in the November 2021 reporting cycle. The difference is due to risks with an impact of five in version 12 that were not included previously due to technical difficulties which have now been resolved. The graph below provides a breakdown of the total number of risks by Division.

Total Risks

	TCS	WBS	VCC	Corporate	Total
Series1	17	51	79	5	152
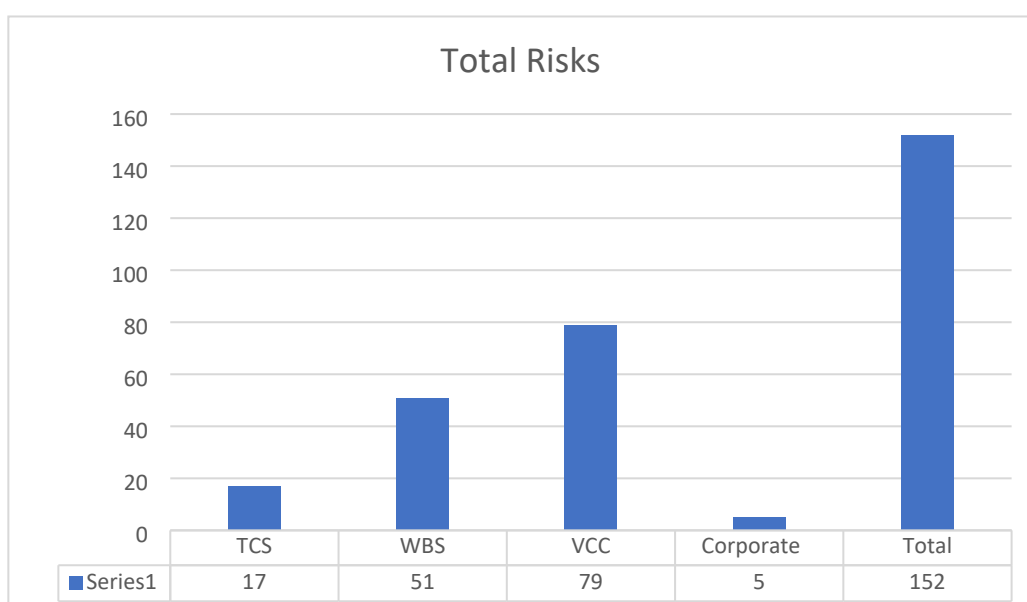
3.3. Risks by level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and Division is also included. Analysis of risks rated 20, 16, 15 and 12 as well as risks with an impact of five are provided under analysis of risks (paragraph 4).

	Level 20	Level 16	Level 15	Level 12	Impact of 5
CORP				5	
TCS	2	2		13	
VCC	3	13	9	32	22
WBS	1			8	42
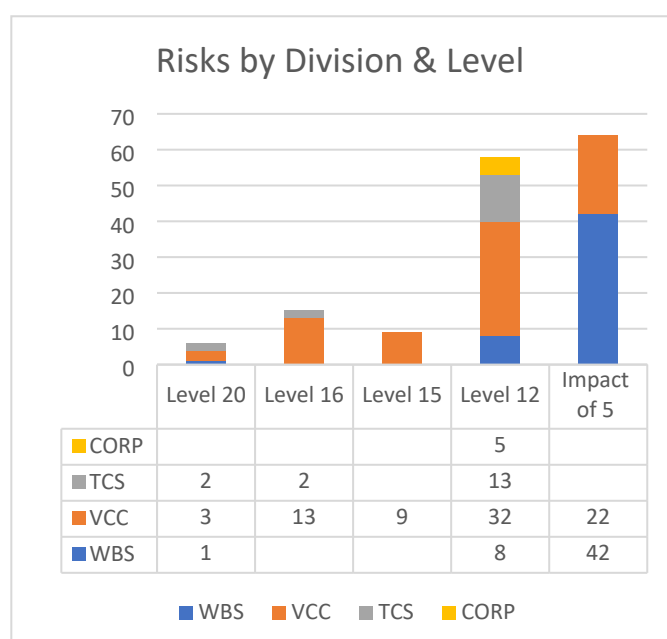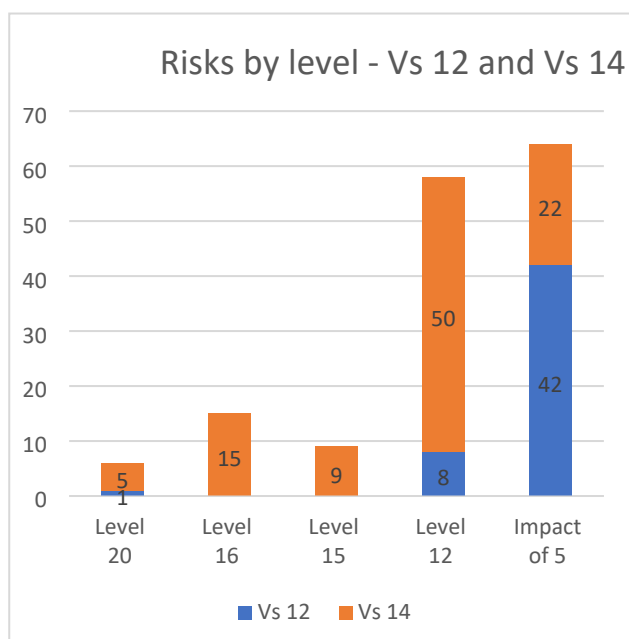
4. Analysis of risks

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

4.1. Risks level 25

There are no risks with a risk rating of 25 recorded in the Trust Risk Register at the time of the data being extracted from Datix.

4.2. Risks level 20

The table below provides a breakdown of risks level 20. There are currently six risks with a current risk rating of 20 recorded, three for VCC, two for TCS and one for WBS. This compares to five in the November 2021 reporting cycle. Of the six recorded risks with a rating of 20, three relate to performance and service sustainability and three to workforce.

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Five of these were scored as 20 in the previous reporting cycle (2191, 14764, 2437, 2401 and 2400) with one additional risk has been rescored level 20.

One risk is recorded with an increase in risk score:

- 2200 - has increased from a risk score of 16 reported in the previous period to a score of 20 in this reporting period. The risk relates to resource capacity within radiotherapy and was previously reported as level 16 in the November reporting cycle. The risk score has increased following analysis and assessment. The actions and controls are described as a maximising capacity for radiotherapy document which was written by the Radiotherapy Management Group. The required escalation processes to address capacity challenges is currently underway.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	14764	Welsh Blood Service	06/04/2022	Brexit - Implications of Exiting the EU - No Deal Situation
	2200	Velindre Cancer Centre	31/12/2021	Radiotherapy Capacity
	2191	Velindre Cancer Centre	31/01/2022	Inability to meet COSC / SCP targets
Workforce and OD	2437	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021
	2401	Transforming Cancer Services	04/02/2022	Risk of insufficient resources being made available to the Project
	2400	Transforming Cancer Services	31/01/2022	Risk that there is lack of project support

4.3. Risks level 16

The table below provides information of level 16 risks as per the Risk Register. There are currently a total of 15 risks with a current risk rating of 16, two for TCS and 13 for VCC. This compares to 16 in the November 2021 reporting cycle. 15 risks remain scored 16 and one (Risk ID 2200) increased to a score of 20 (see paragraph 4.2).

New Risks: No new risks have been reported with a score of 16 in this reporting period.

Risk Type	ID	Division	Review date	Title
Compliance	2428	Velindre Cancer Centre	29/11/2021	There is a risk of increased infection transmission due to poor ventilation.
Financial Sustainability	2198	Velindre Cancer Centre	13/12/2021	VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts
Performance and Service Sustainability	2402	Transforming Cancer Services	31/01/2022	Risk of time-consuming infrastructure work
	2190	Velindre Cancer Centre	31/03/2022	BI Support for reporting of Breaches
	2211	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working
	2203	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme
	2221	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS
	2329	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics
	2328	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes
	2440	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics
	2193	Velindre Cancer Centre	01/04/2022	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)
	2196	Velindre Cancer Centre	01/12/2021	Radiotherapy Department -COVID Isolation Impact
	2345	Velindre Cancer Centre	06/12/2021	Radiotherapy Dept - Change to service due continued response to Covid19

	2326	Velindre Cancer Centre	31/12/2021	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care
Quality	2403	Transforming Cancer Services	07/01/2022	Risk that enabling works construction exceeds timescale

4.4. Risks level 15

There are currently nine level 15 risks recorded in the Trust Risk Register. All nine risks for this level are recorded for VCC with six relating to performance and service sustainability, one to safety and two to workforce. To note that eight of these risks have remained scored at 15 from the previous reporting period.

New Risk: One new risk has been recorded in this reporting period:

- 2480 – There is a risk that there may be a shortfall of oncologists. The identified risk is based on census predictions that go up to 2025, and highlight potential impact on services. There are a number of control measures identified including: an increase in training placements; developing new multi-professional ways of working; and actively seeking to recruit.

Closed risks: One risk has been closed in this reporting period:

- 2218 - This risk related to parking space at VCC in the West car park. Extended and dedicated parking has now been provided and the risk eliminated.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	2253	Velindre Cancer Centre	01/05/2022	Availability of CANISC System
	2187	Velindre Cancer Centre	31/12/2021	Radiotherapy Physics Staffing
	2205	Velindre Cancer Centre	31/01/2022	CANISC failure
	2296	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR010(R) - Data Migration Resource

	2252	Velindre Cancer Centre	01/04/2022	Large number of development projects in Radiotherapy
	2220	Velindre Cancer Centre	31/12/2021	Treatment Planning System End of Life
Safety	2185	Velindre Cancer Centre	31/05/2021	Delination Risk treatment delay (16284)
Workforce and OD	2480	Velindre Cancer Centre	23/12/2021	Current and predicted shortfall of oncologists by 2025
	2217	Velindre Cancer Centre	01/12/2021	Medical Capacity for RT Planning in Job Plans

4.5. Risks Level 12

As per the table below, there are currently a total of 58 risks with a current risk rating of 12, five for Corporate Services, Fourteen for TCS, eight for WBS and thirty two for VCC.

New Risks – Two new risks were opened in the reporting period:

- 2486 – There is a risk that the Section 278 application takes longer than expected to be approved leading to delays in overall construction time. The process has started and is being monitored.

Closed Risks - Four risks have been closed in the reporting period:

- 2227 – The inability to comply with Health Protection (Coronavirus Restriction) (Wales) Regulations 2020. There is continuous implementation of IPC and social distancing measures to ensure all patients are triaged and assessed. Other IPC related risks are recorded and managed (see risk ID 2393 and 2397 in the table below).
- 2234 - Non-compliance to COSHH regulations, which may lead to staff injury or ill health when using chemicals not in the SYPOL system. The Alcumus (SYPOL) system is now in place and the risk has been closed.
- 2414 - There was a risk that application to create public right of way could impact enabling works project's ability to use for a Temporary Construction Access Road (TCAR). Allowance has since been made for handling correctly the newly established public right of way through the railway cutting.

- 2235 - There is a risk at VCC of health and safety breaches due to lack of dedicated H&S support. An H&S audit was undertaken and various improvements in COSHH management and processes have been put in place. Operational Services are supporting the division (VCC) in taking this forward. A number of staff and managers have completed professionally accredited H&S training.
- 16883 – There is a risk that the implementation of Oracle Release R12.2.9 (Phase 1) may affect requisitions for catalogue and non-catalogue items. Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Service point tickets are raised when required for issues/errors identified on an ongoing basis.

Risk Type	ID	Division	Review date	Title
Compliance	2188	Velindre Cancer Centre	24/01/2022	There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service delivery
	2251	Velindre Cancer Centre	30/09/2021	XVI imaging termination faults resulting in repeat acquisitions
Financial Sustainability	16398	Welsh Blood Service	23/12/2021	Review of modules used in Oracle Finance & Procurement System - GxP impact
	2255	Velindre Cancer Centre	31/03/2022	Patients Debt
	2249	Velindre Cancer Centre	20/12/2021	Risk of service disruption due to number of posts funded by soft monies leading to financial instability and recruitment difculties.
Partnerships	2411	Transforming Cancer Services	31/01/2022	Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS
Performance and Service Sustainability	13819	Welsh Blood Service	18/11/2021	Blood Supply Chain 2020 Initiative - Impact on Staff
	15373	Welsh Blood Service	28/02/2022	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA
	16883	Welsh Blood Service	31/12/2021	Implementation of Oracle Release R12.2.9 (Phase 1)
	16266	Welsh Blood Service	01/08/2022	Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain
	16703	Welsh Blood Service	17/12/2021	Risks identified for implementation of Oracle R12.2.9
	2475	Velindre Cancer Centre	31/01/2022	A risk that increase in COVID and the Winter pressures period potentially impacts Int. Care project delivery
	2452	Velindre Cancer Centre	01/02/2022	Intermittent IP telephony failure

	2223	Velindre Cancer Centre	12/01/2022	Delay in re-starting outreach activity
	2224	Velindre Cancer Centre	12/01/2022	Demand for services outstripping capacity
	2206	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic
	2324	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support
	2325	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department
	2438	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record Risk DHCR043(R) - Completion of process maps and ways of working
	2254	Velindre Cancer Centre	06/06/2022	Lack of mechanical ventilation at the VCC site (including inpatient ward areas)
	2222	Velindre Cancer Centre	31/07/2021	Loss of CANISC - compromise patient care
	2258	Velindre Cancer Centre	31/12/2021	Medicines at Home Service:
	2290	Velindre Cancer Centre	31/03/2022	Patients at risk of being lost to follow up
	2361	Velindre Cancer Centre	01/12/2021	Radiotherapy Dept - COVID Social distancing
	2256	Velindre Cancer Centre	01/11/2021	SACT / Divisional
	2245	Velindre Cancer Centre	31/12/2021	Service impact of delay in equipment replacement
	2213	Velindre Cancer Centre	01/05/2022	VCC Phone System - External Phone Lines
	2423	Transforming Cancer Services	04/02/2022	Risk that IRS evaluation process is delayed due to resource pressures
	2431	Transforming Cancer Services	31/12/2021	There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption
	2408	Transforming Cancer Services	04/02/2022	Risk that IRS Project FBC is delayed or not approved
	2413	Transforming Cancer Services	05/01/2022	Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility
	2407	Transforming Cancer Services	05/01/2022	Risk of overlapping timeframes and interdependancies between RSC & IRS Projects
	2394	Corporate Services	28/10/2021	Fundraising Income Targets
	2396	Corporate Services	28/10/2021	PADRs

Quality	2236	Velindre Cancer Centre	03/01/2022	There is a risk of poor patient experience as a result of insufficient space and poor environment
	2486	Transforming Cancer Services	07/01/2022	There is a risk that the Section 278 application takes longer than expected to be approved,
	2416	Transforming Cancer Services	31/01/2022	Risk that COVID may lead to delays on Project progress
	2405	Transforming Cancer Services	31/01/2022	Risk that projected growth assumptions for Outreach will be less than required
	2415	Transforming Cancer Services	05/01/2022	Risk that key resource involved in a number of projects leading to not enough capacity to fulfil commitments
Reputational	2418	Transforming Cancer Services	14/01/2022	Risk that TCS Programme does not have support from Stakeholders
	2417	Transforming Cancer Services	14/01/2022	Risk that there is lack of TCS Programme Comms Plan
Safety	15932	Welsh Blood Service	05/11/2021	Impact of COVID-19 stabilisation phase to WBS
	2424	Velindre Cancer Centre	25/01/2021	Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels
	2389	Velindre Cancer Centre	31/01/2022	Risk that patients with altered airways may not receive appropriate care from the MDT clinical team
	2248	Velindre Cancer Centre	31/01/2022	There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection
	2239	Velindre Cancer Centre	28/01/2022	Pharmacy Stores – inadequate space
	2388	Velindre Cancer Centre	31/03/2022	There is a risk of high temperatures, increased spread of infection a result of lack of ventilation
	2395	Corporate Services	28/10/2021	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre
	2393	Corporate Services	28/10/2021	Infection control
	2397	Corporate Services	28/10/2021	Infection Prevention & Control Service including staff attendance
Workforce and OD	14508	Welsh Blood Service	01/09/2021	Management of Workplace Related Stress
	2432	Velindre Cancer Centre	31/01/2022	Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care
	2202	Velindre Cancer Centre	01/12/2021	Consultant cover for long term absences

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	2436	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR041(R) - Service expecting a 'surge' in patients end of October 2021
12	2229	Velindre Cancer Centre	24/01/2022	Risk to timely communication/engagement activities as a result of dedicated resource leading to low morale, reputational damage
	2244	Velindre Cancer Centre	12/02/2021	Senior Management Capacity
	2410	Transforming Cancer Services	18/03/2022	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme
	2243	Velindre Cancer Centre	15/12/2021	SACT staff turnover

4.6. Impact level 5

Risks in the table below include risks with an impact of 5 and a score below 12. These risks are included in accordance with the risk appetite levels. Each of these risks are going through review during this cycle and updates on these risks will be republished in the March cycle of papers, in line with service priorities. As mentioned above, further insight and analysis from SLT for VCC and SMT for WBS will be included in versions of the paper for QSP and Board

There are a total of 64 risks with impact of five, 23 relate to VCC and 41 to WBS. Of the 64 recorded risks, eleven relate to compliance, 42 to performance and service sustainability and eleven to safety.

New Risks: No new risks with impact of five have been recorded in the period.

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	Not required

ASSESSMENT COMPLETED	
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. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the risks level 20, 16, 15, 12 and impact of 5 reported in the Trust Risk Register and highlighted in this cover paper.
- **NOTE** that a project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust.
- **NOTE** the further work in January to update the profile in light of the recently changing covid risk profile.

ID	Division	Approval status	RA Date	Title	Description	Controls in place	Current Risk Rating	Review date
16894	Welsh Blood Service	Final approval	28/10/2021	Transfusion associated acute lung injury risk reduction strategy	WBS supply of apheresis platelets from female or previously transfused donors, not screened for HNA antibodies	Donor screening identifies donors that may have experienced sensitising events (previous transfusion/pregnancy) but without HNA antibody screening is not able to mitigate the risk of these antibodies being present.	5	28/01/2022
16900	Welsh Blood Service	Final approval	18/10/2021	Apheresis Premises at Velindre cancer Centre	Velindre Cancer Centre Hospital building	Hospital facilities are inspected by an external contractor (Hurley & Davies). The VCC collection suite has been licenced by the HTA and will be regularly inspected by the WBS. H&S, Fire inspections regularly undertaken.	5	18/10/2022
16883	Welsh Blood Service	Final approval	20/09/2021	Implementation of Oracle Release R12.2.9 (Phase 1)	IPROC module - allows users to order catalogue and non-catalogue for non-stock items from suppliers.	(1) Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Servicepoint tickets were raised when required for issues/errors identified. (2) Smoke testing has been performed by eEnablement which incorporated end-to-end testing.	12	31/12/2021
16809	Welsh Blood Service	Final approval	06/09/2021	Malaria Risk – Delay in Implementation of the Process to Support Amended Malarial Testing for a Specific Donor Group	Non-compliance with donor assessment based on the JPAC Donor Selection Guidelines for donors with MALR, MALF and MALP risks. No malaria discretionary test is undertaken following re-exposure to a malarial risk for donors in this group.	This issue has been fully discussed at JPAC / SACTTI-(Parasites) group. The MHRA have laisied with the Chair of JPAC- the conclusion is that whilst WBS practice is safe, the recommendation is to align WBS practice with other UK Services. By definition all these donors will have tested negative for malaria at their first donation - this part of the process is robust. It is the subsequent testing post re-exposure that is missing.	5	06/09/2022
16762	Welsh Blood Service	Final approval	13/08/2021	Supply Chain disruption of Blood Collection tubes	All other tubes not on the shortage list (10ML, 6ML etc)Update-17/08/2021	"Internal stock take and regular monitoring and management of WBS stock position. Stock holding of 8 weeks supply at present. Stock projection received from BD for coming months and identification of WBS allocation."	10	18/03/2022
16703	Welsh Blood Service	Final approval	23/06/2021	Risks identified for implementation of Oracle R12.2.9	Lack of end to end testing	None	12	17/12/2021
16780	Welsh Blood Service	Final approval	22/04/2021	Transport of Donor Records to and From WBMDR Collection Centre	Transport of paperwork that may contain donor personal identifiable information (PII)	Paperwork transported by WBMDR staff is kept to the minimum required (note: all WBMDR documentation only contains the minimum required PII to facilitate the collection). Staff are aware of the GDPR requirements, and have received training in Information Governance. Information and training provided by the WBMDR and stated in the standard operating procedure for the stem cell/PBL collection (SOP HUB-903). Staff advised to drive directly between the WBS and the collection centre unless absolutely necessary to stop or divert. Paperwork stored together securely (in a closed folder or bag) and out of sight in the vehicle.	5	22/04/2022
16778	Welsh Blood Service	Final approval	16/03/2021	Apheresis Premises at Nuffield The Vale Hospital	Nuffield the Vale Hospital building	Hospital is HIW inspected, HTA licenced and inspected by the WBS. H&S, Fire and HIW inspections regularly undertaken.	5	16/03/2023
16398	Welsh Blood Service	Final approval	11/12/2020	Review of modules used in Oracle Finance & Procurement System - GxP impact	Purchasing - used to manage the procurement of both stocked items (using the Inventory module), and non-stocked items (using the IPROC module).	Functionality verified in CQ test scripts for IPROC and Inventory (Note: issues would only be identified in the Live environment during CQ testing)	12	23/12/2021
16467	Welsh Blood Service	Final approval	27/11/2020	Receipt, Storage and Distribution of Covid 19 Vaccines	Recording time of vaccine removal from -80 freezer	Labels printed with time Print labels before removal of vaccine from freezer risk treatment - validate printed labels	5	22/10/2022
16295	Welsh Blood Service	Final approval	22/09/2020	Use of Female Plasma for Manufacturing Pooled Cryoprecipitate	WBS Cryoprecipitate made from female donors not tested for HLA/HNA antibodies	"Prevention 2) Low level of plasma from each donor, reducing any potential antibody concentration"	5	12/04/2022

16266	Welsh Blood Service	Final approval	15/09/2020	Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain	Inability to operate clinics at the same efficiency verses pre-Covid 19 due to social distancing and IPC measures/amount of donors able to attend venue due to social distancing measures.	Escalated to the Director of WBS And Chief Operating Officer for VUNHST, Head of Planning Logistics and Resource to submit SBAR outlining emerging situation and required support. Explored with MOD available venues. Ongoing dialog with PHW and WG about conflict between vaccination and WB venues. Update 28/01/2021 - A number of Health Boards have not yet responded to email , those that have showed that there will be some conflict with venues in certain regions. Working on proof of concept for use of trailers in a socially distanced environment. Also looking at options around a potential fixed site.	12	01/08/2022
15973	Welsh Blood Service	Final approval	19/05/2020	Exposure to Potential Pre-symptomatic, Asymptomatic Individuals at Verification Sample Procurement, Donor Information, Medical A	Donor Exposure to potential pre-symptomatic, asymptomatic individuals at VT sample collection - Performed by a Health Care at Home under contract to the WBMDR.	Assurances received from Health Care at Home that correct protocols are being implemented with regards to social distancing and use of appropriate PPE.	5	06/03/2022
16009	Welsh Blood Service	Final approval	18/05/2020	Social Distancing measures within the Laboratory environment (Lab Services and WTAIL)	See attached FMEA	See attached FMEA. Reviewed FMEA attached. Risk further reduced by staff vaccination program. All other measures remain in place. GS, 27/05/21	5	27/05/2022
15937	Welsh Blood Service	Final approval	04/05/2020	Covid-19 implications of handling biological samples within the WBS	Handling of untested or presumed COVID-19 negative samples for laboratory testing	Appropriate staff training, supervision and comptetence. Good laboratory practice. Use of standard laboratory PPE including nitrile gloves and labcoats. Risk treatment plan and recommended actions: All staff should be aware that there is the potential for any sample to be positive for COVID-19, as patients or donors may be asymptomatic. If appropriate, all primary samples should be centrifuged and left for at least 10 minutes before decapping to reduce aerosol risk. Centrifuge bucket lids must be used to reduce aerosol production risk in the event of tube breakage. Aerosol-generating or potential splashing procedures should be performed in a Class-2 microbiological safety cabinet if possible and appropriate. If these cannot be performed in a cabinet these procedures must be identified and additional proportionate controls put in place, such as capping of tubes, safety screens or PPE. Local Risk assessment within each laboratory should be performed to identify these procedures. Update 06/01/2021. Vaccination for all front line/lab staff has ben tolled out, Increased UK testing capability, increased use of PPE for all staff. No evidence of laboratory COVID-19 transmission has been seen, and no evidence (either locally or worldwide) that COVID-19 has been transmitted by aerosol from laboratory samples.	5	05/10/2022
15932	Welsh Blood Service	Final approval	23/04/2020	Impact of COVID-19 stabilisation phase to WBS	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	VUNHST planning team and WBS blood health team are liaising with hospitals to determine future demand. Existing MOU with the UK blood services to support in the event of a shortage in a blood component. WBS planning team have forecasted future collection models based on potential scenarios. Currently working on a proof of concept around trailer use in a socially distanced environment and also considering fixed site options.	12	05/11/2021

15746	Welsh Blood Service	Final approval	18/02/2020	Process Risk Assessment - Environmental Monitoring	Heat Sealers - including Blood Press Sealers	Maintenance regime in place to ensure equipment remains in peak performance at all times.	5	21/12/2021
15533	Welsh Blood Service	Final approval	27/09/2019	Manual Double Entry of Test Results in Automated Testing - Contingency Process	Manual entry of test results which are normally interfaced directly from an analyser into BECS.	Components from a positive donation are physically removed from the supply chain by Automated Testing staff.	5	15/12/2021
15456	Welsh Blood Service	Final approval	11/07/2019	Clinical RA for not providing HbS negative red cells	HbS negative blood not supplied by WBS as recommended by JPAC guidance	"- low incidence of HbS in Welsh population (0.02% in 2013) '- Most HbAS units block leucodepletion filters and don't make it to a usable donation"	5	22/02/2022
15373	Welsh Blood Service	Final approval	27/06/2019	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	Increased complexity of networking / integration architecture in respect of the middleware used to interface devices that require interfacing to MAK-System products (e.g. ePROGESA). Additional costs incurred for establishment and maintenance of interfaces to MAK-System products (e.g. ePROGESA)	Ability to liaise with suppliers during procurement to advise on WBS preferences in respect of middleware arrangements for connected devices. MAK have recently confirmed "non partners" will still be permitted to interface devices to ePROGESA and other related MAK services. Subject to ongoing monitoring and discussion via International MAK-System User Group (IMUG).	12	28/02/2022
15398	Welsh Blood Service	Final approval	06/06/2019	Facilities Infrastructure	Electrical circuitry is not installed to current standards	Not installing any new equipment until power supply has been updated..	10	18/02/2022
15297	Welsh Blood Service	Final approval	29/04/2019	WBS Cyber Security Attack or Breach	WBS Systems and Services	Antivirus software deployed to detect threats. Device control deployed to limit access to removable devices. E-mail messages are scanned for threats and spoofing by NWIS. Web browsing is via a proxy server that scans for viruses and malicious content. Software updates are rolled out to address vulnerabilities in operating systems and key applications. Firewalls are enabled at device level as well as network levels to restrict access from unwanted systems. Newer operating system deployments are harden against security baselines recommended by suppliers and NCSC. Regular backups of critical and key data. Vulnerability scanning conducted against WBS devices. Phishing exercises targeted at WBS users	10	22/04/2022
15261	Welsh Blood Service	Final approval	01/04/2019	Microsoft Windows 7 and Server 2008 R2 End of Support	Windows Server 2008 R2 server operating system (ePROGESA)	Server operating systems are protected by local and network firewalls - this limits which devices can access the servers. Antivirus software provides detection and remediation against known threats. Internet usage and E-Mail is generally blocked from servers. System have been hardened against best practices. General users are only able to access limited parts of the ePROGESA environment, for example, Database Servers are not accessible	10	22/10/2021
15262	Welsh Blood Service	Final approval	01/04/2019	Oracle Java 8 End of Support	Oracle Java Runtime Environment	Java environment has been hardened to limit where applications can be launched from. Client operating systems are protected by local and network firewalls - this limits which devices can access the clients. Antivirus software provides detection and remediation against known threats. Removable media controls limit threats from USB/DVD drives. Internet usage is monitored to protect from web and downloadable threats. E-mail messages are scanned for threats. System have been partially hardened against best practices	5	22/04/2022
15189	Welsh Blood Service	Final approval	22/01/2019	Red Cell Antibody detection on the PK7300	Failure to detect high level anti-D on PK7300 - impact on Apheresis donations - not neonatal	None	5	14/01/2022
14764	Welsh Blood Service	Final approval	09/10/2018	Brexit - Implications of Exiting the EU - No Deal Situation	Increased expenditure	Public Contract Regulations Budgeting and financial controls	20	06/04/2022
14744	Welsh Blood Service	Final approval	03/09/2018	Abbott Microbiology Platform	Result Transfer to eProgesa	WBS Procedures Peer Review	5	13/01/2022

14508	Welsh Blood Service	Final approval	09/07/2018	Management of Work Place Related Stress	Could affect every activity within WBS including collections, processing and distribution etc. of blood products	Policy (Trust wide Mental Health , Wellbeing and Stress Management WF43) Toolkit to support Good Mental Health, Wellbeing and Reduce Stress. Employee assistance programme All Wales Wellbeing Tool Kit Stress risk assessment (completed by manager with staff member) Sickness absence policy Manager Training Mindfulness / complementary therapy Team Assistance Organisation Development facilitated discussion and mediation Organisation change RA Blood Supply 2020 relating to stress. Work life balance - flexible working. Health and wellbeing - Cycle to work scheme to promote healthy activities. Monitoring of sickness and absence reasons and levels. PADR process - clear roles and responsibilities. Manager support. Update Oct 2019 Continue to monitor sickness and absence levels WBS Sickness and Absence Deep Dive Stress Related Absence document produced Dec 2018 Ongoing wellbeing initiatives Initiatives introduced to look at finances - Home finances impact on stress Menopause Policy developed and initiatives to look at this introduced (Menopause Café) which impacts on work place stress	12	01/09/2021
14215	Welsh Blood Service	Final approval	06/03/2018	Risks associated with the implementation of Prometheus into WTAIL	Failure of WTAIL to meet its regulatory obligations (e.g HTA)	URS signed off and agreed. Regular meetings with supplier to ensure URS requirements are fulfilled. Regular communication with supplier in respect of changing/ new regulatory requirements. Development complete. Update 13/10/2020 UAT is complete.	10	01/04/2022
13819	Welsh Blood Service	Final approval	21/02/2018	Blood Supply Chain 2020 Initiative - Impact on Staff	Revised roles and contractual changes. New ways of working.	Early engagement with staff. Full support package available on intranet. Occupational Health support available. Potential for staff opportunities. Involvement of staff in decision making.	12	18/11/2021
13311	Welsh Blood Service	Final approval	08/11/2017	Reprinting Group Labels for overweight imported red cells	Reprint group label for imported red cell which is overweight (outside maximum volume parameter)	"NHSBT & SNBTS have an automatic discard set for components that are overweight/ over-volume (i.e. all Blood Services comply to the Red Book Guidelines and have their processes controlled accordingly). Laboratory staff identify non-conforming donations.	5	12/04/2022
12342	Welsh Blood Service	Final approval	29/03/2017	Use of the External Plasma Freezer	Safety of staff whilst using the freezer	None (PPE)	5	01/11/2022

12104	Welsh Blood Service	Final approval	02/02/2017	Movement of WBS personnel within the service yard area	Staff movement in the service yard .	Designated speed limit of 10 mph within the service yard area. Entrance gate controlled from central point (reception). Entrance gate is kept closed and access to the service yard is via intercom. Adequate lighting located in service yard area. All transport department staff and CCA drivers who use the service yard are provided with a service yard awareness briefing. This is undertaken as part of their training and is detailed in the training booklet prepared by transport department. Donor Services personnel and facilities staff are issued with hi visibility jackets /vests to wear when working on service yard area and this is a compulsory requirement. Transport and Facilities staff provide hi visibility jackets/vests to visitors and these visitors are escorted whilst on the service yard. Additional controls include hi vis paint work, periodic service yard inspections, contractor leaflet read and understood before work commences. CCTV coverage of the service yard.	10	01/10/2021
11522	Welsh Blood Service	Final approval	17/10/2016	Antibody detection by Luminex based technology	Detection of HLA antibodies by Luminex based methods	sample collection requirements are stated in WTAIL user guide. samples are only taken by trained phlebotomists and nursing staff. Acceptance of results based on review of patient history as and when available and take into consideration patient own type. Platelet cases require increment data for review of increment levels to determine further support required. Multiple samples are tested for those patients requiring long term support.	10	29/10/2022
9515	Welsh Blood Service	Final approval	03/07/2015	WBMDR Sterile Tube Welder	Sterility	Documented system at Collection centre (by two individuals) to check docking undertaken correctly (recorded on form WBM-551). Use of standard concession system (SOP 566/HUB) in the event of a dock failure. Routine sterility testing of all HPC products (100% testing)	5	04/11/2022
8719	Welsh Blood Service	Final approval	17/12/2014	GMP-0273 (Premises)	Storage area	Restricted access to authorised staff only. Physical segregation of product from routine blood stocks. Clear identification as HPC product	5	20/11/2022
8706	Welsh Blood Service	Final approval	15/10/2014	GMP-0062 (PBSC Collection)	Collection of product	pre-assessment of veins by 2 different healthcare practitioners. BM collection available as possible back-up	5	09/02/2022
8712	Welsh Blood Service	Final approval	15/10/2014	GMP-0066 (Assess Donor Fitness)	Failure to receive completed report in time for 'Final Clearance'.	None	5	09/02/2022
8717	Welsh Blood Service	Final approval	15/10/2014	GMP-0071 (HPC Storage & Transport)	Storage of PBSC/PBL	Stored in GMP monitored area of WBS. Stored in secure area. Controlled product release.	5	05/11/2022
8713	Welsh Blood Service	Final approval	15/10/2014	GMP-0067 (G-CSF administration)	Incorrect dose.	Prescription calculated according to SOP by consultant with nurse. Dosage actually given is recorded on prescription at time of administration.	5	03/03/2022
8715	Welsh Blood Service	Final approval	15/10/2014	GMP-0069 (Final Release)	Product Inspection	Visual inspection of each bag in accordance with documented procedure. Documentation to allow audit trail. Formal concession system to account for any sterile docking failures. 02/11/2016 No change to control measures required.	5	09/02/2022
8707	Welsh Blood Service	Final approval	15/10/2014	GMP-0063 (PBL Collection)	Collection of product.	IDM Testing and Lifestyle questionnaire performed	5	09/02/2022
8708	Welsh Blood Service	Final approval	15/10/2014	GMP-0064 (Whole blood for immunotherapy)	Donor Fitness for purpose	IDM testing and lifestyle questionnaire	5	26/11/2022

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

7026	Welsh Blood Service	Final approval	03/10/2013	WTAIL liquid nitrogen automated filling system (low pressure) TT1-17	DATIX 3467 - transferred from paper assessment	Cryostorage refrigerators are sited so their open lids cannot damage the piping; The system has a regular Insurance inspection (Zurich); Piping, valves and controllers have regular maintenance by specialist contractors; Room has mechanical ventilation (monitored and alarmed by the EMS system); Laboratory Safety procedure POL(S)-009; Oxygen depletion sensors are present in the room, with audible and visual alarms; Induction training; Liquid Nitrogen emergency cut-off switches present both inside and outside of room to stop flow in event of problem: SOP 112/TTY, Management of the liquid nitrogen system in the Welsh Transplantation and Immunogenetics Laboratory. CryoVent system bleeds Nitrogen gas from lines before filling to prevent splashing. Use of cryo-protective gloves, coats, enclosed shoes and goggles mandatory. Laboratory safety procedures (POL-S 009), includes 'buddy system' for out of hours access.	10	02/02/2022
6987	Welsh Blood Service	Final approval	23/09/2013	Operation of the BacT/ALERT	Operation of the System	Staff trained to SOPs Good Laboratory Practise Process Design Competency Assessment Appraisal Controls	5	06/01/2022
5394	Welsh Blood Service	Final approval	21/05/2012	Remove the class I HLA-A, HLA-B, PCR-SSP result from the UBM database for stem cell donor 15568709	Remove incorrect HLA type from UBM Database	IT working instructions Post implementation check performed	5	15/11/2022
2556	Welsh Blood Service	Final approval	23/04/2010	Missing Hazardous Items	9-4-10:The standard procedures for storage and transportation of all hazardous material created during a blood donation clinic should ensure that none of these items go missing. Hazardous material is defined for the purposes of this SOP as:- " Sharpsafes containing used items e.g. needles " Boxes containing contaminated waste " Vacutainers containing blood samples " Blood transportation boxes containing full blood donations/Non Conforming Donations	9-4-10: Standard operating procedure SOP: 014/BCT. WBS Transport record sheet (SOP: 022/BCT).Donor are health screened, before giving blood, which reduced the risk of contamination with blood borne pathogens. Training to SOP's. Agency Drivers have ID checks.	5	06/09/2022
175	Welsh Blood Service	Final approval	03/07/2007	Processing Platelets for Bacti Monitoring	25-Jun-2007 - Health and Safety Task Based Risk Assessment completed on QA Lab:processing platelets for bacti monitoring. Task: take samples from platelets and insert component into sealed bottle prior to entering into bacti monitoring system. Hazards: Microbiological status unknown, heat sealer, needle stick. See additional checklist.	SOP's in place covering all parts of procedure. Risk reduction process needlestick: rack placed inside microflow only one sample prepared at a time. Microbiological: if samples confirmed as positive process stopped regardless of stage of process. Heat sealer has protective cover - maintenance contact in place. No history of incidents. Ensure training records up to date for all staff performing tasks. 1/4/9 ongoing process. Risk reviewed 14-6-10, ongoing.	5	13/01/2022

ID	Is this a Private & Confidential Risk?	Risk Type	Division	Approval status	Service	Opened	Review date	Closed date	Title	Risk (in brief)	Rating (initial)	Rating (current)	Rating (Target)	RR - Current Controls
2486	No	Quality	Transforming Cancer Services	Accepted	Enabling Works	07/12/2021	07/01/2022		There is a risk that the Section 278 application takes longer than expected to be approved,	S278 Application There is a risk that the Section 278 application takes longer than expected to be approved, meaning that works traffic accessing the 'straight' TCAR are delayed, leading to a delay to construction and longer overall construction timeline.	9	12	6	This application process has started.
2480	No	Workforce and OD	Velindre Cancer Centre	Accepted	Medics	23/11/2021	23/12/2021		Current and predicted shortfall of oncologists by 2025	A recent census (RCR 2021) has predicted a shortfall across Wales in clinical oncologists by 2025. Medical oncologist were not included in the census but should also fall under this risk due to overlapping clinical roles. There is a current shortfall with predictions that this will worsen over the next 5 years (NB this is likely to be a gradual worsening over a period of time; the census predictions only go up to 2025 so no data suggests sudden improvement after that time). Due to the nature of clinical work, these gaps may fall unevenly, for example one team/tumour site could be seriously affected while others are not. Drivers behind this are: increasing clinical care/complexity (increase in patient numbers, increase in treatment options/complexity for each patient), new demands (eg regional AOS delivery), increasing trend to LTFT working and predicted retirements. On top of this there are potential impacts from Covid (ill health), pension tax impact.	15	15	4	Training places have increased however will not feed through by 2025. Actively seeking to recruit Developing new multi-professional ways of working (but there are also workforce limitations in other professional groups and the time taken to train new colleagues is a challenge)
2475	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Whole Service	19/11/2021	31/01/2022		A risk that increase in COVID and the Winter pressures period potentially impacts Int. Care project delivery	COVID-19 and Winter Pressures - A risk that increase in COVID-19 pressures and the Winter pressures period potentially impacts project delivery Cause: Increase in demand that requires project resource to focus solely on clinical work Increase in staff sickness leading to gaps in capacity/back fills requirements/prioritisation of clinical requirements	16	12	8	Update 10.12.21 - Regular meetings continue to take place with PMO to review status of projects and work plan. Activity monitored via the ICOG and sickness levels monitored by HODs. Mitigating actions: 1. Monitor staff sickness through the IC Operational Group 2. Monitor increase in demands via IC Operational Group 3. Update PM with resourcing issues for further escalation and re-prioritisation. Logged as a Project risk also for Integrated Care as may impact on project work streams

2472	No	Safety	Velindre Cancer Centre	Accepted	Operational Services	18/11/2021	31/03/2022		There is a risk that there is a traffic accident on site which may lead to someone being injured or damage to vehicles	All car parking areas on site. Vehicle movements on site including Staff, patients, deliveries and contractors. Pedestrian walkways on site. Specific risks include adverse interaction of vehicles and or pedestrians, slips trips/ falls, theft and vandalism.	15	10	5	Hazards identified: LPG storage cage close to road with no bollard protection (behind LA 2 and 3) Large vehicles encroach on coming traffic on narrow roads Pedestrians getting hit by cars Poor lighting resulting in slips, trips ,falls List control measures in place: Car park: 5mph speed restriction. Directional flow traffic system and road marking in place. Information signage directing visitors to the different departments on site. Designated ambulance parking areas and Ambulances fitted with audible reversing warning signals. Designated patient drop off/ pick up areas. Designated disabled parking spaces and pharmacy collections. Patient parking located near entrances allowing easier access for users. No parking zones are in place around the site and clearly visible. Dropped kerbs in place with tactile surface for pedestrians. Road and pavement surfaces in good condition
2460	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Risk of privilege escalation on local user accounts	In the event of a successful cyber attack against Velindre Cancer Centre there is a risk that a local user account could be leveraged, to the spread the attack further due to excessive privileges.	20	5	5	Controls in place include national firewalls, Anti Virus & ACLs.
2458	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - End of Life Server Operating Systems on the VCC Network	There is a risk of a cyber security breach as a result of the ongoing presence of servers within the VCC network running the legacy Operating Systems (Server 2003, Server 2008 etc.), which may lead to the disruption or loss of IT services across VCC. There are numerous end of life server operating systems within Velindre Cancer Centre (including Windows 2003 & 2008), which increases the risk of a successful cyber-attack as these devices are not appropriately patched and vulnerable to exploit.	20	10	5	Current controls in place include Firewalls (DHCW), Antivirus software (Mcafee and Defender), access control lists and network segmentation.
2452	No		Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/02/2022		Intermittent IP telephony failure	There is a risk of ongoing (intermittent) IP telephony failures as a result of a recent upgrade to the Wi-Fi central controller, which does not fully support the older Cisco 7925 Wi-Fi IP phones in use across VCC, which may lead to telephony disruption for around 150 users.	15	12	3	New Wifi phones are in stock to replace the critical areas that require upgrades immediately. New Batteries are required to install these which will be ordered ASAP. Plan to replace all 149 handsets ASAP Attempt to fix the issue with the 7925 in the interim.
2451	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - No Client Firewalls on VCC devices	There is a risk of a cyber security breach as a result of the lack of client firewalls on VCC devices, which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls in place. Anti-virus may mitigate malicious software, if attempted.
2450	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Inactive Edge Firewalls on VCC Servers	There is a risk of a cyber security breach as a result of VCC server firewalls being in 'passive' mode (meaning communications are not filtered), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls used as protection for VUNHST.
2449	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - VCC Software Patch Management	There is a risk of a cyber security breach as a result of the lack of a formal patch management approach for software being used within VCC, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Migration of VCC patch management onto Trust-wide 'PDQ' solution. Internal and external (NHS Wales) network protections (device / service isolation, firewalls etc.) in place.

| 2448 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 29/10/2021 | 01/05/2022 | | Cyber Security - NTLM hashed credentials stored in memory | There is a risk of a cyber security breach as a result of NTLM hashed credentials being stored in memory, which can be leveraged and result in the disruption or loss of IT services across VCC. | 20 | 10 | 5 | Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement. |
| 2447 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 29/10/2021 | 01/05/2022 | | Cyber Security - Cleartext credentials stored in memory | There is a risk of a cyber security breach as a result of due to the storage of account credentials in 'cleartext' format, which can be leveraged and result in a loss of IT services across VCC. | 20 | 10 | 5 | Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement. |
| 2446 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 29/10/2021 | 01/05/2022 | | Cyber Security - Weak Passwords in use on Admin / Privileged IT accounts | There is a risk of an external agent compromising VCC admin/privileged IT accounts as a result of the use of weak passwords in use within the VCC Digital Services team, which may lead to a cyber security breach and/or the loss of IT services across VCC, resulting in the disruption or loss of IT services across VCC. | 20 | 10 | 5 | Various Cyber Security tools in place including national firewalls, AV and ACLs which provides defence in depth.

Work ongoing to remove weak passwords. |
| 2445 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 29/10/2021 | 01/05/2022 | | Cyber Security - Risk of malicious payloads not being blocked by anti-virus (McAfee) | There is a risk of a cyber security breach as a result of malicious payloads not being blocked by VCC anti-virus (McAfee),, which may lead to the disruption or loss of IT services across the VCC. | 20 | 10 | 2 | VCC currently migrating to Defender Anti-Virus and will be moving towards Defender DLP.
Mcafee still in use on various servers and DLP enabled. |
| 2444 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 29/10/2021 | 01/05/2022 | | Cyber Security - CVE-2019-0708 BlueKeep Vulnerability | There is a risk of a cyber security breach as a result of the presence of the CVE-2019-0708 BlueKeep vulnerability within the VCC network, which may lead to the disruption or loss of IT services across VCC. | 20 | 10 | 5 | Affected Radiology services are protected behind IT security (firewalls - external to NHS Wales) with access to those systems limited to a small number of named access. |
| 2442 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 29/10/2021 | 01/05/2022 | | Cyber Security - End of Life Desktop/Client Operating Systems on the VCC network | There is a risk of a cyber security breach as a result of the ongoing presence of devices within the VCC network running the legacy Windows Operating System (Windows 7, XP etc.), which may lead to the disruption or loss of IT services across VCC. | 20 | 10 | 5 | National Firewalls.
Anti-virus controls in place. |
| 2440 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | SACT | 18/08/2021 | 29/11/2021 | | Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics | SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients

Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity. | 16 | 16 | 6 | Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints

23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week.

Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed |
| 2438 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Radiotherapy Services | 21/06/2021 | 29/11/2021 | | Digital Health & Care Record Risk DHCR043(R) - Completion of process maps and ways of working | Further maps now having to be drafted due to development of e-IRMER and migration issue. e-IRMER workflow maps required, increased workload for project team, with limited resource. | 20 | 12 | 9 | Project team structure undergoing revision & recruitment planned. Workshop to be arranged to finalise workflow process maps with clinical input |
| 2437 | | Workforce and OD | Velindre Cancer Centre | Accepted | Radiotherapy Services | 22/10/2021 | 29/11/2021 | | Digital Health & Care Record DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021 | Delay in new Radiographer graduates starting, likely to be October/ November 2021. Service will be relying on locum/ agency staff - more staff to train and higher risk of error. | 20 | 20 | 12 | DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource. |
| 2436 | | Workforce and OD | Velindre Cancer Centre | Accepted | Radiotherapy Services | 22/10/2021 | 29/11/2021 | | Digital Health & Care Record DHCR041(R) - Service expecting a 'surge' in patients end of October 2021 | Service expecting a 'surge' in patients end of October 2021. Will place increased pressure on service & staff, difficult to release for training & UAT. Risk of staff burnout. | 16 | 12 | 12 | DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource.

To continually review & monitor situation via workstream leads |

| 2432 | No | Workforce and OD | Velindre Cancer Centre | Accepted | Whole Service | 05/10/2021 | 31/01/2022 | | Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care | Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care DHCR036(R) - DHCR project support: Availability of Inpatient Staff, Psychology, Therapies, Infection Control, Clinical Coding, Assessment Unit and Supportive Care staff and CNSs, to support DHCR project due to continued increased demand across all these services.

1. Project timelines could be delayed as training, testing may be seen as secondary to providing clinical care.

2.Once ways of working have been identified, time required to employ, train any additional resource required could impact project implementation | 16 | 12 | 4 | Update 10.12.21 - Regular meetings continue to take with project leads. Ways of working almost completed for IC. Some process maps completed and signed off by service.
Update 03.11.21 -Regular update meetings scheduled with project team leads to review progress and outstanding work. Attendance at Project Team meetings.

Update 27/10/2021 -Dedicated time made available for operational lead. Continuous review of service capacity across the inpatient workstream prioritisation process. Weekly reviews with the Department Leads to monitor progress in DHCR project, but also to sense check the demands of the services |
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| 2431 | No | Performance and Service Sustainability | Transforming Cancer Services | Accepted | Programme | 23/07/2021 | 31/12/2021 | | There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption | There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption resulting in potential misalignment of project activity and as such further impacts to Programme Plans and Deliverables | 16 | 12 | 4 | 1) Project plans being reviewed with programme support to ensure they are up to date and where projects are now 'unpaused' to bring plans in line with more mature projects. Complete

2) Master Programme Plan updated to reflect update to projects and to show dependencies across projects and programme activity. Complete

3) Review and reporting on Master Plan to PDB and Scrutiny committee. Ongoing |
| 2428 | No | Compliance | Velindre Cancer Centre | Accepted | Nursing | 02/08/2021 | 29/11/2021 | | There is a risk of increased infection transmission due to poor ventilation. | Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward.
Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description | 16 | 16 | 9 | UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan.

* Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc.
* Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc.
* Full root cause analysis undertaken to ascertain cause(s) of any infections.
* Business Case currently under development to seek funding for compliant ventilation system. |

2424	No	Safety	Velindre Cancer Centre	Accepted	Therapies	28/07/2021	25/01/2021		Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels	There is a risk that there could be breaches of waiting times, reduced patient experience and outcomes as a result of reduced staffing levels in the Dietetics department which may and stress on the remaining staff members. Due to x1 maternity leave (Clinical Lead DT) and x1 LTS (band 6 PSU cover) with the Dietetic department the workforce is currently reduced from 5wte qualified staff to 3.5wte. Scrutiny approved 1.0wte band 6 DT and an internal upgrade band 6-7. Unfortunately we did not recruit into either of these posts. Our locum also finished on 7th July 2021. Scrutiny have however approved an external band 7 Clinical Lead DT 1.0wte, which is currently out to advert and in the recruitment process. There is therefore a current risk on the workforce that will hopefully be mitigated by recruitment into the vacant post. For the next 2-3 months, there will not be the required capacity to deliver a high quality, timely DT service. This will lead to breaches of waiting times, reduced	12	12	6	Remaining DT staff are trained to appropriate levels and clear re what they can and cannot do Clear prioritisation criteria is in place Discussions with Senior managers and exec colleagues to make them aware of situation Locum agency searches. Temporary cessation of some services will be required. Recruitment for the 1x external Clinical Lead Dietitian vacancy is underway
2423	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	08/09/2021	04/02/2022		Risk that IRS evaluation process is delayed due to resource pressures	There is a risk that as the nVCC Competitive Dialogue clashes with the IRS Final Tender evalutation, there is pressure on resource availability leading to delays in finalising the evaluation process	12	12	6	1) Works has started to understand which staff and resource are impacted to explore availability and potential impact of this to the Project
2418	No	Reputational	Transforming Cancer Services	Accepted	Programme	05/10/2020	14/01/2022		Risk that TCS Programme does not have support from Stakeholders	Risk that the TCS Programme does not have support from Stakeholders (pts, HB, politicians, WG, clinicians) Causes - Lack of engagement with all relevant stakeholders/ Misinformation shared from external sources / Inconsistent engagement from specialist resource / Change of views over a period of time / Lack of alignment between TCS programme and other strategic priorities across the organisation and individuals / Political leadership change Consequences - WG and LHBs do not support key decisions / Reputational damage for Velindre Trust as an organisation / Petitions & opposition to plans for TCS Programme / Delays to programme and project progress / Failure to deliver some/all of programme benefits	16	12	4	1) Further engagement is being planned with specialist stakeholders – broader and more targeted who are not fully supportive. Programme Communications resource in place & recruitment of additional comms resource to support comms/engagement activities 2) Better use of technology being reviewed and rolled out to share key messages 3) Variety of stakeholder events held over a number of years - complete 4) Clinical workshops held throughout Programme lifetime - ongoing 5) Professional meeting forums held e.g. DoPs, MDs, CEO's etc - ongoing 6) Ongoing engagement with local elected members (MS, MP, Councillors) 7) Dialouge beteen exisiting cancer forums e.g. cancer leads in SE Wales HBs - ongoing through CCLG 8) Monthly meeting with WG Head of
2417	No	Reputational	Transforming Cancer Services	Accepted	Programme	08/07/2020	14/01/2022		Risk that there is lack of TCS Programme Comms Plan	There is a risk that there is a lack of TCS Programme wide communications plan resulting in the objectives of projects and interdependant links are not communicated effectively and the wider networked clinical model not understood.	12	12	4	1) Revise TCS website - complete 2) Improve internal TCS teams Comms - complete 3) Improvements to intranet - started 4) Improvements to the link between Programme Governance and Comms - tbc
2416	No	Quality	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that COVID may lead to delays on Project progress	There is a risk that potential further waves of COVID may lead to delays that effect the development & key activity of the outreach project	20	12	6	Agreement with HBs of ways of working during any possible covid resurgence to ensure that project is able to continue making progress

2415	No	Quality	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	17/12/2019	05/01/2022		Risk that key resource involved in a number of projects leading to not enough capacity to fulfill commitments	There is a risk that as key resource are involved in both the RSC, IRS & nVCC Projects which are being managed in parallel could mean there is not enough capacity to fully commit to both projects. This could impact on the quality of the work or the ability to complete the requirements to agreed schedules.	16	12	6	1) A matrix to consider commitments of colleagues to consider priorities and timings to be developed. - ongoing 2) Resource review to understand if additional resource may be required to support project teams. 3) Alignment of meetings and agenda's for 'pressured' colleagues to be looked at to manage this. E.g. when there are items in meetings that are not relevant they can be released from the meeting
2413	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	29/06/2020	05/01/2022		Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility	There is a risk that the Radiotherapy Satellite Centre will not have required skilled staff in place to run the facility once ready to be operational. This would impact on radiotherapy capacity and resilience for the Trust.	15	12	6	1) An integrated Radiotherapy and Physics workforce plan is required to consider the service as a whole taking account of a full operating model that includes current activity, projected activity, IRS and RSU. 2) Provisions from across the whole service will be reconfigured to meet the requirements of the satellite unit.
2411	No	Partnerships	Transforming Cancer Services	Accepted	Programme	04/11/2020	31/01/2022		Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS	Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS Causes - Poor communications between VF & TCS teams Delays in agreement of VF scope & governance arrangements Lack of clarity of scope for VF Lack of understanding of the interdependent timescales and activity Lack of knowledge and understanding of both programme objectives Consequences - key deliverables get missed as not picked up by either TCS or VF Delaying progress of current live projects Change of priorities Adjustment of plans Agreements / decisions have been made already (i.e. could be contractual agreements in place) TCS may not be delivering the agreed VF scope & clinical outputs Disengagement of stakeholders	12	12	6	1) Agree clear scope and role of VF and its programme board. Complete 2) Understand the interfaces that VF has on the scope of TCS and its programme board to be clear about the delegations that result. Complete 3) Communicate the scope of both and any implications for TCS. Complete 4) Prioritisation of key work items and workshops to agree the appropriate routes for decision making. Complete - new ways of working with EMB Shape, Transformation Board & Strategic Infrastructure Board and Velindre Futures in place with clear governance structures in place 5) Understanding and agreement of key stakeholders within and outside the organisation. Stakeholder mapping reviewed, no significant changes within and outside of organisation. Complete
2410	No	Workforce and OD	Transforming Cancer Services	Accepted	Programme	05/10/2020	18/03/2022		Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet the needs of the TCS Programme outputs. Causes - Workforce supply not available in required professionals groups or with required skills / Requirements for workforce capacity and capability no longer accurate. Consequences - Inadequate staffing of Velindre facilities across the SE Wales region / Impact on providing treatment and care to patients	12	12	2	1) Service planning is sufficiently developed to facilitate effective workforce planning techniqies to be applied 2)Ensuring each project has clear and well developed workforce plans which are predicated on clear service plans 3) Clarity of expectations for workforce team involvement 4) Clarity of Role & Responsibility for Workforce planning input team in relation to Project & Programme need 5) Workforce team to support service to ensure the right people are available and allocated to support

2408	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	22/04/2021	04/02/2022		Risk that IRS Project FBC is delayed or not approved	There is a risk that the approval for the FBC for the IRS Project is delayed or not approved, due to changes in approval timescales which would lead to delays to project delay, project abandonment impacting on other TCS Projects (nVCC & RSC) deliverables	16	12	8	1) Engagement with Capital & Treasury teams - ongoing 2) Previous presentations to IIB - complete 3)OBC shared with WG Officers for comment - complete 4)WG notified of timescales for FBC so they can align resources - complete 5)Specialist advisors used to support delivery of Business Case - ongoing
2407	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	17/01/2020	05/01/2022		Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	16	12	4	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline
2405	No	Quality	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that projected growth assumptions for Outreach will be less than required	There is a risk that the projected growth assumptions for outreach delivery of SACT, ambulatory care and outpatients is less than will be required, leading to undersized locations.	16	12	6	1) Re-run projections around growth assumptions. 2) Activity model will be re-run with outputs presented to project Board. Any additional requirments will be presented to the Programme Delivery Board with recommendations. Individual meetings with Health Boards to ascertain their requirments will be undertaken.
2403	No	Quality	Transforming Cancer Services	Accepted	Enabling Works	08/06/2020	07/01/2022		Risk that enabling works construction exceeds timescale	There is a risk that enabling works construction, including bridges, exceeds 15 months, leading to delays to nVCC construction and incurring financial loss claims from the MIM contractor.	12	16	9	1. Regular review of possible areas which may cause delay: Most recent review of the plan shows only minimal slack between the end of the enabling works construction and beginning of MIM construction Ongoing 2. Partial mitigation through normal contract condition re liquidated and ascertained damage – where events in the contractors control can result in compensation for costs incurred by the client resulting from time or cost overruns. Need to be within expected reasonable limits. Care required in setting that limit to steer away from punitive damages as few contractor would price the works, pushing up tender prices. Scaling delay damages clause added to tender documentation to ensure contractor is incentivised to complete work on time. Complete 3. Focus to be applied to detailed construction programme following return of FM,D&P bids. Complete
2402	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Transforming Cancer Services	10/05/2021	31/01/2022		Risk of time-consuming infrastructure work	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	16	9	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment

2401	No	Workforce and OD	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	26/02/2021	04/02/2022		Risk of insufficient resources being made available to the Project	There is a risk that insufficient resources (people) being made available to the project will have an adverse impact on the quality of the procurement process	16	20	8	1) Detailed project Plan to identify resource requirements 2) Approved Capital Budget for the Legal & Staffing Costs 3) Regularly monitor staff availability (annual leave & sickness)
2400	No	Workforce and OD	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2397		Safety	Corporate Services	Accepted	Quality and Safety	18/05/2018	28/10/2021		Infection Prevention & Control Service including staff attendance	1. Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2. Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3. Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4. There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT / sepsis leading to reduced engagement. This will hinder required service	16	12	9	Control Measures in place: 1. Risk assessment in place for ICNet and duplication of data entry but it doesn't take into account additional demands of imminent National Enhanced surveillance. 2. Core Microbiology service provision continues but opportunities for learning and clinical review missed as reduction in weekly microbiology ward rounds to every 3/ 4 weeks
2396		Performance and Service Sustainability	Corporate Services	Accepted	Workforce and OD	20/04/2017	28/10/2021		PADRs	Not all employees are receiving meaningful PADRs -PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	9	12	6	-PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.

2395		Safety	Corporate Services	Accepted	Quality and Safety	26/05/2020	28/10/2021		Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	15	12	9	1. As noted above, site has holistic fire strategy where compartmentation plays a key role 2. Site has high level of fire detection to WHTM 05 (Firecode) 3. Provision of fire safety training to support implementation of fire safety strategy 4. Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5. Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6. In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7. Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8. Consideration of fire risk assessment findings (including compartmentation issues) as part of
2394		Performance and Service Sustainability	Corporate Services	Accepted	Governance	21/04/2016	28/10/2021		Fundraising Income Targets	This risk applies to external charities as well as those based on site at Velindre Cancer Centre. However, the control measures and focus of the remainder of this risk assessment relates to onsite charities.	12	12	3	The Trust has a clear fundraising strategy in place. Velindre Cancer Centre's branding guidelines introduced in July 2015 states that: - The Velindre University NHS Trust, NHS Wales, Velindre Cancer Centre and Velindre Fundraising will be the prominent brands on Velindre Cancer Centre premises. - Only 'Velindre Fundraising' and 'Friends of Velindre', charities which raise funds exclusively for Velindre NHS Trust, will be allowed to display publications, materials or media alluding to any form of fundraising on Velindre Cancer Centre premises. - Non-fundraising materials from other charities and organisations will be promoted where there are clear benefits for patients and carers
2393		Safety	Corporate Services	Accepted	Quality and Safety	19/06/2020	28/10/2021		Infection control	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex	12	12	9	To be inserted

ID	No	Category	Location	Status	Department	Date	Date		Risk Title	Risk Description				Mitigating Actions / Updates
2389	No	Safety	Velindre Cancer Centre	Accepted	Therapies	28/05/2021	31/01/2022		Risk that patients with altered airways may not receive appropriate care from the MDT clinical team	There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management. Definition of these patients fall into 3 groups; • Head and neck patients with tracheostomy or laryngectomy stoma. • Respiratory patients requiring suction • Palliative patients requiring suction	12	12	6	Update 10.12.21 - Recruitment underway for a Head & Neck Advanced Nurse Practitioner with interviews taking place w/c 13.12.21. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Update 03.11.21 - additional mitigating actions: We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team. •Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level
2388		Safety	Velindre Cancer Centre	Accepted	Nursing	18/06/2021	31/03/2022		There is a risk of high temperatures, increased spread of infection a result of lack of ventilation	OPD Environment - Temperature of the Outpatients department There is a risk that during the summer months, due to a lack of ventilation and air conditioning in the outpatients department, the temperature exceeds that which is comfortable or safe for patients and staff. There is a risk that due to the extremes of heat, patients and staff could become unwell. Wall mounted fans should not be used due to covid restrictions.	12	12	8	Doors and windows left open where possible to increase ventilation. Staff providing cold drinks to patients in the department throughout the day. Increased seating outside the OPD entrance. Staff issued with lightweight scrubs. Staff to take regular breaks to ensure they remain hydrated.
2361		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	12/06/2020	01/12/2021		Radiotherapy Dept - COVID Social distancing	COVID Social distancing – Radiotherapy In response to national guidance to reduce the risk of contraction of COVID-19 due to close contact with persons and objects, social distancing measures have been introduced into the radiotherapy department in line with COVID-19 guidance. This may result in reduced capacity and the contraction of the radiotherapy service.	16	12	2	High-risk staff shielding. Symptomatic staff isolating. Staff aware of social distancing guidelines. See attached risk assessment for controls within each zone. 22.7.20. No change to actions. 20.10.20. Risk reviewed. New lockdown announced 19.10.20. No change to social distancing measures in radiotherapy department pj. 16.2.21. No change to measures in radiotherapy pj. 21/5/2021 – Risk reviewed by PJ & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service.

2345		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	06/12/2021		Radiotherapy Dept - Change to service due continued response to Covid19	There is a risk that there will be a continued change to service as a result of Covid 19 measures which may lead to contraction of the service and the creation of a waiting list As the service moves in to the recovery phase there is a continued risk of the availability of staff being impacted through infection prevention and control measures, thus potentially impacting on the service ability to deliver the required capacity to meet demand 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.	9	16	1	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary 'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infection Development of outsourcing contract to private provider to deliver external beam for prostate and breast 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2.Undertaking escalation work to minimise breaches
2343		Compliance	Velindre Cancer Centre	Accepted	Estates	20/12/2010	27/07/2021		Water Systems - Legionella	Maintaining the water systems free of Legionella at the Velindre Cancer Centre using a range of monitoring and control systems for water treatment and flushing across the VCC site. Continual improvement to remove redundant pipework and upgrade water systems where possible.	20	5	5	Regular monitoring of water temperatures. Regular testing and sampling. HEPA filters on shower outlets in the patient areas. Risk assessment and audit of water system by external consultant. Water Safety Group in place with appropriate members which meet regularly. Water Safety plan and written scheme are in place. Pre-planned preventative maintenance are also on FACTS and are routinely undertaken by competent staff. Removal of redundant pipe work where possible. Legionella management policy in place. Responsible person trained. Water sampling regime has been constructed and reviewed by Water Safety Group members and is currently in place on all sites.
2342		Safety	Velindre Cancer Centre	Accepted	Estates	22/10/2013	03/08/2021		Risk of patient using curtain track as ligature point	Risk of patient using curtain track as ligature point.	10	5	5	Approved contractors will install and validate anti ligature curtain rails where it has been identified via discussions with department managers as they are required.

2341		Safety	Velindre Cancer Centre	Accepted	Estates	02/12/2006	03/08/2021		Risk of injury to staff/contractors when working at height where there is a lack of edge protection	Injury to persons from falling from roof, and exposure to radiation whilst being on the roof.	5	5	5	Method statements and permits to access roofs from contractors. Working at heights has been a topic during team meetings to raise Estates staff awareness. Roof edge protection fitted to commonly accessed areas. Access to roof areas controlled through gate and locking system.
2340		Compliance	Velindre Cancer Centre	Accepted	Operational Services	22/10/2013	03/08/2021		Risk of injury to staff, patients, visitors if equipment hasn't been PAT tested	There is a potential risk of injury to building users if equipment have not been PAT tested.	15	5	5	No equipment to be used on site unless it has a valid PAT sticker. Patients equipment is tested and PAT sticker is applied (staff are responsible for informing Estates via the FACTS system of patients' equipment which requires testing. Industry Guidelines consulted to decide frequency of testing for IT equipment (every three years). Medical equipment is tested by Bio engineering (outside of the Estates remit). All other equipment is tested annually. Asset register of appliances created during testing by contract labour. Department managers are informed prior to annual testing taking place within their department. Any incidents regarding portable electrical equipment are raised on DATIX and discussed at the Electrical Safety Group.
2339		Safety	Velindre Cancer Centre	Accepted	Estates	07/04/2007	03/08/2021		Risk of injury to staff whilst using single and double extension ladders and steps	Risk of injury to staff whilst using single and double extension ladders and steps.	15	5	5	Operative using ladder will inspect before use and report any defects. Safety man should be utilised when required. Barriers are available should they be required. Steps and ladders are regularly inspected and results are documented. Ladder training provided to staff.

| 2338 | | Safety | Velindre Cancer Centre | Accepted | Estates | 03/11/2005 | 01/09/2021 | | Risk of injury or ill health to staff whilst working in subterranean ducts (confined space) | Maintenance staff working in confined spaces such as the subterranean service ducts to either run in new services or to maintain existing ones. The ducts are not full height and therefore staff will have to crawl along these spaces. In the event of a person collapsing, difficulties would arise with emergency evacuation. Issues noted when working in confined areas include, but are not exclusively, cramped conditions, heat, gas, fire/explosion, radon gas, exposure to asbestos and problems carrying out an emergency evacuation in the event of injury or illness. | 15 | 5 | 5 | Staff not trained in confined spaces are prohibited from entering confined spaces under any circumstances, therefore should an occasion arise when entry to a confined space is required out of hours and an untrained Estates worker is on call, he will have to contact one of the confined space trained tradesman to assist. Members of the Estates department have received confined space training and two have received confined space supervisory training.

Lighting has been upgraded in the ducts. An asbestos removal has taken place in the ducts, however residual asbestos is still in the Horseshoe and main duct therefore Estates workers are not to enter either the Horseshoe or main duct. An asbestos survey was carried out in the Whitchurch duct and no asbestos was recorded (additional sampling is to take place). Staff have completed Health and Safety training. Hot works permit to works are in use on site. PPE is available for all members of Estates (this includes CAT B disposable suits and over boots, FP3 masks, safety shoes, and gloves) |
| 2336 | | Safety | Velindre Cancer Centre | Accepted | Estates | 08/06/2009 | 03/08/2021 | | Risk of injury or ill health to Estates staff whilst working in a lone working environment | Risk of injury or ill health to Estates staff whilst working in a lone working environment and a possible delay in receiving medical treatment in the event of an adverse event. Due to slips, trips and falls, contact with machinery, contact with electricity, serious illness, overcome by noxious fumes, falls from height or coming into contact with an aggressive violent person. | 15 | 5 | 5 | Safety shoes with non-slip soles provided. Hard hat areas identified or hazard tape used to identify bump hazards. Toughened gloves available. Two way radios are available should the Estates worker deem them necessary. Machinery has guards to prevent entrapment. Trained qualified staff to work within their capabilities. Staff carry Cisco WIFI phones and/or mobile phone. Some plant rooms have telephones

Permit to work required for electrical work. Ongoing program to barrier roof areas. Violence and aggression training is provided. Health and Safety training is provided. All plant rooms have automatic smoke detection. Co2 detector is fitted in the main boiler house. All boiler rooms have ventilated doors. Regular boiler maintenance is carried out. Basic Life Support training level 1 with practical CPR for maintenance technicians is delivered. Outside stairs are illuminated.

Medical staff available on site should a medical emergency occur. Maintenance staff will assess the need to use a safety person when required (out of hours |
| 2329 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | SACT | 09/06/2021 | 29/11/2021 | | Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics | There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required.

Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care. | 16 | 16 | 16 | SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary.

This is not comprehensive and does not cover all of the clinics at present. |

2328		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes	The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care Potential risk to patient safety because clinical staff are distracted by the administrative task Documentation will not be accurate impacting on clinical decision making Protracted administrative process causing stress to clinical teams whose primary focus is clinical care	16	16	16	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2326		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	24/05/2021	31/12/2021		There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care R	A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	16	9	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2325		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department	There is a Risk of Canisc being shut down on 17/09/21 before SACT & MM have completed required activity in Canisc. Clinical teams will be unable to access patient records during Canisc switch off, leading to delays in decision making and potential error, along with poor patient experience There could also be an impact on data migration if all SACT switch off activities are not completed in time	20	12	8	All clinical teams and SACT administration to complete all work before switch off deadline. During this time, SACT & MM have requested that switch off of Canisc be delayed until 19:00 on Friday 17/09/2021. This aligns with RT & OP clinics
2324		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	DHCR024(R) - DH&CR project support: There is a risk regarding the availability of SACT support for the DH&CR project, due to increased demand on the SACT service if & when SACT surge demand occurs or SACT capacity reduces The SACT DH&CR operational lead also provides clinical leadership for SACT booking services. Impact on clinical patient escalation & prioritisation process for SACT scheduling with potential impact on clinical outcomes if SACT DH&CR operational lead is unable to provide sufficient time to this element of service should SACT demand increase or capacity reduce. Conversely, there is the potential impact on the DH&CR SACT project progressing if resource is focussed on clinical prioritisation	16	12	8	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.

2296		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	11/01/2021	29/11/2021		Digital Health & Care Record DHCR010(R) - Data Migration Resource	DHCR010(R) - The Head of Information who manages the Business Intelligence (BI) Service within VCC is actively involved with the Data Migration work. This includes assisting the Data Migration Specialist with the development and testing of data migration extracts from Canisc to WPAS. In addition, the Head of Information provides subject matter advice and guidance to the whole project team. There are currently competing priorities on the Head of Information time due and the need to delivery Capacity and Demand planning, ad hoc information requests etc. during the COVID pandemic, whilst supporting a new team. The impact of these competing demands and a number of new team members is the reduced availability of focused time for the Head of Information to undertake the complex data migration work. This has impacted directly on the capacity of the Head of Information to assist in the development and testing of the data migration extract and provided support/guidance in a timely manner.	15	15	6	Clear prioritisation of the BI Service work and Head of Information's workload is required. Notification to service users of unavoidability of BI Head for 3 weeks period in April 2021. A deep dive is planned to support this prioritisation. 09/06/2021 - LM & JH reviewed risk - situation still stands. LM to discuss with WJ.
2290		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nursing	07/11/2019	31/03/2022		Patients at risk of being lost to follow up	Patients at risk of being lost to follow up Due to the volume of patients and the processes by which patients are booked for follow up appointments, There is a risk that patients could be lost to follow up.	10	12	8	UPDATE June 21 - Third analysis of FUNB ongoing and additional validation also being undertaken. Expected completion date is 30 June 2021. Clinic Outcome Forms to be completed after each patient consultation documenting next steps in patient pathway and ensuring appropriate outcome and that patient not lost to follow up. New Clinic Outcome Form has been implemented and if completed correctly for each patient appointment should help to reduce FUNBs. However, recent audit shows poor compliance. Medical records team to continue to work with SSTs to improve compliance. Further audit to be undertaken next month. Regular FUNB reports submitted to the OP Operational Group.
2262		Safety	Velindre Cancer Centre	Accepted	Estates	16/08/2018	03/08/2021		Releasing passenger lift release	In the event of a person being trapped in a lift, they will need to be released in a manner that will not endanger themselves or others.	10	10	5	The lift release key has been removed from Switchboard and has been placed in the Estates key safe to prevent unauthorised use. Staff will not release people or the lift be lowered by manually hand winding unless they have been trained on that lift in accordance with BS 7255 (training has been provided by OTIS). Furthermore there must be at least three members of staff available if the lift is to be lowered by manually hand winding. Persons trapped within a lift are only to be assisted out of a lift if they are within 200mm of a landing. A maintenance contract for lifts at VCC which includes the releasing of persons have been set up with OTIS Lift Company. Any derogation from the above in an emergency situation must be discussed with a senior member of the Estates Management team prior to any action. British Engineering insurance inspections are also undertaken on all lift throughout the Trust.

| 2261 | | Safety | Velindre Cancer Centre | Accepted | Pharmacy | 10/12/2015 | 01/12/2021 | | Lack of electronic prescribing at Teenage Cancer Trust | There is a potential safety risk to Teenagers and Young Adults who are under the care of VCC and TCT and therefore can be admitted to either facility. Currently VCC and TCT have two different systems, VCC operate an e-prescribing system whilst TCT still use paper prescriptions. | 16 | 10 | 4 | Experienced medical and nursing staff - familiar with both processes. TCT staff have access to CANISC but any changes to dose etc. would be via chemocare. The actual dose prescribed will be transferred to Canisc in the next version of chemocare. Pharmacy staff clinically check script(only if access to medical records/prior treatment). Inpatients will receive visit from pharmacist/med recs/clerking but this is not always the case for outpatients so its probably a highter risk for outpatients.

Business case is being developed for an all Wales National e-Prescribing solution (single solution). VCC to provide input and implement procured solution. Timescales to be confirmed.

31.08.20 - Working group has been established between VCC Pharmacy, UHW Pharmacy and wider UHW TCT reps since Feb 2020. An interim work around solution has been developed to enable TCT access to VCC ChemoCare and thus for the prescribing of regimens to occur electronically. Development of |
| 2260 | | Compliance | Velindre Cancer Centre | Accepted | Estates | 02/09/2011 | 03/08/2021 | | Control of Asbestos at VCC | Working on the infrastructure or fabric of the building and causing the release of asbestos which may endanger patients, staff, visitors and contractors. | 15 | 10 | 5 | Large areas of Asbestos have already been removed from Velindre Cancer Centre. Trust Asbestos Policy and Management Action Plan in place. Supervision on site has received "Management of Asbestos in Building Training" (P405). VCC has and maintains an asbestos register which Estates staff can access. The maintenance ducts have been identified as having asbestos material within them; maintenance staff have been informed not to enter these ducts.

Safe systems of work are in place at VCC, all jobs competed by Estates staff are automated through the FACTS system which locates any asbestos in the working area and records them on the job sheet identifying the risk as Level 1, 2, or 3. Estates staff have completed Asbestos Awareness Training within the last 12 months. Estates staff complete Health and Safety training.

Contractors are given tool box talks before being allowed to work on site which includes information on Asbestos and known locations. Prior to any |

| 2258 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | SACT | 17/05/2021 | 31/12/2021 | | Medicines at Home Service: | There is a risk that patient pathways and supporting professional procedures and practices (eg SOPs) will not be appropriately or adequately reviewed because of a lack of resource OR that pharmacist attempts to review in the absence of an alternative suitable clinician are clinically insufficient which may lead to patient safety incidents

There is a risk to service continuation and sustainability because of limited alternative clinical leadership within pharmacy (or wider SACT and MM Directorate) for the MaH service which may lead to the service needing to be reduced or discontinued with resultant negative impact on SACT and MM capacity and cost savings opportunities.

There is a risk to financial sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been avoided OR because of lack of strategic leadership to continue to | 16 | 12 | 4 | Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2256 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | SACT | 26/03/2020 | 01/11/2021 | | SACT / Divisional | Reporting on treatment pathway changes
As a result of the COVID-19 Pandemic, it is likely that some patients will not be initiated on a new Systemic Anti-cancer Treatment (SACT) treatment regimen, whilst others will have their current SACT regimens deferred or discontinued earlier than originally planned.

It is expected that VCC will be requested to report on the number of patients whose treatment pathway has been affected by the COVID-19 Pandemic. Thus, the number of patients that require deferral or cancellation of their SACT or who are not offered / do not accept SACT must be captured.

There is a risk that this data will not be captured correctly / adequately which will result in VCC being unable to report the information | 16 | 12 | 12 | A paper providing an overview of the possible methods which are available to capture this data along with the challenges of doing so was submitted to the VCC Clinical Group on 26.03.20 and accepted.

Staff guidelines for clinical staff were sent out in the daily Coronavirus Staff Update via e-mail and also made available in the Coronavirus section of the VCC Intranet

1 - All Clinical Staff to be directed to (where appropriate):
 - utilise the drop down reason code "COVID-19" on ChemoCare,
 - include COVID-19 in all Canisc annotations and
 - include "COVID-19" as the "Description" title when utilising the "Other" tab in Canisc

2 - Clinical Audit Department to lead on the capture on this data and to ensure compliance with these recommendations

3 - Recognition that a solution to identify patients whom have not been referred |

| 2255 | | Financial Sustainability | Velindre Cancer Centre | Accepted | Private Patients | 24/02/2021 | 31/03/2022 | | Private Patients Debt | An internal audit under in 20/21 reviewed debt management as one of its objectives. A key area requiring attention was the management of aged debtors by the Private Patient Service. The conclusion was that the aged debtors are not monitored or acted upon and there was no action plan in place to improve the situation. Also that there is no liaison between the private patient service and the corporate finance team. Analysis has shown that debtors go back a number of years and include self paying individuals as well as insurance companies. As at the time of submitting this risk the outstanding amount is £328,791. | 12 | 12 | 4 | 1. Full review of all debtors in 2017 and 2018 to assess current situation and recommendation for follow up to be provided to Director of Finance.
2. Action plan developed for Trust Audit Committee which will be monitored by weekly meetings.
3. All debtors to be written to by 5th March 2021 providing 14 day payment period requirement.
3. Meeting arranged to discuss automation of process options.
4. Private Patient Manager to benchmark systems with other organisations.
5. Private Patient Manager to review current Standard Operating Procedures (SOP's) to improve current process.
6. Head of Operations and Delivery to work with Deputy Director of Finance to review Trust SOP's and engagement process.
7. Regular meetings with Private Patient Manager and corporate Finance lead to be established |
| 2254 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Estates | 16/06/2020 | 06/06/2022 | | Lack of mechanical ventilation at the VCC site (including inpatient ward areas) | This risk has 3 elements – 1. Potential for increased risk of infection due to a lack of mechanical ventilation, 2. Staff and patient discomfort in hot weather due to sub-optimal ventilation, and 3. Breach of Health & Safety regulations and Health & Safety Executive regulation to provide ventilation systems that are sufficient to ensure that high risk patients are protected from exposure to potentially harmful airborne microbiological organisms | 12 | 12 | 4 | Taking each of the three key elements of the risk:

1. Increased potential for infection due to sub-optimal ventilation
• Full infection prevention processes are in place, and any patient with suspected infection is cared for in a side room which usually has a window for natural ventilation (in the summer months).

2. Staff and patient discomfort in warm weather due to sub-optimal ventilation
• Some mitigations are in place, but further work is required with pace to ensure the well-being of staff and patients during the rest of this summer.
• An external specialist will be commissioned to provide recommendations to reduce the heat, and a Task & Finish group has been set up w/c 15/06/20 to develop a hot weather business continuity plan
• Further mitigations are being assessed, including use of theatre scrub uniforms for nursing staff and washable cooling blankets and mattresses for patients |

| 2253 | No | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 27/10/2020 | 01/05/2022 | | Availability of CANISC System | There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff.

In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc. | 15 | 15 | 5 | Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services.

In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g.

- WCP CANISC Case Note Summary to provide historic record
- Chemocare (existing patients)
- Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary.
- WCP is linked to Master Patient Index (MPI) to access patient demographic information
- Welsh Results Reporting Service (WRRS) for all VCC radiology reports |
| 2252 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Whole Service | 14/09/2020 | 01/04/2022 | | Large number of development projects in Radiotherapy | Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand | 20 | 15 | 10 | Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work

Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR |

2251		Compliance	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	18/03/2016	30/09/2021		XVI imaging termination faults resulting in repeat acquisitions	There is a risk that the patient will require an additional CBCT scan to confirm treatment position as a result of a known fault with XVI which may lead to additional patient imaging dose. Under new IRMER guidance if 3 scans are required to achieve 1 usable dataset this becomes reportable. This fault is known UK wide issue. When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy treatment targets the tumour and spares Organs at Risk and critical structures. This is a known issue nationally and Public Health England and HIW are aware.	15	12	9	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining imaging fractions. 4. All partial scans to be recorded on the imaging form. 5. Radiotherapyl Physics and the treatment superintendents must be
2249		Financial Sustainability	Velindre Cancer Centre	Accepted	Operational Services	27/02/2020	20/12/2021		Risk of service disruption due to number of posts funded by soft monies leading to financial instabiity,recruitment difficultie	A high proportion of VCC workforce are funded via 'soft monies' from the Trust Charity or Third Sector. This leads to risks around service continuity, recruitment and retention and staff wellbeing. It also poses a financial and reputational risk for the Trust should funding be ceased. For 20/21 there is approximately £2.8 million of charity/3rd sector funding which is supporting service delivery.	12	12	4	Funding ending in the next year to be included in cost pressures for 2020/21. Review posts funded externally to establish: Number of posts, length of funding, contribution to service, and contractual position of postholder. Establish Financial contingency. Through the scrutiny process ensure future risks are considered for all new and extended posts. Prioritise work in order of funding stream end date.
2248	No	Safety	Velindre Cancer Centre	Accepted	Nursing	29/10/2020	31/01/2022		There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection	There is a risk a risk that that non-compliance with the Health Protection (Coronavirus Restriction Wales) Regulations 2020 could place patients and staff (FFW, CIU) at increased risk of infection and contracting COVID-19, resulting in illness. Regulation 7A of the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 dictates: - that all reasonable steps have been taken for staff to work from home; - when they are in work environment, all reasonable steps have been taken to maintain a 2m distance; - and where people cannot be 2m apart, everything practical done to manage transmission risk.	16	12	12	Update 10/12/21 - Regular updates and guidance given by IPC Team to all staff to remind them of IPC requirements. Enhanced cleaning still in place; social distancing measures remain in place; cleaning wipes and sanitiser freely available along with face masks. Mitigation -Cleaning regime reviewed as part of changes made, e.g. all ward staff including visiting staff wearing suitable PPE (e.g. cleaners, admin, pharmacy, RT etc) - Hand Sanitiser stations installed - Hand washing posters at sinks - Sterilising materials, wipes, spray etc available for all staff - Enhanced hand washing regime - Staff who can work from home being assessed and if applicable currently doing so - Care taken to manage 2m space where applicable - Social distancing posters - If appropriate reduce amount of staff in working area where applicable. The FFW offices, are areas where social distancing is unable to be maintained for hand overs etc PPE is provided for use

2245		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	12/04/2019	31/12/2021		Service impact of delay in equipment replacement	Service impact of delay in equipment replacement Current provisions for Radiotherapy Services at VCC are based on the assumption that a new Cancer Centre and associated Satellite Centre will be clinical by 2021/22. Delays on these projects will impact negatively on the Radiotherapy Department at VCC. Linear Accelerators have a recommended clinical life of 10 years. In 2019, there are currently 3 (out of 8 (38%)) linacs aged 10 years or above. In 2021 there are currently 5 (out of 8 (62%)) linacs aged 10 years or above. Identified hazards are to be found in the risk assessment attached as a document.	15	12	3	Timely / effective communication with Commissioners / Government re. Linac life, performance etc. Older linacs can receive deep services / upgrades with the intention of extending clinical life. Ability to add functions / services to older linacs / equipment such as RPM / DIBH make this viable. Uptime is maximised by good in-house engineering support. Engineers are very experienced at VCC. Service contracts allow access to Manufacturer's engineers when required. Complaints procedure in case of issues with quality of service. Gaps procedure assist with direction in times of breakdown. Experience and skill of staff allow effective dealing with delays and patient issues. RCR guidelines guide protocols for acceptable prolongation of treatment courses prior to compensation (NB. Latest update suggests that standard 3-week course of breast treatment should ideally not be prolonged for more than 2 days). Regular update of staff from
2244		Workforce and OD	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	12/02/2021		Senior Management Capacity	Senior Med Physics Management Capacity is under pressure due to some staff being utilised on IRS Multiple major programmes pull senior staff away from service delivery. COVID exacerbates the situation Separation between service and major programme means there is a loss of continuity and ownership	12	12	4	Deputies for the programs to be identified without affecting service delivery
2243			Velindre Cancer Centre	Accepted	SACT	30/06/2021	15/12/2021		SACT staff turnover	There is a risk that SACT Daycase may not be able to deliver care at the current level as a result of staff turnover which may lead to SACT reducing capacity at the SACT Daycase Unit which will impact on patient care and patient experience.	16	12	3	Senior SACT management working in the numbers Clinical trainer working alongside junior staff closed mobile unit on MONDAY Senior staff working on helpline Deputy Director of Nursing undertaking a review on the turnover/retention and education pathways
2239		Safety	Velindre Cancer Centre	Accepted	SACT	06/06/2012	28/01/2022		Pharmacy Stores – inadequate space	There is an increased risk of accidents and injuries to staff and a security of product issue, due to inadequate space in the pharmacy stores, which is leading to products being stored outside official areas.	12	12	9	Staff are trained in manual handling. Regular contact with VCC Manual Handling Advisor. Staff are partially involved in managing risks. 25.06.19 - new aseptic unit expected to be clinically operational September 2019 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing consumables and non-medical dressings to be relocated to nursing stores. 20.01.2020 updated by RWD- new aseptic unit expected to be clinically operational February 2020 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing consumables and non- medical dressings to be

2236	No	Quality	Velindre Cancer Centre	Accepted	Operational Services	08/04/2019	03/01/2022		There is a risk of poor patient experience as a result of insufficent space and poor environment	The design of the OPD department is not fit for purpose, there is a lack of available accommodation, insufficient space in waiting area, the reception desk is not ideally placed and the fabric of the area is in poor condition.	15	12	12	1. Nurse 'rounding' in place to monitor patients on regular basis 2. External 'canopy' waiting area 3. Information provided explaining visiting restrictions but process in place to call relatives into consultation if appropriate 4. High level of virtual consultations 40-50% 5. Clinic planning and preparation undertaken daily 6. Task and Finish Group to lead repatriation of OPD and phlebotomy to HB's 7. Service improvement programme to reduce waiting times, improve experience etc 8. Appointment system implemented for phlebotomy appointments
2229		Workforce and OD	Velindre Cancer Centre	Accepted	Operational Services	12/03/2019	24/01/2022		Risk to timely communication/engagement activities as a result of dedicated resource leading to low morale, reputational damage	There is a risk that positive communications are not distributed in a timely manner as a result of lack of dedicated VCC resource therefore positive communication is not provided in a timely manner to staff or externally. VCC has no dedicated specialist communication resource to support the patient and staff experience. This limits the processes that can be developed and also poses a risk to media handling. There is no dedicated support to develop social media policy or channels which limits communication options.	12	12	4	Resource increased within corporate communications and TCS teams.
2224		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	07/11/2019	12/01/2022		Demand for services outstripping capacity	Demand for services outstripping current capacity resulting in patients not being seen in a timely manner and waiting time breaches. Also results in overbooked clinics which are extremely busy. In addition, many of the outreach clinics continue to be run from VCC which is adding to the pressure on clinic rooms.	16	12	16	UPDATE June 21 - Risk rating increased to reflect current situation. Increasing referrals are leading to an increase in outpatient attendances resulting in very busy clinics. Continue with planning for any surge in activity due to cancer backlog and latent demand from health boards is being undertaken by VCC. Continue with weekly monitoring of outpatient referrals and activity. Progress with the work of the Demand Modelling group being led by the BI team. Continue to have discussions with health boards re. outreach clinics and likely demand for services.
2223		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	21/07/2020	12/01/2022		Delay in re-starting outreach activity	The delay in re-starting outreach activity which is as a result of the COVID-19 pandemic, is impacting on outpatients resources and the availability of clinic rooms in VCC. This is because all outreach services have been repatriated to the cancer centre for the duration of the COVID-19 pandemic.	12	12	12	UPDATE June 21 - Discussions to repatriate outpatients clinics continue with health boards. Previously agreement from ABUHB to re-start outreach clinics in Nevill Hall but subsequently notified that space is not available, although not Royal Gwent. VCC group established to manage repatriation of clinics and SACT to NHH. Continue with ongoing discussions with other HBs as this remains a priority for VCC. SSTs have been asked to review all their clinics and highlight priority clinics for repatriation. Undertake surge planning and discuss impact with health boards

| 2222 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Nursing | 07/11/2017 | 31/07/2021 | | Loss of CANISC - compromise patient care | There is a risk that as Canisc is an 'end of life' system, it could fail which could compromise patient care. It could mean that some patients cannot be seen in clinic or some would experience long delays. This can lead to increased patient anxiety, frustration and stress for staff, overcrowding in waiting areas and a possible delay in prescribing chemotherapy. | 16 | 12 | 12 | Update June 2021 – DH&CR project continues at pace which includes plans to replace CANISC with WPAS. Regular meetings taking place to review OPD processes and clinics. CANISC BCP remains in place. Implementation of the Document Management Solution – copy of correspondence available electronically on local infrastructure. Correspondence viewable in the Welsh Clinical Portal. Correspondence sent to the GP electronically (via WCCG). Welsh Clinical Portal to link to the Master Patient Index – in the event of Canisc being unavailable this version of the WCP would be invoked enabling access to documents, test results and the GP Summary. Authorised staff members have direct access to Synapse (local infrastructure) – VCC radiology images and reports available to view. Aria and Mosaiq not reliant on Canisc – Radiotherapy treatment can continue in the event of a Canisc outage. ChemoCare decoupled from Canisc and held of local infrastructure – SACT prescribing, dispensing and delivery can |
| 2221 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Digital Services | 24/02/2021 | 29/11/2021 | | Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS | 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 | 16 | 16 | 12 | The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected |

2220		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	07/11/2018	31/12/2021		Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2217		Workforce and OD	Velindre Cancer Centre	Accepted	Medics	14/09/2020	01/12/2021		Medical Capacity for RT Planning in Job Plans	Medical time for RT Planning within job plans is not efficient, timely or in many cases, sufficient, particularly with the RCR requirement for peer review. Any time allocated may not be protected due to the increase in clinical admin work and email requests. Outlining delays have a knock-on impact on the pathway which has the potential to delay the patient's treatment start date and increase breaches.	4	15	2	Review job plans to ensure adequate time available. Job Planning is ongoing annual process however it is not always possible to allocate time for RT Planning into the job plan without dropping alternative work. Each case is individually assessed to factor RT Planning into job plans.
2213		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/07/2018	01/05/2022		VCC Phone System - External Phone Lines	There is a risk that external telephony services in VCC may be disrupted as a result of the ongoing use of the 'end of life' PBX gateway ISDN30 line, which may lead to the inability to make inbound and outbound external calls, resulting in significant disruption to clinical / patient and administrative services.	16	12	4	22 phone lines are strategically placed around VCC site to enable dialling to public telephones in the event that an ISDN30 line is lost. Discussion with supplier commenced. Capital funding to be secured for delivery of resilient SIP.
2211		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/10/2020	29/11/2021		Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	16	12	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working

2206		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/10/2020	29/11/2021		Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic	DHCR003(R) - Could impact on key project team members capacity due to service requirements being prioritised, childcare needs, the need to self-isolate etc. The ongoing impact of the Covid 19 outbreak continues to have a significant impact of staff in terms of their well-being, their availability and their ability to absorb new ways of working and new systems within an already stretched environment. Also, additional clinical pressures/demand on; clinics, inpatient activity, treatments and the presentation of potentially sicker patients, resulting from the impact of COVID19.	20	12	9	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.
2205		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	14/09/2020	31/01/2022		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads
2203		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	12/01/2021	29/11/2021		Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed from 18 months to 6 months. Data Migration Phase 1 (Patient Demographics and casenotes) and Phase 2 (Referrals, activity, Clinics, pathways and waiting lists) both need to be completed by prior to UAT testing which is due to commence in July 2021. There is a risk that any delay to these data migration activities could have a direct impact on the quality of the patient data migrated from Canisc into WPAS as there will be no time to review and cleanse the data prior. There is also a risk that any delay to the data migration activities will have a direct impact on the WPAS implementation date which may lead to the Service having to rely on an unstable and unsupported Canisc instance for a longer period of time.	16	16	8	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.

2202		Workforce and OD	Velindre Cancer Centre	Accepted	Medics	23/02/2021	01/12/2021		Consultant cover for long term absences	Two consultants will be taking Maternity Leave in 2021 in Urology and Breast tumour sites. One Consultant is planning a sabbatical in Spring 2022. One Consultant on Long Term Sick Covid related from Mar 2020.	20	12	4	The Directorate has employed a Consultant for a 1 year post to cover the Urology gap for Mat Leave in 2021 but may require extending the contract to Mid 2022 depending on how long the Consultant will be off on Mat Leave and also to cover the sabbatical in 2022. An additional temporary consultant will be required to cover the breast sessions for the 2nd Mat Leave.
2200		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	01/05/2011	31/12/2021		Radiotherapy Capacity	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes. 2/7/19 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. 23/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet. Any delay in the development of the	20	20	6	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy booking processes, and staff flexibility used to maximise use of resources. Project to be commenced to address
2198		Financial Sustainability	Velindre Cancer Centre	Accepted	Operational Services	29/12/2017	13/12/2021		VCC mayface financial loss, legal action, inaequate service provision as a result of no coordinated system for SLAs, contracts	VCC has numerous contacts and SLA's for services delivered by NHS organisations and external companies. To manage such legal agreements it is crucial to have robust governance structures for the development, management, monitoring and renewal of such documents. There are a lack of processes, clarity regarding responsibility regarding responsibility, management etc and a varied level of monitoring.	16	16	6	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism
2196		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	01/12/2021		Radiotherapy Department - COVID Isolation Impact	COVID Isolation Impact Staff isolation as a result of coming in to contact with a COVID positive person, exhibiting COVID symptoms or receiving a COVID positive test result will affect the capacity (Linac & Pre-Treatment hours) of the radiotherapy department as the majority of staff are patient facing and are unable to work from home. Resulting in the need to contract the radiotherapy service.	16	16	4	Ability to work from home with relevant IT equipment on completion of DSE risk assessment Isolations rules to be reviewed regularly. 7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.

2193		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nuclear Medicine	05/02/2021	01/04/2022		Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	Medical Physics Experts (MPEs) for Nuclear Medicine. This risk combines 8438 (submitted by S Hooper – MPE cover for clinical trials) and 15684 (submitted by M Talboys – Ra223 service) on the current risk register and has been expanded to encompass new developments on the immediate horizon. There is a significant risk that Velindre Cancer Centre will not be in a position to safely and sustainably offer the Molecular Radiotherapy (MRT) demand, likely to be required in the next 12-18 months. This arises because of a lack of experienced Medical Physics Experts (MPEs), the timescales over which the implementation of new MRTs may be required, the predicted increase in workload and the anticipated number of other significant developments which will lead to not being able to implement MRT MPE cover within Nuclear Medicine for MRT has been extremely stretched for a number of years.	20	16	2	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).
2191		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	31/01/2022		Inability to meet COSC / SCP targets	Inefficiencies in current pre-treatment pathways and failure to meet agreed timescales - link to breach report against time to treat targets.	20	20	4	Workforce requirements highlighted Service improvement project to be initiated
2190		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	31/03/2022		BI Support for reporting of Breaches	BI Support for reporting There is a risk that lack of high quality data informing in real time key activity (demand/ capacity) Key data inputs (RTDS) are done manually Different staff groups only understand their own systems. Resulting in a lack of ability to accurately forecast and model future demand for services which may impact on accurate capacity planning for the scheduling of patient pathways	16	16	10	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes
2188		Compliance	Velindre Cancer Centre	Accepted	Operational Services	18/04/2018	24/01/2022		There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service de	Lack of physical space to accommodate the current service requirements, statutory building note requirements, health and safety standards and other legal requirements at Velindre Cancer Centre. This risk affects all areas within VCC. A number of internal and external audits have demonstrated a significant lack of physical space within all areas of VCC. COVID 19 pandemic has further reduced available site capacity by 40-50%. Increased provision of clinical services and workforce requiring additional space. Requirement for Digital Programme Team to return to VCC site in view of DHCR replacement programme, testing and training requirements etc.	12	12	6	1. Ongoing review of current accommodation to ensure best use and maximisation. 2. Review service models and the balance between on site and outreach services to make best use of all resources. 3. Implement changes in working practices where appropriate (e.g. working from home, extend the working day) 4. Office sharing principles reviewed in light of COVID19 which has led to reduction in available office accommodation due to 2m rule. 7. Open plan and flexible working. 8. Additional space within CRW to be utilised as a temporary measure for Digital Programme Team as part of DHCR Programme. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work. 12. Business case being produced for ventilation improvements in clinical areas

| 2187 | | Performance and Service Sustainability | Velindre Cancer Centre | Accepted | Medical Physics (previously Radiotherapy Physics) | 14/09/2020 | 31/12/2021 | | Radiotherapy Physics Staffing | NB - see Progress Notes for latest update 13/09/21

The recently received 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 Head of Medical Physics retired in November 2019. This post has not been replaced and, consequently, approximately 0.5 WTE of management or Medical Physics Expert (MPE) tasks have been absorbed by the department at the detriment to other tasks as described below. Senior staff are also working significantly over their contracted hours, which can be evidenced as time owed in lieu.

The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are | 25 | 15 | 5 | Medical Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation.

Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC.

Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk |
| 2185 | | Safety | Velindre Cancer Centre | Accepted | Medical Physics (previously Radiotherapy Physics) | 14/09/2020 | 31/05/2021 | | Delination Risk treatment delay (16284) | There is a risk of physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets. These errors are generally not picked up at medic peer review or during the physics planning process but by more experienced clinical scientists at final physics check, often the day before treatment. There is a lower risk that errors are missed at physics check and make their way to treatment.

A number of Datix incidents have been attributed to target and organ at risk delineation errors. These incidents are generally identified at final physics check and so the effect is treatment delay and repeat work (planning) within physics. However, these errors would be classed as near misses as the errors were not detected during the medic peer review process, approval, or at the physics planning stages. Action is required to ensure these errors do not propagate to treatment | 15 | 15 | 9 | Discussions at the RMG quality focused meeting to ensure the medical workforce are aware of the issues and to enable discussions and learning within SSTs. Medic peer review processes (for some treatment sites).
A physics quality improvement project has been initiated to ensure effective multidisciplinary learning. This should reduce the requirement to replan due to errors not being detected until the final checking stages, and should also reduce the likelihood of a radiotherapy mis-treatment.
Further controls required – a Datix medic representative to ensure joint investigations. |

AUDIT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	11 January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

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 DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Strategic Development Committee	09.12.2021	**NOTED**

1. SITUATION

The purpose of this paper is to provide the Audit Committee with an update on the further development of the Trust Assurance Framework (TAF), together with the ongoing work to support its continued development, articulation and operationalisation within the Velindre University NHS Trust.

2. BACKGROUND

The Trust Board received the first iteration of the populated Trust Assurance Framework at its September 2021 meeting, which outlined the high level principal risks that may threaten the

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

However, in working through the detail in September 2021, the Executive Leads for **Demand & Capacity** and **Quality & Safety** highlighted that their respective strategic risks required further articulation and reframing to more accurately reflect some of the recent activity to support continuous improvement underway across their service areas. In addition, work was to be initiated to support the articulation of the **Organisational Culture** strategic risk, key to which was the impending approval and adoption of the Trust People Strategy and its three themes of a Healthy and Engaged Workforce, a Skilled and Developed Workforce and a Planned and Sustained Workforce.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Revised Reporting Mechanism

There have been a number of key developments to the Trust Assurance Framework since its first iteration in September 2021, the first of which includes a revised reporting mechanism. The agreed template for the Trust Assurance Framework was initially implemented via Microsoft Word as the chosen platform. However, this meant that any coding to enable subsequent analysis and the development of future dashboard reporting could not be effectively achieved. As such, the previously agreed information captured in the Trust Assurance Framework has now been reformatted and transferred to Microsoft Excel. This will ensure plans to develop dashboard reporting by Quarter 1 of 2022/23 can be realised.

A number of further enhancements have also been implemented as part of the move to a different platform, via active engagement with end users to improve user application. This includes increased automation and drop down menu facility. In addition, all definition criteria referenced in the overarching Trust Risk Assurance document have been compiled into a more easily accessible '**TAF Definitions'** tab provided on the Trust Assurance Framework. Furthermore, all ten agreed strategic risks have been collated together on the Trust Assurance Framework (marked 1-10), this will enable end users to more readily reference each of the individual strategic risks for transparency and to aid consistency of reporting.

3.2 Further Articulation of Strategic Risks

Since September 2021, the Executive lead for the **Demand & Capacity** strategic risk has undertaken a holistic review of the detail captured to facilitate a fuller assessment of the key controls currently in place together with any gaps in assurance and actions required. This is included at *Appendix 1,* via *TAB 01*.

The Executive Lead for the **Quality & Safety** strategic risk has also reframed the articulation of this risk to reflect the developments in framework approach in recent months for Quality & Safety. In addition, the articulation of the controls and assurance mechanisms described have been further enhanced, the detail for which is included at *Appendix 1,* via *TAB 06*.

The **Organisational Culture** strategic risk has also now undergone its first iteration and is included at *Appendix 1*, via *TAB 04*. This is to be worked up further to reflect the many facets of work that the Trust has underway or in development that will ultimately effect the culture of the organisation and the way in which it works as a whole to effectively deliver services and achieve its ambitions. As outlined above, key to this will be the approval of the Trust People Strategy anticipated to be in place by the end of this calendar year.

The **Organisational Change / Strategic Execution** risk remains in the early stages of development reflecting the emerging Trust wide strategy for 2032, this was anticipated to be included in the further developed Trust Assurance Framework and inserted at *TAB 05* in readiness for presentation to the January 2022 Audit Committee and Trust Board. However, due to the emergence of the prevalence of the Omicron variant and increased demands on Trust officers to respond to the escalating position, this has not been able to be progressed at this point in time. This will now be progressed in the New Year with exact timescales for completion to be confirmed.

3.3   Next Steps in Development
i.   Document Control & Supporting Evidence

To help ensure that the Trust Assurance Framework remains a live tool this is to be made available to all end users via Microsoft Teams. This will enable all updates to be made in 'real' time and ensure that all users have full visibility of the most up to date and correct version of the Trust Assurance Framework.

A file structure will also be created within this shared Microsoft Team folder to save all supporting evidence referenced within the populated Trust Assurance Framework, to aid transparency and completeness.

ii.   Trends in Assurance

By the end of Quarter 4, a graphical representation will be provided to record and detail any **Trends in Assurance** for each of the strategic risks. This will signal just one of the early developments planned to move to increased utilisation of dashboard reporting functionality.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to *Appendix 1* for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Velindre University NHS Trust Audit Committee is asked to:

I. **NOTE** the progress to date, and **DISCUSS / REVIEW** the next iteration of the Trust Assurance Framework included at *Appendix 1*.

II. **NOTE** the next steps in the development pathway to support further operationalisation of the Trust Assurance Framework.

TAF DEFINITIONS

RISK NUMBER	RISK THEME/TITLE	DRAFT RISK DESCRIPTION	RISK OWNER
		RISK DESCRIPTORS	
01	Demand and Capacity	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	Partnership Working / Stakeholder Engagement	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	Workforce Planning	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	Organisational Culture	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	Organisational change / 'strategic execution risk'	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	Quality & Safety	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	Digital transformation - failure to embrace new technology	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	Trust Financial Investmnet Risk	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance
09	Future Direction of Travel	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	Governance	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

TAF DEFINITIONS

LEVELS OF ASSURANCE DESCRIPTORS		
First Line of Defence functions that own and manage risk	**Second Line of Defence** functions that oversee or specialise in risk management	**Third Line of Defence** functions that provide independent assurance
Self-Assurance	**Internal oversight/**specialist control teams, such as:	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management	Quality & Safety	External Audit
Staff training and compliance with policy guidance	IT	Regulators & Commissioners
Teams take responsibility for their own risk identification and mitigation	Governance (corporate/Clinical)	Wales Audit Office reviews
		Stakeholder reviews
		Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures	*Board, Committee and Management Structures which receive evidence from the 1st Line of Defence that risks are being*	*Recent internal audit reviews and levels of assurance*
Local management information / departmental management reporting	*Finance reports*	*External Audit coverage*
Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting		
Staff Training Programmes	*Compliance against Policies*	

TAF DEFINITIONS

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

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

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

TAF DEFINITIONS

DEFINITIONS

CONTROL EFFECTIVENESS

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

ASSURANCE RATING

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

TAF DEFINITIONS

RISK SCORE
IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
Domains	**1** Negligible	**2** Minor	**3** Moderate	**4** Major	**5** Catastrophic
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complain (stage 2) complaint Local resolution (with potential to go to independent Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffin g/competence	Short term low staffing level that temporilly reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for manadtory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours	Local media coverage	Local media coverage	National media	National media

TAF DEFINITIONS

	Potential for public concern	short-term reduction in public confidence Elements of public expectation not being met	long-term reduction in public confidence	coverage with <3 days service well below reasonable public expectation	coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruptionenviron mental impactr	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on enrionment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

TAF DEFINITIONS

LIKELIHOOD MATRIX

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

RISK RATING MATRIX - IMPACT X LIKELIHOOD

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

TAF DASHBOARD

01 DEMAND AND CAPACITY

RISK ID:	TAF 01	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** (See definitions tab)
NEXT REVIEW	Jan-22	Goal 2

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Cath O'Brien	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		4	5	20	3	4	12	3	3	9

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

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Business Intelligence Strategy and delivery plan	Cath O'Brien	X		X	NE	Divisional management review of demand and capacity via Senior Team meetings	IA	Comissioning meetings	P		
C1a	Business intelligence Plan which is based on the Velindre Cancer Service	Lisa Miller	X		X	PE	Divisional Performance Review and the Quality & Perfomance Report review by COO and EMB	IA	Internal Audit	IA		

TAF DASHBOARD

01 DEMAND AND CAPACITY

	KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1b	Trust Business intelligence plan which is based on the Welsh Blood Service	Alan Prosser	X		X	PE	Donor and patient feedback	P				
C2	Active work ongoing to establish data sets and pathways for the Cancer Service with health boards supported by the Delivery Support Unit.	Cath O'Brien	X			PE						
C3	Structure and function of Business Intelligence and the interface with operational planning, finance and the comissioning arrangements.	Cath O'Brien	X			PE						
C4	Active engagement with Health Boards in Service Planning including the established Service Level Agreement Arrangements in place to plan demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Alan Prosser	X			PE						
C5	Active operational engagement with health boards on demand	Paul Wilkins	X			PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
Business Intelligence strategy and resource plan to be finalised together with implementation plans to build on the existing Business Intelligence functions, capacity and capability that are in place.	More comprehensive overview and traingulation of demand and capacity model shared with Executive Team through divisional review
Wider Business Intelligence alignment with Health Boards	
Further work to improve data insight and use of dashboards in operations	

TAF DASHBOARD

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1 Finalise Business Intelligence strategy	Cath O'Brien	Drafts in progress	TBC
1.2 Structure and function review in Business Intelligence	Cath O'Brien	Further resource identified and review commencing Jan 22	TBC
1.3 Explore participation in national Business Intelligence developments	Cath O'Brien	Awaiting update from Welsh Government	TBC

TAF DASHBOARD

02 PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.

LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	Goal 2

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Carl James	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		4	4	16	3	4	12	2	4	8

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

GAP IN CONTROLS	GAPS IN ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1.1	System structures – core cancer services commissioning arrangements.		X			PE	Commissioning contracting reporting	IA				
C1.2	effectively delivering ways of working/ work programmes.			X		PE	Supply and demand reporting	IA				
C1.3	Data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
C1.4	Blood - core blood services commissioning arrangements.			X		PE	Commissioning contracting reporting	IA			Regulatory scope re MHRA tbc	
C1.5	Effectively delivering ways of working/ work programmes.			X		PE	Supply and demand reporting	IA				

TAF DASHBOARD   02 PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

			GAP IN CONTROLS					GAPS IN ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1.6	Data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
C1.7	South Wales Collaborative Cancer Leadership Group system model.		X			PE	Agreed to model for next phase	IA				
C1.8	Effectively delivering ways of working/ work programmes.			X		PE	Collectively agreed to and documented work programme	IA				
C1.9	Data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	IA				
C1.10	Partnership Board arrangements with partner Health Boards model.		X			PE	Agreed to model for each organisation	IA				
C1.11	Effectively delivering ways of working/ work programmes			X		NE	Collectively agreed to and documented work programme	NA				
C1.12	Data and measures to clearly track progress against objectives.				x	NE	With respective measures reported	NA				

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

TAF DASHBOARD

	Action Plan	Owner	Progress Update	Due Date
	ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James		Dec-21
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Dec-21

TAF DASHBOARD

03 WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** (See definitions tab)
NEXT REVIEW	Jan-22	Goal 2

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Sarah Morley	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	3	9	3	3	9	2	3	6

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

TAF DASHBOARD

03 WORKFORCE PLANNING

	KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE						
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE						
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE						
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE						
C9	Agile Workforce Programme established to assess implications for planning a workforce followinf COVID and learning lessons will inlcude technology impact accessments.	Sarah Morley			X	PE						

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

TAF DASHBOARD

03 WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Sarah Morley		Dec-21
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Dec-21

TAF DASHBOARD

04 ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL CULTURE:** The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** (See definitions tab)
NEXT REVIEW	Jan-22	Goal 1

EXECUTIVE LEAD	Sarah Morley	**RISK SCORE** (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	3	9	3	3	9	2	2	4

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

	KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group					
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group					
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group					
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group					
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					

TAF DASHBOARD   04 ORGANISATIONAL CULTURE

C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group					
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings					
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Edcucation and Training Steering Group					
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined					

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

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

TAF DASHBOARD

05 ORGANISATIONAL CHANGE 'STRATEGIC EXECUTION RISK'

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.							
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** (See definitions tab)							
NEXT REVIEW	Jan-22								

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Carl James	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
				0			0			0

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

KEY CONTROLS | SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating

Timescales for completion TBC

Timescale for completion TBC

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	Owner	Progress Update	Due Date

06 QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	Goal 1

EXECUTIVE LEAD	Nicola Willams	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		5	5	**25**	3	5	**15**	2	5	**10**

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

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback		Internal Audit Reviews		Audit Wales Reviews	
C2	CIVICA patient/donor feedback system system being implemented	Nicola Williams			X	PE	Patient/Donor Feedback		Quality, Safety & Performance Committee		Health Inspectorate Wales Inspections	
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE	15 Step challenge / EMB		Peer reviews		Medicines and Healthcare products Regulatory Agency / Professional bodies	

		KEY CONTROLS					SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	NE	Divisional Q&S Groups / PMF				Delivery Unit	
C5	Performance Management Framework (PMF) in place & under review to include experience & outcomes	Carl James			X	NE	Perfct Ward audits / PMF					
C6	Trust Risk Register in place	Lauren Fear	X	X	X	NE	Mortality reviews					
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			NE	Staff surveys/ feedback		Internal Audit Reviews			

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

	ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Trust Quality & Safety Framework to be finalised and implementation plan developed.	Nicola Williams	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	Dec-21
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	Mar-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team	Will be developed once Framework finalised	
		Divisional Directors		
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams		Apr-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training planned for January 2022	Mar-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams		Jun-22
		Cath O'Brien		
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
		Nicola Williams		
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear		Jan-22

1.11	Complete Risk Register Review, transfer onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear		Mar-22

TAF DASHBOARD

07 DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Nov-21	Most Relevant Strategic Goal: (See definitions tab)
NEXT REVIEW	Jan-22	Goal 2

EXECUTIVE LEAD: Carl James

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Digital Strategy	Carl James	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy		SIRO Reports		To be completed as per compliance/ reg tracker update	
C2	Active work on-going to leverage existing and deliver on new technologies – e.g. LIMs, IRS, Becs	Stuart Morris		X		E	Trust digital governance reporting		Internal Audit Reports			
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Stuart Morris	X			PE	Staff feedback		Trust Board reporting against Trust Digital Strategy			

07 DIGITAL TRANSFORMATION

	KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C4	Training & Education packages for donors, patients	Stuart Morris	X			PE	Patient and donor feedback		Feedback and progress of working with Universities			
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Carl James	X			PE						
C6	Specifically development of digital resources capacity and capability	Stuart Morris	X			PE						
C7	Digital inclusion – in wider community	Stuart Morris	X			PE						
C8	Opportunities for digital career paths	Stuart Morris	X			PE						
C9	Prioritisation and change framework to manage service requests	Stuart Morris	X			PE						
C10	Levels of unsupported applications/ legacy systems	Stuart Morris			X	PE						
C11	Trust digital governance	Carl James		X		PE						
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Stuart Morris			X	PE						

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Stuart Morris		December Strategic Development Committee
1.2	December Strategic Development Committee	Stuart Morris		December Strategic Development Committee

TAF DASHBOARD

08 TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.							
LAST REVIEW	Nov-21	Most Relevant Strategic Goal: (See definitions tab)							
NEXT REVIEW	Jan-22	Goal 5							

EXECUTIVE LEAD	Matthew Bunce	RISK SCORE (See definitions tab)							
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	4	4	16	3	3	9

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

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

TAF DASHBOARD

08 TRUST FINANCIAL INVESTMENT RISK

	KEY CONTROLS						**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PE	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA		
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA				
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE						
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA				
C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE						

TAF DASHBOARD

08 TRUST FINANCIAL INVESTMENT RISK

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Velindre Cancer Centre	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.	Nov-21
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Oct-21
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Dec-21

TAF DASHBOARD

09 FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.		
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** (See definitions tab)		
NEXT REVIEW	Jan-22	Goal 2		

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Carl James	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		4	4	16	3	4	12	2	4	8

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

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (Research Development & Innovation; Digital etc) which articulate strategic areas of priority					PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy					
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy					
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel					PE						
C4	Development of improved local, regional and national clinical commissioning arrangements					PE						

TAF DASHBOARD   09 FUTURE DIRECTION OF TRAVEL

	KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services					PE						
C6	Change in strategic workforce plan to recognise/address any new leadership/clinical/management skills related to strategic growth					PE						
C7	Refresh of Investment and Funding Strategy					PE						
C8	Development of commercial strategy					PE						
C9	Attraction of additional commercial and business skills					PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
To be finalised - please refer to action identified in readiness below	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity om future	Carl James		
1.2	Board decision on strategic areas of focus/to pursue	Board		
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		
1.4	Identify capability required and funding solution/source	Execs		

TAF DASHBOARD   10 GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.							
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** (See definitions tab)							
NEXT REVIEW	Jan-22	**Goal 1**							

EXECUTIVE LEAD	Lauren Fear	**RISK SCORE** (See definitions tab)							
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		4	4	16	3	4	12	2	4	8

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

TAF DASHBOARD   10 GOVERNANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	KEY CONTROLS						**SOURCES OF ASSURANCE**					
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance)

Audit Wales review outcomes of report as part of Annual Report - Accountability Report | PA |
| C4 | Board Development Programme | Lauren Fear | X | | | PE | Programme established | IA | Independent member oversighnt via repurposed 'Intergrated Governance Group' | IA | | |
| C5 | All-Wales Self-Assessment of Quality Governance Arrangements | Lauren Fear | | X | | E | Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year. | PA | Monitoring and oversight via EMB and Quality, Safety & Performance Committee | PA | Audit Wales review of Quality Governance Arrangements | PA |

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.		Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Jan-22
Ongoing input from the Independent Members via the repurposed Integrated Governance Group		Terms of Reference and supporting refreshed standard agenda has been reviewed and is to be agreed by Independent Member by mid December.	Dec-21

AUDIT COMMITTEE

AUDIT ACTION PLAN

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Analysis:

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

2.1.2 The Audit Committee, at its meeting held on 8 October 2020, reviewed the full Audit Action Tracker which included **all** actions currently on the Audit Action log.

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

3. IMPACT ASSESSMENT

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

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. **RECOMMENDATION**

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

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

Audit Action Plan

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 passed management action not complete

Priority	
Low	
Medium	
High	

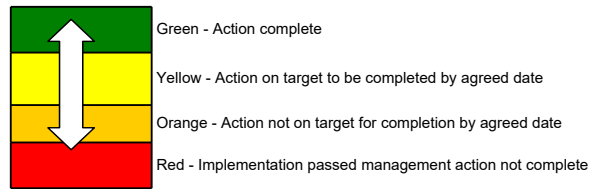| INTERNAL AUDIT - Governance Arrangements during COVID-19 Pandemic							
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee
1	**Strategic Governance** **Board and Committee Meetings** Priority should be given to the following: * Ensure the papers and minutes are available as soon as possible after a committee meeting * Updating the Trust's internet pages to advise on status of committees.	Recommendations		Lauren Fear, Director of Corporate Governance	30/09/2021 **Update October 2021: Extension agreed to 14th October 2021.**		Although much action completed, there remain at time of publishing papers examples of gaps. This will be completed and reported to the Committee as such by 14th October.	Complete

Audit Action Plan

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Priority	
Low	
Medium	
High	

Velindre UNHS Trust

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

Audit Action Plan

Velindre UNHS Trust

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Red	Red - Implementation passed management action not complete
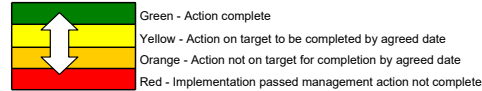
Priority	
Low	Yellow
Medium	Green
High	Red

	Final Internal Audit Report - WAO - Structured Assessment 2019 /20 - Reasonable Assurance							
Ref	**Recommendation**	**Priority**	**Management Response**	**Responsible Manager/ Department**	**Agreed Implementation Date**	**Status**	**Update for October 2021 Committee**	**Update for January 2022 Committee**
2019-R3	Board Assurance and Risk Management The Trust should complete the development of its BAF with pace, ensuring that it is appropriately underpinned by up-to-date risk management arrangements. Specifically, the Trust should; a) review the principle risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; b) update the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; c) provide risk management training to staff and Board members on the resulting changes to the risk management framework.	Medium	A BAF which triangulates risk, performance and assurance is planned for implementation in 2020-21, and is a priority of the Interim Director of Corporate Governance who commenced with the Trust on the 2nd December 2019.	Lauren Fear, Director of Corporate Governance	31/05/2020 Revised date 31st Oct 2020, revised March 2021. **Update 08 July 2021 - Extension to September 2021.** **Update October 2021: Extension agreed until 30 November 2021.**	Red	a and b complete, regarding finalising framework and completing a first version of the BAF- and c, regarding training for Board, execs and staff, to be completed by end November 2021	Recommend Training completed by end March 2022 in line with current service pressures. Extension to 31 March 2022 is requested
2579A2021-22	**Recomendation 1** **Transparency of Board business** Some committee meeting papers are missing from the website, as are links 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 • Recordings of Board meetings	Low		Lauren Fear, Director of Corporate Governance		Green		Complete
	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.	Red		Matthew Bunce, Executive Director of Finance	No progress (overdue) No progress has been made on this recommendation.	Red		

Audit Action Plan

Velindre UNHS Trust

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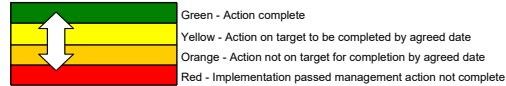
Priority	
Low	
Medium	
High	

FINAL INTERNAL AUDIT 2019/2020 - VCC Control and Governance - Reasonable Assurance								
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee
VT1920 11 VCC Final Internal Audit Report	Management should ensure that urgent action is taken to ensure that key staff within the Therapies Department are given appropriate access and training on DATIX in order to be able to maintain the information recorded and also produce reports for review.	Medium	Therapies Manager to meet with the DATIX team to ensure that the dashboard is correctly set up to run departmental DATIX reports. ☛ Ensure that all leads have relevant permissions and training. ☛ Dispense with additional records once above complete and rely wholly on DATIX system.	Lisa Love-Gould This action will be transferred to Kate Baker from 22 August 2021	~~31/10/2019 Plan~~ October 2020. **Extension given to 31/03/2021.** **Update 08 July 2021: Extension to September 2022.**		Interim Deputy Head of Therapies, Siobhan Pearce is now in post (recent return from 12 months maternity leave). Therefore datix training is required for Siobhan. 2 out of the 4 Clinical Leads are on maternity leave and will require Datix training when they return. To review in May 2022.	DATIX training arranged fro Siobhan Perace and Nia Oakes (Interim Clinical Lead SLT) for January 2022. SP linking with John Kelland to ensure that leads / management staff have correct dashboard / report reviewing access.

Audit Action

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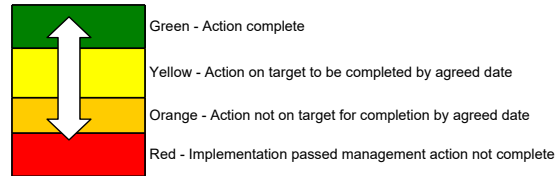
Priority	
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Medium	
High	

Velindre UNHS Trust

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

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee
		High	Datix and risk management training will be provided in conjunction with the role of out of the new Datix risk module, due to go live April 2021.	Lauren Fear, Director of Corporate Governance	July 2021 **Update October 2021: Implementation date 30 November 2021.**		Datix form finalised • Training to be completed by end Nov 2021 • Approach to migration of risks from version 12 of Datix module to version 14 of the module to be agreed and implemented in full for VCC and Corporate - WBS in plan to follow by end November • Updated to risk Policy package, including user guides etc, to be refreshed through Trust Board November 2021	Recommend Training completed by end March 2022 in line with current service pressures. Extension to 31 March 2022 is requested.

Audit Action Plan
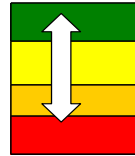
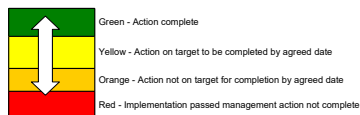|	
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Priority	
Low	
Medium	
High	

Velindre UNHS Trust

	Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Assurance Report						Date received at Audit Committee: 22 March 2021	
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee
1	A register of compliance requirements for all IG/ICT related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.		Work is already underway in respect of a centralised (Trust-wide) service catalogue. As such the Digital Services Infrastructure team will implement and maintain a central register of compliance requirements and report annually the status of the organisation in respect of each of these to the Quality, Safety & Performance Committee.	Deputy Chief Digital Officer	Quarter 4 2021/2022		Service Catalogue in development, published in SharePoint. Aiming to complete by Q3/Q4 2021/22.	Service Catalogue now live. Being maintained as an ongoing concern in respect of relevant digital systems / services and contracts. Separately, a register of external compliance requirements has been developed, to be maintained by the VUNHST corporate team. This register includes relevant IT compliance requirements - e.g. NIS Directive.
2	Management should consider providing an annual report that identifies risks that have a low likelihood but a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.		To complement existing risk management reporting, an annual summary report setting out all digital services risks will be presented for review to the Quality & Safety and Performance Committee.	Deputy Chief Digital Officer	Quarter 3 2021/2022		Significant / Critical risks now being reported to Trust Board via QSP Committee, as per new risk reporting arrangements for Trust Board. Annual report setting out all Digital Services risks to be submitted to QSP Committee in Q3.	Digital Services risks now consolidated into a single pan-Trust view. All risks entered onto DATIX. As per last update, all significant / critical (>12) risks and all risks with an impact of 5 (catastrophic) risks reported to Trust Board. Annual report of Digital Services risks presented to Executive Management Board on 4th January 2022. Agreement that annual summary report specific for Digital Services not required, as Trust risk management approach now sufficiently mature so as to enable appropriate visibility of digital services risks through Divisional Senior Management Teams, EMB and Trust Board.
3	The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.		The establishment of the new Digital Service Desk in March 2021 and the associated reporting procedures will improve the ability of the Digital Services team to track and manage IT issues. Improved reporting functionality that is possible through these new procedures improves traceability and will support improved links between IT problems and incidents and risk management. These will form a key performance metric for the Digital Services function and reported to the Strategic Transformation, Planning, Estates and Digital Directorate on a quarterly basis.	Deputy Chief Digital Officer	Quarter 3 2021/2022		New internal process for identifying and managing risks will be linked to known service issues / problems. Aiming to have full suite of Digital Services risks updated by end of October 2021.	Complete. Identification and management of risks now being handled and routinely reviewed via regular meetings of Digital Delivery and Digital Programmes teams. Also reviewed monthly via Digital Services Senior Team meeting.
14	The VCC firewall(s) should be implemented to provide a filtering function. The use of Windows Defender / ATP should be implemented within VCC. Work should continue on segmenting the network and applying a level of device level authentication.		Firewalls will be implemented as recommended Segmentation is an ongoing work package	Deputy Chief Digital Officer	Quarter 1 2021/2022 Quarter 4 2021/2022		Client firewall implementation is being prioritised due to the protection in place by DHCW perimeter firewalls. Once client firewalls have been enabled and implemented, focus will turn to enabling VCC perimeter firewalls. Windows Defender / ATP is currently being rolled-out across the Velindre estate nearing 100% completion for all Windows 10 client devices and various servers.	Firewall configuration complete. Network segmentation is an ongoing work priority for the team / BAU. Windows Defender for Endpoint now on all windows 10 client devices - With firewall configuration complete, testing is underway.

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Priority	
Low	
Medium	
High	

Velindre UNHS Trust

Digital Health & Care Record for Cancer (Canisc Replacement)						Date Received at Audit Committee: 14 October 2021
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee
	Process change not fully understood (Operation). The adjusted ways of working across all departments should be finalised and agreed across the Trust departments.	Medium	Following the established process for approving ways of working, all changes to operational process will be approved at a workstream and project board level prior to transition from Canisc to WPAS & WCP.	Paul Wilkins, Interim Director of VCC	29/05/2022		The majority of the new ways of working have been signed off by the by the operational leads and ratified by the Project Board. The remaining processes are dependent on the delivery of software from Digital Health & Care Wales.

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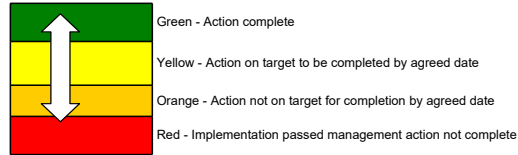
Priority	
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Velindre UNHS Trust

Waste Management - Reasonable Assurance							Date Received at Audit Committee: 14 October 2021

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee
	Monitoring & Reporting (Operation). 4.1.a The Trust Corrective Action Register & Tracker should incorporate recommendations made in Division Pre-Acceptance audits.	Medium	4.1.a Accepted. The Trust Corrective Action Register will incorporate recommendations made in Divisions Pre-Acceptance Audits.	David Harding, Operational Services Compliance Manager (VCC)	October 2021		The Pre accescptance Audit (Upstream Waste Audit) is reported to the Divisional Quality and Safety Meeting following the auditas part of the Operatioanl Services Highlight Report.

Audit Action

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Priority	
Low	
Medium	
High	

Velindre UNHS Trust

Divisional Review - Risk Management - Final Internal Audit Report						Date Received at Audit Committee: 14 October 2021	
Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee
	New Risk Management Framework (Design). 1.1 a. The Trust should • publish the new Risk Management Framework and supporting documents on its intranet as soon as possible; and • ensure the divisions are aware of the new Framework and its application in practice (see also matter arising 2).	Low	1.1a Recommendation agreed	Lauren Fear Director of Corporate Governance	October 2021	Red	Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
	1.1 b. Divisional management should: • ensure local risk management procedures are updated to reflect the new Framework; and • ensure all relevant staff are aware of the updated procedures.	Low	1.1 b. Divisional response: • WBS: This is an established and documented process at WBS. The audit trail will be kept in Q-Pulse. •	Peter Richardson, Head of Quality & Regulation WBS	October 2021	Red	Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
		Low	1.1 c. VCC: – The new Risk Management Framework was included on the agenda at the VCC Quality & Safety Management Group in August 2021. The Framework and supporting documents will be published on the VCC intranet by the target date. – 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.	Tracey Langford, VCC Quality & Safety Officer Tracey Langford, VCC Quality & Safety Officer	September 2021 October 2021	Red	This was received at the August VCC Quality and Safety Management Group on the 12.08.2021. Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
	Risk Management Training (Design). 2.1 a. The Trust should ensure: • the new risk management training programme development is completed and rolled out as soon as possible; and • mechanisms are in place to capture attendance at risk management training.	Medium	2.1 a. Recommendation agreed	Lauren Fear, Director of Corporate Governance	October 2021	Red	Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
	2.1 b. Divisional management should ensure that attendance at risk management training is monitored at appropriate forums.	Medium	2.1 b. Divisional response: • WBS: WBS Divisional Management will support the roll out of training once finalised and will capture all records of attendance for audit purposes.	Peter Richardson, Head of Quality & Regulation WBS	October 2021	Red	Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues

		Medium	2.1 b.• VCC: – The training on the new risk management programme, including training materials, is currently in development and due to be finalised by 5th October 2021. – Training will be made available to all directorates and training compliance will be captured and monitored by Directorate leads and regularly reviewed by at the VCC Quality & Safety Management Group as an assurance measure. – The Senior Leadership Team will monitor training compliance by exception.	VCC Quality & Safety Manager	October 2021		Training on the new risk management programme is still under development. Training will be rolled out to Directorate Leads once training materials are received from Trust team
	Consistency of approach to risk mangement (Design). 3.1 a. The Trust should implement a mechanism to ensure risk management practice is consistent between the divisions and good practice can be shared. 3.1 b. The Trust should ensure that WBS follows the risk scoring system set out in the Risk Management Framework when reporting to the Board and its Committees.	Low	3.1 Trust response: a & b Recommendation agreed.	Lauren Fear Director of Corporate Governance	October 2021		Recommended by March 2022 – as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
		Low	WBS: a. The WBS Risk Management Team is engaged with the Corporate Governance team to agree an approach to risk management practice that meets the specific regulatory needs of WBS and can be applied consistently across the Trust.	Peter Richardson, Head of Quality & Regulation WBS	October 2021		Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
		Low	VCC: a. Further discussions needed with Trust Risk Management leads and in turn, Senior Leadership teams of VCC and WBS to agree consistent approach to risk management and sharing of good practice.	Lauren Fear / Paul Wilkins / Alan Prosser	October 2021		Recommended by March 2022 - as relates to training content being finalised so that content available to staff all aligned at each source. Timeline also reflects current service pressues
		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. 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	All Directorate leads / Sarah Owen, VCC Quality & Safety Manager / Sarah Owen, VCC Quality & Safety Manager	October 2021 / October 2021 / September 2021		VCC - Risk registers are being reviewed by each Directorate. This has now been completed and directorates have now been set up / For Corporate and WBS - Recommended by March 2022 Timeline also reflects current service pressues

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High	

Velindre UNHS Trust

Infection Prevention and Control Final Internal Audit Report | **Date Received at Audit Committee: 14 October 2021**

Ref	Recommendation	Priority	Management Response	Responsible Manager/ Department	Agreed Implementation Date	Status	Update for January 2022 Committee
		Medium	The Infection Prevention & Control Group to have oversight of the corporate IPC Policy and procedure position 6 monthly as part of the work programme.	Muhammed Yaseen, Head of Infection Prevention & Control	From November 2021	Ongoing	Reviewed monthly by the Infection Prevention and Control (IPC) Team, the Trust IPCMG bi-monthly/ quarterly (dependent on the meeting frequency)
		Medium	All Corporate IPC policies and procedures to have a review date of no longer than 3 years.	Muhammed Yaseen, Head of Infection Prevention & Control	November 2021	Ongoing	
	IPC reporting (Design). 2.1 a. Divisional management should clearly identify the level of IPC reporting they require and ensure this is regularly reported to the appropriate divisional management forum (for example, the divisional Quality and Safety meetings).	Medium	2.1 a. Divisional responses: • VCC: The VCC IPC agenda and highlight report will be shared with SLT monthly as a standing agenda item for the SLT part 2 Performance meeting, this will enable the VCC Head of Nursing to provide oversight and assurance.	Vivienne Cooper, VCC Head of Nursing	October2021	Red	Infection Prevention & Control highlight/update is a standing item on the SLT agenda
		Medium	2.1 a • WBS: The Infection Prevention and Control agenda at WBS is now reported formally through the Regulatory Assurance and Governance Group (RAGG) to enable relevant oversight and assurance upon a Monthly basis by the Head of Nursing. WBS RAGG & IPC Group Terms of Reference to be amended to reflect the formal divisional reporting lines for IPC.	Zoe Gibson, WBS Head of Nursing	October 2021		This action is now resolved and complete
	2.1.b. The Trust should review all IPC related KPIs.	Medium	2.1 b. The Trust has not formally reviewed its IPC KPIs for some time. The Trust IPCMG to formally review IPC KPIs including target compliance levels and make recommendations through EMB in relation to these and inclusion in the Trust performance management framework	Muhammed Yaseen, Head of Infection Prevention & Control	December 2021	Completed	KPI tracker to be completed at the VCC and WBS divisional IPC summit meetings, and the results included in the highlight reports for the Trust IPCMG meetings.

IPC Audit Action Tacking (Design). 3.1 We understand that Estates is developing an action tracker for estates-related IPC actions. The Corporate IPC Team should expand on this and develop a tracker for all corporate IPC audit actions. For each action, the tracker should identify: • the required action(s); • the individual responsible for implementation; • deadline for implementation; and • progress update, where necessary. The tracker should be regularly monitored by the Trust IPCMG, with divisional actions being monitored by the respective divisional IPCMGs. Note: whilst the Corporate IPC Team may be responsible for developing and maintaining this tracker, it is important that the Trust ensures clarity over the ownership of audit actions, particularly those which lie within the divisions and their IPCMGs.	Medium	3.1 Trust IPC action tracker (possibly using the Datix action module) will be developed and implemented.	Muhammed Yaseen, Head of Infection Prevention & Control	March 2022	Completed
IPC SOP Non-compliance (Operation). 4.1 We concur with actions already taken to address some of our findings and further recommend: a. The Corporate IPC Team should ensure the IPC audit programme focuses on areas of concern highlighted by our testing.	Medium	4.1 a. The Trust Corporate IPC audit plan to be formally reviewed to ensure it adequately covers the areas highlighted in the review	Muhammed Yaseen, Head of Infection Prevention & Control	November 2021	Completed	The issues identified have been addressed appropriately, and have been included on the audit tracker.
4.1 b. The Corporate IPC Team should issue a Trust-wide communication highlighting the findings of our on-site fieldwork and emphasising the importance of compliance with IPC SOPs. This message should also be communicated through the divisional line management structures, via the divisional IPCMGs.	Medium	4.1 b. The findings of the on-site field work will be communicated to staff across the Trust through the IPC newsletter and disseminating the report through divisional SMT and IPC Meeting structure.	Muhammed Yaseen, Head of Infection Prevention & Control	October 2021	Completed	The results of the audit were communicated to staff through the VCC and WBS Divisional IPC summit and the Trust IPCMG meetings. They were also included in the highlight reports for the SLT meetings.

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Velindre UNHS Trust

Divisional Review - Incident Management Final Internal Audit Report						Date Received at Audit Committee: 14 October 2021	
Ref	**Recommendation**	**Priority**	**Management Response**	**Responsible Manager/ Department**	**Agreed Implementation Date**	**Status**	**Update for January 2022 Committee**
	Incident Reporting and Investigation Policy (Design). 1.1 a. As soon as the Datix O4W system is finalised, the Trust should: • review and update its Incident Reporting and Investigation Policy, incorporating updated definitions on incidents and the good practice identified in the WBS SABRE reporting flowchart; • ensure the updated Policy is approved by the Board; and • ensure the divisions are made aware of the new Policy.	Low	1.1 a. Trust Incident Policy to be reviewed and approved by the Board. Revised Policy to be tabled at EMB on 1st November 2021. The policy is to reflect the new Once for Wales system requirements and the WBS SABRE reporting flowchart. Both Divisional teams to support the policy development to ensure it meets divisional requirements, including definitions aligned to legislation and regulatory requirements specific to WBS.	Jennie Palmer Trust Quality & Safety Manager Quality leads at VCC & WBS	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed and issued out.
		Low	1.1 b VCC: Divisional Quality and Safety Manager will write the incident management SOP to reflect any changes to the Trust Incident Reporting and Investigation Policy.	Sarah Owen, VCC Quality and Safety Manager	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.
	Timeliness of recording incidents (Operations). 2.1 a. Divisional management should remind staff of the requirement to record incidents in Datix within the Policy timeframes.	Medium	WBS: 2.1 a. All staff communications to be issued. Specific issue with Health and Safety Manager access to Datix Incidents module has been followed up and resolved, backlog of entries.	Peter Richardson, Head of Quality & Regulation WBS	October 2021		Complete
		Medium	VCC: 2.1 a. The Divisional incident management SOP will reflect the requirement of staff to record incidents within the expected timeframe. Incident management SOP will be reviewed by SLT out of committee to ensure timeliness of action.	Tracey Langford, VCC Quality and Safety Office to facilitate	November 2021		Divisional Quality & Safety Officer will develop the incident management SOP when Trust Incident Policy has been reviewed.
	2.1 b. The Policy on input to Datix applies to paper-based forms and we understand responsibility for input lies with the individual who identified the incident or their operational manager. WBS divisional management should review its process for recording paper-based incident reports in Datix to ensure compliance with the Policy.	Medium	2.1 b. WBS: Datix O4W Access Issues for the Health and Safety Officer have now been resolved, the paper-based incidents to be entered into Datix.	Peter Richardson, Head of Quality & Regulation WBS	September 2021		Complete
		Medium	VCC: 2.1 c. The Divisional incident management SOP will reflect the required reporting and escalation	Sarah Owen, VCC Quality & Safty Manager (VCC), supported by the Tracey Langford, Quality & Safety Officer (VCC)	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed and will ensure the required reporting and escalation processes are included.
	Incident Investigation Quality (Design). 3.1 Recording investigations in Datix a. Divisional management should: • remind staff of the need to record all investigations (or a clear explanation of why an investigation was not undertaken) in Datix; and • ensure that incidents are not closed in Datix until the above has been recorded. Incident management training	Medium	3.1a WBS response: a. Communications will be issued to all WBS managers responsible for investigating/closing incidents in Datix to reinforce the need to record details of the investigation or a rationale for not investigating. Relevant SOP's will be reviewed and updated where necessary to ensure this requirement is clearly stated.	Peter Richardson, Head of Quality & Regulation WBS	September 2021		Complete
		Medium	VCC: 3.1a. The Divisional incident management SOP will reflect the need for all staff to record incident investigations in DATIX and the closure process.	Sarah Owen, VCC Quality and Safety Manager	November 2021		Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.
	3.1 b. Divisional management should maintain a robust audit trail for incident management training delivered.Quality assurance of investigations	Medium	VCC: 3.1b. All incident training records will be maintained and held by the VCC Quality and Safety Officer and departmental managers. VCC to review WBS use of Q-Pulse to assess if transferrable to VCC.	Tracey Langford, VCC Quality and Safety Officer Amanda Jenkins, Workforce Business Partner / Lisa Miller, Head of Operational Services and Delivery	September 2021 October 2021		Training records are being maintained by Quality & Safety Officer. Managers required to maintain training records for staff within their directorates. WOD exploring how these can be added to ESR which should be the repository for such information. The use of QPULSE requires further exploration on a Trust wide basis.
		Medium	3.1. c. VCC: Formalise work to include Divisional incident activity to be visible on the Clinical Audit Plan.	Sara Walters, VCC Clinical Audit Manager / Sarah Owen,	December 2021		A meeting has been arranged with Quality & Safety Team and Clinical Audit Team for 07.01.2022 to instigate discussions.
	Incident Reporting and Scrutiny (Design). 4.1 a. Divisional management should ensure that incident reporting and scrutiny is undertaken regularly at divisional and directorate / OSG level. The approach should be consistent across the Trust, where appropriate.	Medium	4.1 a WBS response: a. WBS Quality Assurance team to produce a standard KPI template based on the Laboratories OSG for Incident reporting to be used by all Operational Service Group, Regulatory Assurance and Governance Group, and Senior Management Team reports. (also 4.1 c)	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021		Template will be introduced following approval at the January 2022 Regulatory Assurance and Governance Group meeting
	4.1 b. Incident reporting at all levels should include:• defined KPIs (including targets) for incident management, for example, timeliness of recording and investigation closure, level of open incidents, recording of investigations and learning in Datix, etc;• trend monitoring on the above KPIs and other metrics, for example, incidents by type, severity and location; • KPIs and narrative around learning (see matter arising 5); and• the requirement to clearly identify of areas of concern.	Medium	WBS: 4.1 b. This template will take account of the KPI's identified in this audit and will incorporate them in the template once the reporting functionality is in place for Datix O4W.	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021		Delayed to February 2022, awaiting BI reporting tool for Datix OfW.
	4.1 c. Divisional and directorate / OSG meeting minutes should clearly evidence the scrutiny of incident reports.	Medium	VCC: 4.1 c. DATIX leads will provide information to directorate meetings to facilitate scrutiny and escalation	Tracey Lanford, VCC Datix leads	31 October 2021		Datix incidents are being discussed at departmental level and the Directorate Lead will escalate as and when required.
	Learning from Incidents (Design). 5.1 Divisional management should: a. remind staff of the requirement to record lessons learned in Datix;	Medium	5.1a WBS response: a. Communications will be issued to all WBS managers responsible for investigating/closing incidents in Datix to reinforce the need to record details of lessons learned. Completion date. Relevant SOP's will be reviewed and updated where necessary to ensure this requirement is clearly stated.	Peter Richardson, Head of Quality & Regulation WBS Peter Richardson, Head of Quality & Regulation WBS	30 September 2021 31 October 2021		Complete Complete
	5.1 b. ensure that incident reporting at all levels (see matter arising 4 also) includes:• KPIs around recording lessons learned in Datix; and• the requirement to clearly identify concerns in trends and lessons for wider sharing (the new report template for Infection Prevention and Control performance could be used to develop this requirement).	Medium	WBS: 5.1 b. The WBS Donor and Patient Clinical Governance groups will amend their monthly incident report templates to include details incidents where lessons learned have not been recorded, and to allow for review and challengewhere appropriate. This is dependent on the reportingfunctionality being in place for Datix O4W.	Peter Richardson, Head of Quality & Regulation WBS	January 2022		Delayed to February 2022, awaiting BI reporting tool for Datix OfW.

AUDIT COMMITTEE

AUDIT WALES REPORT
STRUCTURED ASSESSMENT 2021:
Phase 2 Corporate Governance & Financial Management Arrangements

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Katrina Febry, Audit Lead (Performance), Audit Wales
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1.   SITUATION/BACKGROUND

1.1   Audit Wales' Structured Assessment 2021 Phase 2 Corporate Governance & Financial Management Arrangements Report is attached for the Committee's information.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   This report sets out the findings from phase 2 of the Auditor General's 2021 structured assessment work at the Trust.

3.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4.   RECOMMENDATION

4.1   The Committee are asked to note the report.

Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements – Velindre University NHS Trust

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

Contents

Summary report

About this report

1   This report sets out the findings from phase two of the Auditor General's 2021 structured assessment work at Velindre University NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004. Our 2021 structured assessment phase one report considered the Trust's operational planning arrangements and how these are helping to lay the foundations for effective recovery.

2   The COVID-19 pandemic required NHS bodies to quickly adapt their corporate governance and decision-making arrangements to ensure timely action was taken to respond to the surge in emergency COVID-19 demand and to ensure the safety of staff and patients. Our 2020 structured assessment report considered the Trust's revised governance arrangements and was published in September 2020.

3   NHS bodies have continued to respond to the ongoing challenges presented by COVID-19, whilst also starting to take forward plans for resetting and recovering services affected by the pandemic. Our 2021 structured assessment work, therefore, was designed in the context of the ongoing response to the pandemic thus ensuring a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continued to respond to COVID-19.

4   Phase two of our 2021 structured assessment has considered how corporate governance and financial management arrangements have adapted over the last 12 months. The key focus of the work has been on the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. We have also considered how business deferred in 2020 has been reinstated and how learning from the pandemic is shaping future arrangements for ensuring good governance and delivering value for money. We have also sought to gain an overview of the Board's scrutiny of the development and delivery of the Trust's 2021-22 Annual Plan.

5   We have provided updates on progress against any areas for improvement and recommendations identified in previous structured assessment reports.

Key messages

6   Overall, **the Trust is well governed with clear, effective arrangements to manage its finances.**

7   The Trust has good governance arrangements which adapted well to the pandemic. The Trust has streamlined its Board committee structure and postponed Board and committee business is being reactivated. The quality and presentation

of information at Board and committees are good, but on occasions, papers include content which is perhaps too detailed. Transparency of Board business to the public is good, but there are some opportunities for improvements.

8   The Trust has introduced improved risk management arrangements and is currently refreshing quality governance arrangements. The Trust is developing detailed plans to ensure ongoing business continuity and increase capacity to respond to increasing demand for services. However, not all strategic priorities are supported by specific, timebound actions for delivery.

9   The Trust has good arrangements to manage its financial resources and continues year on year to meet its financial duties. Financial controls are effective, and the Trust uses clear, timely financial information to monitor and report its performance.

Recommendations

10   Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**. **Appendix 1** will be completed once the report and management response have been considered by the relevant committee.

Exhibit 1: 2021 recommendations

Recommendations
Transparency of Board business
R1   Some committee meeting papers are missing from the website, as are links 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 • recordings of Board meetings.
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.

Detailed report

Governance arrangements

11   Our structured assessment work considered the Trust's governance arrangements while continuing to respond to the challenges presented by the pandemic.

12   **The Trust is well governed with a commitment to continuous improvement and embedding good governance across its business.**

Conducting business effectively

13   **The Trust has good arrangements to conduct Board and committee business effectively, but opportunities to enhance public transparency remain.**

Public transparency of Board business

14   The Trust's Board and committee meetings continue to be virtual, with people attending remotely. All public Board meetings are broadcast live to allow the public to attend virtually and video recordings are made available on the Trust's website. Our review of the Trust's website in August 2021 identified that recordings were available for six out of eight Board meetings held since July 2020[1] (see **Recommendation 1**). The Trust currently has no plans to live stream or make available recordings of committee meetings.

15   Board papers are published in advance of meetings on the Trust's website. Committee meeting papers should be published in advance, but we identified some exceptions[2]. We note that the Trust upgraded its website earlier in 2021, and therefore needed to migrate content from the previous website, which may explain some omissions. (See **Exhibit 2, 2018 R1** and **Recommendation 1**).

16   Board and committee minutes are published on the Trust's website when included in papers for the next meeting. The Trust may want to consider publishing unconfirmed minutes a few days after each Board and committee meeting, whilst retaining agreement of accuracy in the following meeting. This would help increase transparency, particularly as the public is currently unable to attend committee meetings in person or watch a live stream or a recording.

17   The Trust has continued to engage regularly with patient advocates from the Community Health Council. Representatives also regularly attend Board and committee meetings and provide views on service changes and public accessibility to Trust business.

[1] There were no video recordings available for March and June 2021 Board meetings on the website.

[2] Papers for the 28 June 2021 Strategic Development Committee meeting are omitted, as are papers for the 15 July 2021 and all 2020 Quality, Safety and Performance Committee meetings.

18   The Trust's register of Board members' interests is updated on an annual basis.

Exhibit 2: progress made on previous year recommendations

Recommendation	Description of progress
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**.

Board and committee arrangements

19   Last year, our structured assessment set out the Trust's streamlined Board and committee arrangements implemented in March 2020 to respond to COVID-19 and allow focus on business-critical matters. Rather than revert to the pre-pandemic Board committee structure, the Board approved a new streamlined structure in September 2020[3] (see **paragraph 20**).

20   Assurance of Trust performance is now considered alongside quality and safety matters in the Quality, Safety and Performance Committee. Whilst agenda items are relevant and appropriate, we feel that the amount of detail provided to the committee on many items is too great[4]. Further work is needed to agree the amount and level of detail needed to provide necessary assurance to the committee. Consideration is also needed on how to best summarise and synthesise information to help provide focus on key matters.

21   The new Strategic Development Committee provides space for the Board to discuss and approve aspects of strategy direction and development prior to full Board approval. The Trust is still developing the work programme for the committee; however, Board members told us that it provides a good opportunity to scrutinise matters relating to developing strategic intent.

[3] The required variation to the Board's Standing Orders was scrutinised and approved by the Audit Committee and Board in autumn 2020, and again in July 2021 (to reflect changes to the NHS Model Standing Orders).

[4] The May 2021 and July 2021 Quality, Safety and Performance Committee papers were both more than 700 pages.

22   We have considered the Board committees' cycles of business and agendas and have undertaken observations of committee meetings. The new structure provides clarity in Board committee (and sub-committee) assurance responsibilities. The structure has good potential to ensure increased triangulation of workforce and financial data alongside both performance and quality/safety issues.

23   Until April 2021, the Audit Committee agenda included assurance on NHS Wales Informatics Service matters as a service hosted by the Trust. On 1 April 2021, hosting arrangements ceased[5]. This presents an opportunity for the Audit Committee to allocate greater time to undertake deeper dives in existing agenda items, or support the work of other committees, for example, matters relating to information governance and/or cyber security.

24   The Board plans to undertake a review of its new streamlined committee structure later in 2021 and has confirmed it will consider our views on the Quality, Safety and Performance Committee at the same time (**paragraph 18**). Given the length of some committee meetings, the Board should consider piloting re-ordering agendas by placing items for assurance at the start of meetings. At other health bodies, we have observed that re-ordering agendas in this way helps to manage the time and energy levels in meetings to enable good scrutiny where it is needed most.

Board and committee information

25   During the first peak of COVID-19 in 2020, some items of Board and committee business were necessarily paused and added to the recovery log. In autumn 2020, items were brought back into active management with appropriate scrutiny arrangements mapped to the new committee structure. In February 2021, whilst the Trust was responding to the second peak of COVID-19, the Board reviewed and agreed proposals to pause items of Board and Committee business and some Trust work programmes. At the time of writing this report, paused items had either recommenced, or there was an agreed timescale by which to do so.

26   The Trust continues to provide good quality, accessible information to its Board. As we observed last year, officers provide clear verbal presentations identifying specific issues or under-performance. Cover reports set out the purpose of papers and include relevant impact assessments undertaken. There is clarity about which committees and/or management groups have previously considered papers. The Trust told us it intends to provide guidance and training on writing and presenting Board and committee reports. The training/guidance provides an opportunity for the Trust to ensure that all Board and committee papers focus on key issues and address concerns we set out in **paragraph 18**, regarding the amount and level of detail in some committee papers.

[5] NHS Wales Informatics Service ceased as a hosted service following the creation of Digital Health and Care Wales as a separate Strategic Health Authority.

27   The Trust has long intended to make significant improvements to performance information reports (the performance measurement framework). Progress has been delayed due to the pandemic. However, the Trust has undertaken an initial tranche of work in relation to Velindre Cancer Centre performance reporting. A summary dashboard of performance across all measures is now included, and improvements have been made to the explanations of current performance and actions to be taken. Further work is planned later in 2021 and in 2022 to develop a fully revised performance measurement framework using improved business intelligence reporting. Plans also include developing more outcome-based measures, adding benchmark comparisons, and aligning reporting to strategic priorities.

Board commitment to continuous improvement

28   The Board is required to undertake an annual self-assessment of its effectiveness. The Board concluded that it could define itself as 'having well developed plans and processes and can demonstrate sustainable improvement throughout the organisation'[6]. Our observations of Board and committee meetings found they continue to be effective and well chaired. Attendees abide with good meeting etiquette and opportunities are provided for questions and comments. There continues to be a constructive relationship between executive officers and independent members.

29   During the pandemic, board development sessions were paused at times to enable regular Board briefings, ensuring IMs have been fully briefed on the Trust's response to COVID-19 and associated issues and risks. In September 2020, a Board development programme was developed to support the Board and executives in meeting the challenges of a continually evolving operating environment. The programme will be delivered by the end of 2021.

30   The Trust has undertaken a review of governance lessons learnt across NHS Wales whilst responding to the pandemic. The Trust assessed its governance arrangements to identify areas where improvements could be made. Generally, the Trust's governance arrangements compared well, although some further improvements were identified.

Ensuring organisational design supports effective governance

31   In our Structured Assessment 2020 report we described the Trust's incident management structure that was set up to ensure agile and rapid decision making during the pandemic. Whilst the incident management structure was stood down

[6] Velindre University NHS Trust, Accountability Report 2020-21.

during summer 2020, Gold and Silver Command groups[7] were reactivated in October 2020 until spring 2021, which enabled continued agility in the Trust's decision making through the second wave of COVID-19. The Trust is now considering how to embed new ways of working implemented during the pandemic, including improved clarity of decision-making responsibilities, agility of decision making and retaining the Clinical Advisory Group (set up during the pandemic) to provide expertise in developing strategic intent.

32   The Trust has aligned some key business support functions, such as digital support, to enable more efficient working across the Trust (see **Exhibit 3**, **2018 R8**). The Director of Corporate Governance has taken on an additional Chief of Staff role, for an interim period. After six months, the Trust will assess whether the arrangement should continue on a permanent basis; this will be dependent on ensuring that there is no impact on the postholder's existing responsibilities, including ensuring the effective functioning of the Board and its committees.

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
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 and capability gaps.	**Complete** The Trust has aligned some business support functions where similar services are provided by separate teams within the two divisions. The Trust told us that aligning support functions has enabled it to work more efficiently and ensure organisational learning across the divisions.

[7] Gold Command Group was responsible for strategic decision making. Silver Command groups in the Welsh Blood Service and Velindre Cancer Centre were responsible for tactical decision making, supported by Bronze Command groups making operational decisions.

Planning for recovery[8]

33 **The Trust is developing detailed plans to ensure ongoing business continuity and increase capacity to respond to increasing demand for cancer and blood services. However, not all strategic priorities are supported by specific, timebound actions for delivery**.

34 The Board discussed and approved the Trust's draft operational plan for 2021-22 (the Annual Plan) in its March 2021 private Board meeting. In June 2021, the Strategic Development Committee endorsed the final Annual Plan and supporting financial plan. The Board subsequently approved the final Annual Plan on 30 June 2021 via a Chair's Urgent Action. There was good scrutiny of both the draft and the final versions, with the Board seeking assurance that the plan was realistic and achievable.

35 The Annual Plan focusses on continued service sustainability and ongoing recovery. It provides detail on how the Trust intends to increase capacity to meet the anticipated surge in referrals for cancer services and increased demand for blood and blood products during 2021-22 and beyond. Welsh Government feedback on the draft plan noted that further information on 'prevention, inequalities, mental health, decarbonisation and social partnerships' would strengthen the final plan, but the Trust did not add any further information in these areas.

36 The Annual Plan sets out six overarching strategic priorities for the Welsh Blood Service. Each strategic priority is underpinned by several objectives with specific and timebound actions for delivery. There are five strategic priorities for Velindre Cancer Centre, each supported by only one key objective covering many topics; actions for delivery are generally vague and none include delivery milestones. It will be difficult to assess whether the action was delivered or not, and whether delivery was on time. Velindre Cancer Centre should develop strategic priorities underpinned by specific, timebound actions for delivery. Both divisions would benefit from articulating intended outcomes to help assess the impact achieved (**Recommendation 2**).

37 The Trust has a Consolidated Action Tracker, which contains a summary of delivery of the actions set out in its plans. The tracker is regularly updated with a short summary of progress against each action and a traffic light system shows the status of the action. The tracker is reviewed each month by the Operational Management Groups and the Executive Management Board. The Trust provides a

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[8] NHS bodies are required to submit a three-year Integrated Medium Term Plan (IMTP) to the Welsh Government on an annual basis. The IMTP process for 2020-23 was paused by the Welsh Government in March 2020, to allow NHS bodies to focus on responding to the COVID-19 pandemic. Instead, health bodies were required to submit quarterly plans during 2020-21 as well as prepare an annual plan for 2021-22 by 31 March 2021. Our 2021 structured assessment phase one report considered the Trust's operational planning arrangements.

summary of progress against actions set out in the plans to the Board on a quarterly basis (see **Exhibit 4**, **2019 R3**).

38   In June 2021, the Board received a report on the progress set out in the Trust's 2020-21 quarterly plans. 185 out of 235 actions were completed, nine were considered no longer relevant, seven were paused due to COVID-19 and 34 rolled forward to the Annual Plan.

Exhibit 4: progress made on previous year recommendations

Recommendation	Description of progress
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 remedial actions.	**Complete** The Board has agreed the information need to scrutinise delivery of strategic priorities, and reviews progress on a quarterly basis.

Systems of assurance

Managing risk

39   **The Trust is making good progress to develop and embed new risk management arrangements.**

40   In previous structured assessments, we have recommended that the Trust develop a Board Assurance Framework[9]. During 2020, several workshops were held to seek staff views, and independent members were involved in developing a Board Assurance Framework. Ten principal risks to achieving strategic priorities and a template were approved by the Board in 2020.

41   During 2021, work to progress the Board Assurance Framework was paused due to COVID-19 pressures. Work recommenced in summer 2021, with executive officers taking the lead for populating the template with key controls and sources of assurance for the risks falling in their areas of responsibility. The first draft

[9] A key document for recording and reporting the risks to achieving strategic priorities, the controls needed to mitigate against risks, sources of assurance, responsible executive officers and committee scrutiny arrangements.

populated Board Assurance Framework was shared at the September 2021 Board meeting. The next steps involve refining the information in the Board Assurance Framework and ensuring it is comprehensive and progressing work to fill identified gaps in sources of control and assurance.

42   The Trust and Board recognise that the Board Assurance Framework must be a live tool which drives the Board's agenda and requires regular Board committee scrutiny and oversight of delegated risks. Our view is that significant positive progress has been made, but it is too early to comment on the success of application of the Board Assurance Framework. The Trust will need to ensure there is sufficient training for Board members, and the Board will collectively need to agree how to utilise the Board Assurance Framework to assess the risks to achieving strategic priorities (see **Exhibit 5**, **2019 R2**).

43   When reviewing the performance measurement framework and addressing **Recommendation 2** (specific, timebound actions for delivery), the Trust should consider how to map/align performance information to the Board Assurance Framework as an additional layer of intelligence.

44   Last year, our structured assessment found that the Trust had effectively adapted its risk management arrangements to identify and manage new COVID-19-related risks and was making good progress towards introducing longer-term risk management improvements. In September 2020, the Board approved the Trust's new Risk Management Framework, Risk Appetite Statement and associated risk management procedures and user guides. Risk management training for managers and staff has been developed, with plans for roll out later in 2021. The new Risk Management Framework (and associated documents) is comprehensive and provides clarity on arrangements to manage risk; however, it is too early to assess its application (see **Exhibit 5**, **2019 R2**).

45   The Trust undertook a significant review of all open risks on operational risk registers during 2021. The review was necessary to ensure all risk information is current and complete prior to the migration of all risks to a new version of DATIX[10]. Once complete, operational risk registers will be standardised across the Trust. Escalation of risks to the Trust Risk Register will be consistent Trust-wide, with escalation trigger scores appropriate to risk tolerance levels set out in the risk appetite.

46   The Trust took the Trust Risk Register to the September 2021 Board meeting. An update confirmed that most, but not all risks had been transferred to the new version of DATIX. There were 111 risks on the Trust Risk Register. The Trust recognises that there may need to be some consideration of either scoring, or escalation trigger scores as it was felt that some of the risks were not significant enough to warrant Board level scrutiny. Further refinement is planned. The Trust must ensure that all teams/departments within the Trust are consistently using

[10] Datix is a web-based incident reporting and risk management system used by healthcare organisations.

DATIX risk registers, and do not use separate, local arrangements[11]. See **Exhibit 5**, **2016 R7c** and **2019 R2**.

47   The Trust had originally intended to start reporting the revised Trust Risk Register, (incorporating the changes set out in **paragraph 43)** by December 2020. However, the review of operational risks was impacted by COVID-19 pressures and capacity gaps in the risk management team. Consequently, prior to September 2021, the Board and its committees last received a Trust Risk Register in July 2020, this was not challenged by the Board. In our view, the legacy Trust Risk Register should have continued to be maintained and considered by the Board in the absence of the new version. The Trust told us that the Executive Management Board and the Board and its committees have continued to review key risks relating to quality and safety; Transforming Cancer Services[12]; research, development, and innovation; Brexit-related issues; and COVID-19. We found that papers in these areas have been provided to the Board and/or its committees for consideration. However, the absence of a Trust Risk Register for more than 12 months means it is not possible for us to assess whether any other significant risks had arisen, but not sighted by the Board.

Exhibit 5: progress made on previous year recommendations

Recommendation	Description of progress
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 Trust-wide.

[11] Internal Audit's Velindre Cancer Centre Divisional Review (March 2021) identified at that time some departments that did not use DATIX to record risks.

[12] The Transforming Cancer Services programme aims to meet the increasing demand and complexity of cancer care and to deliver more care closer to home.

Recommendation	Description of progress
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.

Tracking progress against audit and review recommendations

48   **The Trust has good arrangements to monitor its progress in responding to audit and review recommendations, although there is no mechanism to ensure that action taken fully addresses the recommendation**.

49   The Audit Committee has an established approach for tracking progress against audit recommendations. However, there is still no mechanism in place for the Audit Committee to satisfy itself that actions taken were satisfactory (see **Exhibit 6, 2018 R4b**). The Quality, Safety and Performance Committee has a tracker for external and internal audit improvement recommendations.

50   The Trust has developed a record of their regulatory and inspection. The record includes the date of last formal review, management responses to recommendations and any further scheduled reviews. It is proposed that the document become a standing item on the Audit Committee agenda.

Exhibit 6: progress made on previous year recommendations

Recommendation	Description of progress
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.

Quality and safety assurance[13]

51 **The Trust continues to provide assurance on staff and service user safety and is refreshing its quality governance framework.**

52 The Trust provides good information on staff safety and wellbeing to the Board. In the early stages of the pandemic, the Board took responsibility for overseeing staff safety and wellbeing, with updates provided at Board meetings. In July 2021, the Quality, Safety and Performance Committee received a wellbeing update, which set out the initiatives in place, results from staff surveys and associated learning, and a summary of further actions. The Trust continues to work closely with Trade Union representatives to monitor the workforce dashboard, which includes performance information on personal protective equipment training and risk assessment completion rates along with sickness absence rates.

53 Through its scrutiny of the performance measurement framework, the Board continues to monitor potential harm to patients from longer than normal waits for treatment. The Quality, Safety and Performance Committee receives regular patient and donor feedback, and reports outline learning and resulting actions. The Quality, Safety and Performance Committee continues to consider patient stories and how learning is shared.

54 In previous structured assessments, we have made recommendations relating to addressing weaknesses in the scrutiny of clinical audit planning and reporting. We have provided our recommendations on clinical audit in **Exhibit 7,** we will consider the progress made in our review of quality governance arrangements.

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[13] We have limited the work we have undertaken on quality governance arrangements as part of our 2021 structured assessment as we are undertaking a separate review of quality governance arrangements at the Trust. The review will consider whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We will report our findings later in 2021.

Exhibit 7: progress made on previous year recommendations

Recommendation	Description of progress
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.
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.	
Clinical audit scrutiny The Quality and Safety Committee should assure itself that clinical audit findings are addressed.	
2018 R5d Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective.	

Managing financial resources

55 Our work considered the Trust's financial performance, financial controls and arrangements for monitoring and reporting financial performance.

56 **The Trust manages its financial resources well and has good arrangements to monitor and report its financial activity.**

Achieving key financial objectives

57 **The Trust achieved its financial duties at the end of 2020-21, and has a clear financial plan to deliver services in 2021-22.**

Financial performance 2020-21

58 In 2020-21, the Trust reported a small surplus of £16,000. The Trust also achieved its statutory financial duty to achieve break-even over a rolling three-year period (2018-19 to 2020-21). However, COVID-19 had a considerable impact on the Trust's finances in the year.

- the Trust reported a year-end underachievement of £1.077 million on income, this was largely related to underactivity caused by COVID-19.

- the Trust underspent (against the plan) on pay by £1.116 million, partly caused by vacancies and staff being re-directed and supported by additional Welsh Government COVID-19 funding (see **paragraph 56**). However, pay costs increased on the prior year, due to the pay award, the NHS bonus payment, an increase in agency spend and additional staff recruited to respond to COVID-19.

- the Trust reported an overall underspend (against the plan) of £23,000 on non-pay expenditure. General reserves were used to support overspending in some areas.

59 The Trust had a savings requirement of £1.4 million for 2020-21 (£1.2 million recurrent and £200,000 non-recurrent). Of this amount, £800,000 was categorised as savings schemes and £600,000 as income generating schemes. A significant proportion of the savings were expected to be delivered through service redesign and workforce rationalisation; however, COVID-19 meant it was impossible to enact the changes. The Trust reported an underachievement of £700,000 against the savings plan as a direct result of COVID-19.

60 The total expenditure relating to COVID-19 during 2020-21 was £15.591 million[14] – £11.532 million relating to non-pay and pay expenditure, £3.984 million relating to pay and £700,000 relating to non-achievement of savings. This was offset by a reduction in activity-related costs of £625,000, and the rest by additional funding

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[14] This excludes NHS Wales Shared Services Partnership expenditure.

from the Welsh Government. Additional costs included hospice funding, the Wales convalescent plasma service pilot, and mass vaccinations.

Financial performance 2021-22

61   The Trust's financial plan for 2021-22 was included in the Annual Plan. The financial plan includes:

- an underlying deficit of £700,000 brought forward from 2020-21 (the underachievement of savings);

- new cost pressures/investment of £9.307 million, with a recurring effect of £1.357 million;

- an ambition to achieve new recurring income of £8.582 million and achieve savings of £1.1 million (with a recurring effect of £925,000); and

- the aim to reduce the underlying deficit into the next financial year to £500,000.

62   By month six, the Trust had received an additional £4.846 million funding from the Welsh Government towards COVID-19 response and recovery costs. The Welsh Government has confirmed the Trust will receive additional funding for COVID-19, costs.

63   The Trust's approved capital funding for 2021-22 totalled £9.156 million. This includes all-Wales capital funding of £7.245 million and discretionary funding of £1.911 million. The Trust reported capital spend to Month 6 was £2.045 million and is forecasting to remain within the agreed £9.156 million. The Trust is seeking additional all-Wales capital funding for bespoke infrastructure projects.

64   The Trust's month six 2021-22 financial report shows that it is likely to meet its financial duty to break even over a three-year rolling period and achieve its saving target for the financial year.

Financial controls

65   **The Trust continues to have good controls to monitor financial activity, and to prevent, detect and respond to fraud**.

66   Internal Audit's review of the Trust's financial systems, reported in January 2021, gave reasonable assurance of financial controls it examined; these were debt, cash, and financial management. Whilst the review found there were sound processes in place in the areas examined, the review made recommendations to improve controls and monitoring in specific areas of debt management.

67   No significant control weaknesses were identified from our 2020-21 accounts opinion work at the Trust.

68   The Trust reports regularly to the Audit Committee on procurement, losses, and special payments, and counter-fraud matters. Procurement reports clearly set out the number of Single Tender Actions and Single Quotation Authorisations and the

reasons why officers did not follow standard procurement procedure. The value and reasons for deviation from standard procurement procedures are clearly set out in the Trust's procurement reports which are scrutinised by the Audit Committee.

69   Where Chair's actions out of committee have been necessary, there is a log of the decision, evidence of Board scrutiny and subsequent ratification by the Board.

70   The Trust has maintained decision logs relating to COVID-19 financial expenditure. Expenditure relating to COVID-19 is included on the monthly monitoring returns to the Welsh Government and reported to Board.

71   Our October 2020 review of the Trust's counter-fraud arrangements found that the Trust demonstrates a commitment to counter fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

Monitoring and reporting

72   **The Trust uses clear and accessible information to monitor and report its financial performance.**

73   The Trust reports financial performance at every Board meeting, and we have observed good scrutiny of their content. Alongside verbal presentations from officers, the reports provide more context on the reasons for over or under spends and the factors affecting planned savings. The information is published on the Trust's website with its Board papers. Our review of financial reports reported to Board found they provide high-quality and timely information on financial performance, including financial savings and cost drivers related to COVID-19. Finance reports also clearly identify financial risks and cost implications.

Appendix 1

Management response to audit recommendations

The following table sets out the Trust's management response to our 2021 (phase 2) structured assessment audit recommendations. The Trust should also ensure that outstanding recommendations from previous structured assessments are actioned. Any recommendations from previous years, that we consider to still be open are set out in the body of this report.

Recommendation	Management response	Completion date	Responsible officer
Public transparency of board business R1 Some committee meeting papers are missing from the website, as are links 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 in advance of meetings; and • recordings 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. A review of the website content has been completed and all missing content has been added All of the Corporate Governance team are to be trained to upload papers directly on the Trust website to further increase resilience.	November 2021 (Completed) November 2021 (Completed) March 2022	Director of Corporate Governance and Chief of Staff

Recommendation	Management response	Completion date	Responsible officer
	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 is unavailable.	November 2021 (Completed)	
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.	March 2022	Chief Operating Officer and Director of Strategic Transformation Planning and Digital

AUDIT COMMITTEE

AUDIT WALES AUDIT COMMITTEE UPDATE

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Katrina Febry, Audit Lead (Performance)
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Audit Wales' Audit Committee Update at December 2021 is attached for the Committee's information.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report provides the Committee with an update on the progress of Audit Wales' current and planned work.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The report provides an update on the Audit Wales audit planned work for the current year.
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 review and note the report.

Audit Committee Update – Velindre University NHS Trust

Date issued: December 2021

Document reference: APS202105

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 2021 audit plan was presented to the Audit Committee in March 2021.

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

Exhibit 1 summarises the status of our key accounts audit work concerning the 2020-21 financial year.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2020-21 Financial Statements	Audit work complete and our ISA260 report was presented to the Audit Committee on 8 June 2021. The Auditor General certified the accounts on 15 June and laid them on 16 June. Our additional 2020-21 Financial Audit report was presented to Audit Committee in October 2021.
Audit of 2020-21 Charitable Funds Financial Statements	At the time of writing, our audit work is ongoing and we are scheduled to present our findings to the Trust's Charitable Funds Committee on 22 December, with Auditor General certification scheduled for 6 January 2022.
Audit of S1 and S2 forms	Welsh Government require us to audit the S1 and S2 forms in relation to the transfer of assets and liabilities between the Trust and Digital Health and Care Wales (formerly NWIS). This work is happening in December 2021.

3   We have also commenced some initial planning as part of our 2021-22 opinion work. This has focussed on planning our approach to the audit of the inventories balance within the Trust's 2021-22 financial statements given the complications posed by the Covid-19 pandemic. A briefing paper will be presented at the Trust's Audit Committee scheduled for January 2022.

Performance audit update

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

Exhibit 2 – Performance audit work

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Quality Governance (2020 Audit Plan) 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.	Field work in progress, draft report anticipated in 2022
NHS Structured Assessment (2021 Audit Plan) Director of Corporate Governance	This year's work is designed in the context of the on-going response to the pandemic. As in previous years, the work focused on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Progress against previous recommendations will be included where these relate to	Phase 1 – final report issued, presented to July Audit Committee Phase 2 – final report issued, to be presented to January 2022 Audit Committee

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	ant aspects of organisational governance and financial management. The work will be undertaken in two separate stages: Phase 1 – operational planning Phase 2 – leadership and governance; financial management	
Local study (2021 Audit Plan)	Topic to be confirmed	To be confirmed

Good Practice events and products

5   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.

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

7   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

8　　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
Taking Care of the Carers?	**October 2021**
A Picture of Healthcare	**October 2021**
Infographic on the NHS (Wales) summarised accounts for 2020-21	September 2021
Picture of Public Services 2021	September 2021
NHS Wales Finances Data Tool - up to March 2021	June 2021
Rollout of the COVID-19 vaccination programme in Wales	June 2021
Welsh Health Specialised Services Committee Governance Arrangements	May 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021

Title	Publication Date
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Public bodies' digital resilience – cyber security (Due to the sensitivity of content, this report is not available publicly, but is available to health bodies)	January 2021
NHS structured assessment – Doing it Differently, Doing it Right?	January 2021

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

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

Title	Indicative publication date
Orthopaedic services	2022
Unscheduled care – a whole system view	2022
NHS waiting times tool	2022
Care homes commissioning	2022
Recovery planning	2022

Audit Wales Fee Consultation

11   The Audit Committee may also be interested in the Auditor General's consultation with stakeholders upon audit fee scales. Consultation closes on 7 January 2022.

Audit Wales

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

Date issued: December 2021

Velindre Audit Committee – update on the 2021-22 approach to the audit of Inventories

Introduction

1   Circumstances relating to the Covid-19 pandemic prevented us from obtaining the necessary assurance on the Trust's Inventory balance as at 31 March 2021 of £95.564 million. As this balance was material to the financial statements, this absence of audit assurance resulted in a Limitation of Scope qualification on the 2020-21 financial statements.

2   This paper sets out our broad approach to obtain the appropriate audit evidence and assurance on the Trust's Inventory balance for 2021-22 in accordance with the requirements of IAS501.

3   Our overall objective is to put in place an approach which obtains the evidence and assurance needed, by working with the Trust throughout the audit in a dynamic and flexible way, to reduce any risks which may prevent us from gaining our assurance as much as we can, whilst acknowledging risk cannot be removed completely.

Expected 2021-22 inventory balance

4   Based on the paper presented to officers at the October 2021 Audit Committee and subsequent updates from management, we are again expecting the Trust's Inventory balance to be material. This is mainly as a result of the significant PPE stock balances held by Shared Services at its various stores locations across Wales.

5   Although our 2021-22 materiality is not yet finalised – our 2020-21 materiality level was £8.5 million – it's certain that the Inventory balance will again be material as at 31 March 2022.

Our planned approach for 2021-22

Assurance over the closing stock balance

6   Per the requirements of ISA501 we are required to attend physical stock counts where the stock balance is material in order to obtain appropriate audit evidence upon the existence and condition of the stock.

7   In addition to reviewing the latest information provided to the Audit Committee in October we have held a number of meetings with Internal Audit (who are in the process of undertaking their own review of the stores systems) and with officers and management of the Trust and Shared Services. These discussions have helped shape our approach and we are grateful for the input of all concerned.

8   We have identified the following stores as those likely to have material stock balances as at 31 March 2022:

- Newport IP5;
- External – South West; and
- External – South East.

9   The total of the remaining non-material stock balances will, in aggregate, be material and so we will need to obtain assurance over the Trust's stock arrangements for some of this remaining balance and will review a sample from this sub-balance.

10 Overall, based on current information, there are 7 stores locations for which we will need to obtain assurance on the Trust's stock counting arrangements (including Welsh Blood Services). However our risk assessment remains live and may identify other stock balances which we will need assurance over.

11 The stock counting arrangements for each of Trust's stores locations vary – for example, for some the stock is counted on a daily perpetual count basis, others are subject to monthly counts and only one stock balance is counted at the year-end. We will undertake visits to each of the stores facilities subject to our review. The exact nature of our work will vary in accordance with the type of stock counting arrangement in place at each facility, but we must comply with ISA501 which requires us to:

- Document, understand and evaluate the stock counting arrangements for each of the stores facilities on which we need require assurance; and
- attend those stores facilities, to observe and review the stock counting controls, perform test counts and inspect stock.

12 Ideally stock counts would take place at year-end, or as close to year-end as possible. Where the stock counts do not take place at year-end, we will need to undertake additional testing to provide assurance on the year-end balance, including obtaining assurance on the movements between the date of the stock count and the year-end position. Where stock counts are undertaken on a perpetual daily basis, we will attend a number of counts through the year.

13 If on the basis of the Trust's or our own risk assessment, we again find ourselves in a position where we are unable to attend planned stock counts at or prior to the year end, we will endeavour to attend after the year-end and undertake additional work as set out in paragraph 12 above. Note however, that where any of our risk assessments conclude that we should not make a visit, we will firstly work with the

Trust to look at possible actions which could reduce risk sufficiently to enable a visit.

14   Alternative procedures of evidencing physical stock counts virtually via live streaming should be considered a last resort and in our view is unlikely to be practicable, nor able give us the assurance we need on the procedures set out above at paragraph 11.

Impact of the previous year's qualification

15   We need to consider the impact of not obtaining the required assurance on the Trust's closing 2020-21 Inventory balances on this year's audit. The audit opinion does not cover corresponding balances in the financial statements, so we do not need to gain assurance on the opening balance itself. However we do need to obtain sufficient assurance that the cost of stock items charged to the Statement of Comprehensive Income in the year is not materially misstated. We are considering our approach to this, which may include testing of transactions, controls, or a combination of both.

Next steps

16   We intend to commence our visits to the stores locations during January 2022 and, if necessary, will continue our audit work here through to May 2022.

17   In advance of our visits we will need:

- a satisfactory Audit Wales risk assessment for each stores facility to be visited;

- confirmation from both the Trust and Shared Services that they remain comfortable with our attendance at stores facilities; and

- no significant changes to Welsh Government guidance preventing our attendance.

18   Although we cannot rely on any Internal Audit stock take visits (we must undertake stock take visits ourselves), we will consider the conclusions of their work and assess their findings, including any matters arising, and use this work more broadly in assessing risks and risk levels for our work.

19   We will keep the Trust, Shared Services and the Audit Committee informed of how this work progresses and will be working closely with officers as we progress through our work.

GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre

Velindre University
NHS Trust

AUDIT COMMITTEE

DATE OF MEETING	11th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	James Quance, Head of Internal Audit
PRESENTED BY	James Quance, Head of Internal Audit
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR OF CORPORATE GOVERNANCE

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
IA	INTERNAL AUDIT

1. SITUATION/BACKGROUND

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	IA cover Quality and Safety in their work
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	IA reports can cover multiple Healthcare Standards
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

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

Internal Audit Progress Report
Audit Committee

January 2022

Velindre University NHS Trust

NWSSP Audit and Assurance

Contents

1. Introduction

1.1 The purpose of this report is to:

   a. highlight progress of the 2021/22 Internal Audit Plan as of 23 December 2021 to the Audit Committee; and

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

2. Progress against the 2021/22 Internal Audit Plan

2.1 There are 17 reviews in the 2021/22 Internal Audit Plan, two of which are undertaken at NWSSP. In addition, there are four audits in respect of the new Velindre Cancer Centre Integrated Audit and Assurance Plan. Two reviews in our original plan have been replaced (see section 3). Overall progress is shown below:
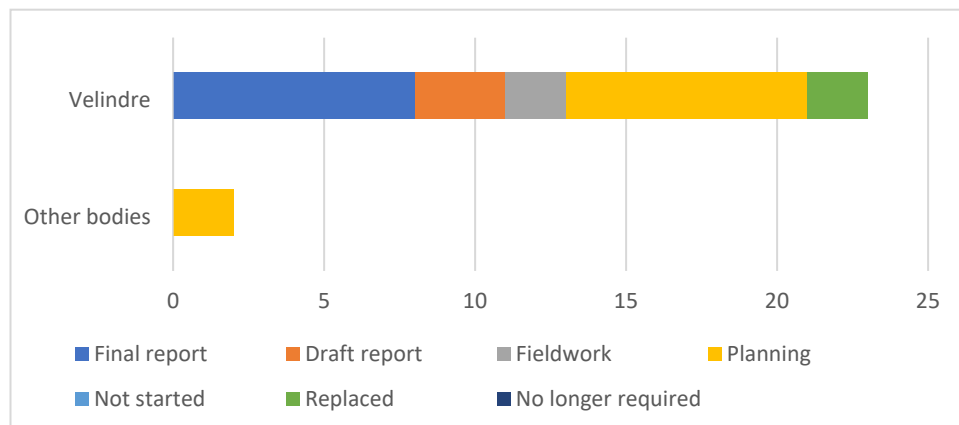
2.2 Since the October 2021 Audit Committee meeting, we have finalised three reports which will be presented at this meeting.

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

3. Changes to the 2021/22 Internal Audit Plan

3.1 We reported to the October meeting of the Committee that we had agreed with senior management that the Private Patients and Quality and Safety Framework reviews would be replaced. We have agreed that they will be replaced by reviews of:

   • Ways of Working (Advisory).

   • Disclosure Barring Service (DBS) Checks.

3.2 Work is underway to scope and plan these reviews.

4. Engagement

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

   a. regular meetings with the Director of Corporate Governance, including discussions over future assurance over the Trust transformation agenda;

   b. regular meetings with the Head of Corporate Governance;

   c. regular meetings with the Executive Director of Finance;

   d. initial 2022/23 planning meetings with Executive Directors;

   e. regular liaison with Audit Wales;

   f. observation of Board and Committee meetings;

   g. audit scoping and debrief meetings; and

   h. liaison with senior management.

5. Recommendation

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

Appendix A: Progress against 2021/22 Internal Audit Plan

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

[1] May be subject to change

Review	Status	Rating	Summary of matters arising			Audit Committee[1]
			High	Medium	Low	
Private & Overseas Patients	Replaced					
Capital & Estates						
Estates Assurance – Waste Management	Final report	Reasonable	-	4	-	October 2021
New Velindre Cancer Centre Integrated Audit Plan:						
Contract Management	Draft report	Reasonable				March/April 2022
Mutual Investment Model (MIM) Procurement	Fieldwork					March/April 2022
MIM Governance	Draft report	Substantial				March/April 2022
Enabling Works Integrated Audit Plan	Planning					TBC
Reviews at other bodies (undertaken within NWSSP Plan)						
Purchase to Pay	Planning					TBC
Payroll	Planning					TBC

Appendix B: Key Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22	🟢	March 2021	By 30 April	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 days]	🟢	6 of 6	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 days]	🟢	4 of 5	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	🟢	4 of 4	80%	v>20%	10%<v<20%	v<10%

Note: KPIs are reported monthly. The figures above are at the end of November 2021.

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

Advisory Review: Use of Digital Technology – Fit for the Future

Final

December 2021

Velindre University NHS Trust

NWSSP Audit and Assurance

Contents

Review reference:	VT-2122-11
Report status:	Final
Fieldwork commencement:	27th May 2021
Fieldwork completion:	10 August 2021
Final report issued:	10th December 2021
Auditors:	James Quance, Head of Internal Audit
	Martyn Lewis, IT Audit Manager
Executive sign-off:	Carl James, Director of Strategic Transformation, Planning and Digital
Distribution:	
Committee:	Audit Committee

Acknowledgement

Thank you to management and staff for the time given to us and for their cooperation while we carried out this review.

We conform to all Public Sector Internal Audit Standards.

Validated through an external quality assessment undertaken by the Institute of Internal Auditors.

1. Introduction and Background

The advisory review to provide an assessment of Velindre University NHS Trusts' (the Trust) position and preparedness for the current and future provision of services using digital technology was completed in line with the Internal Audit Plan.

Digital transformation is a process of using technology to radically change service delivery. This transformation includes changing how the organisation works at every level and how technology underpins all digital transformation projects. The technology changes as time goes on, but organisations need to adopt technologies that help them harness and make sense of the vast quantities of data they are sitting on, as well as preparing for trends like the Internet of Things (IoT) and mobile.

These technologies have the potential to transform health care and organisational service delivery. Today the patient or service user is at the centre, surrounded by technologies transforming experience, reimagining care and providing opportunities to manage their health and engage with health care providers. Technologies that provide tools for health care professionals are embedded within the organisation, such as decision support, the capacity to access other professionals' expertise, tools to prioritise and manage their clinical workload and tools to identify the patients at greatest risk.

The move to a digitally enabled organisation should be part of a Digital Strategy which should support the organisational strategy and provide a holistic view of the current business and IT environment, the future direction, and the initiatives required to migrate to the desired future state.

2. Scope and Objectives

The objective of the advisory review was to evaluate and determine the ability of the Trust to move to a digitally enabled organisation and ensure that it drives value from investment in new technology.

The review seeks to answer the following key questions that act as signifiers for organisational readiness for digital and provide recommendations for actions which will improve the organisations position.

- Is the Trust re–imagining service delivery and business processes?
- Is the Trust redefining the relationship with the service user?
- Is the Trust leveraging the wider ecosystem in Health and Social Care?
- Do Trust staff have the right technology skill-set and mind-set?
- Does the Trust have leaders who see the bigger picture?
- Does the Trust have a good system for prioritising digital transformation initiatives?

In particular, the review covers the following areas to identify any improvements to processes that will further enable digital transformation:

- the decision making process within the Trust;

- the awareness of the Board level management of why digital, what a digital organisation looks like, what the digital aims of the organisation are, and championing of it at Board;

- the culture within the Trust in terms of the ownership of services / systems and the management of changes;

- project control and resources / skills for digital technologies;

- whether the strategic investment decisions are aligned to the digital ambition and the level of current investment is appropriate to deliver the ambition when compared to industry benchmarks; and

- barriers to digital transformation within the Trust.

3. Conclusion

Overall, the Trust is well positioned to take forward the use of digital technologies. There are opportunities for digital transformation and potential funding with the Transforming Cancer Services and Velindre Futures programmes moving forward together with the previous WBS Blood Supply 2020 Programme and the upcoming laboratory modernisation work. Linked to these, there are structures in place for redesigning service delivery and digital staff are engaged in these processes. The engagement with service users has an outline structure and the detail is being redeveloped to ensure it is fit for purpose moving forward.

A vision of how technology can be used to redefine and support service delivery is taking shape and this vision is included within various programmes such as the Transforming Cancer Services Business case, New Velindre Cancer Centre programme, WBS Blood Supply 2020 and the WBS laboratory modernisation work.

The Digital Department is developing the appropriate structures to enable digital transformation within their resource constraints and staff across the Trust are generally positive about the potential benefits of technology and there is an appetite for increased use of it.

However, this position is impacted by a number of barriers to progress. There is no overall Digital Strategy for the Trust, or Digital Transformation Programme and as such the vision has not been fully articulated and communicated to all staff and the digital work within the various programmes referenced above may be misaligned and not coordinated at a Trust level. There is a lack of visibility and leadership on digital at the Board level, with insufficient Board discussions relating to digital transformation. The funding position for digital is not secure, with funding sought on a case by case basis and a lack of formulated strategy impacting on the

success of funding claims. In addition the level of resource in the Digital Department is not fully sufficient to allow for full collaborative working with users or to develop the capacity and capability within the Department and across the Trust.

The organisational culture and understanding of the potential in relation to digital is not at the stage where it is fully understood and seen as owned by the services themselves and there is still a strong reliance on the Digital Department to lead on digital transformation. Digital transformation is a complex organisational change process which must be led by the business strategy and owned and led collectively by the Board and Executive Directors.

The chart below indicates the current position assessment against each of the key questions within the report (scored against a maximum of 100), together with an assessment of the extent to which the barriers may affect the success of each point.

Figure 1: Current Position Assessment
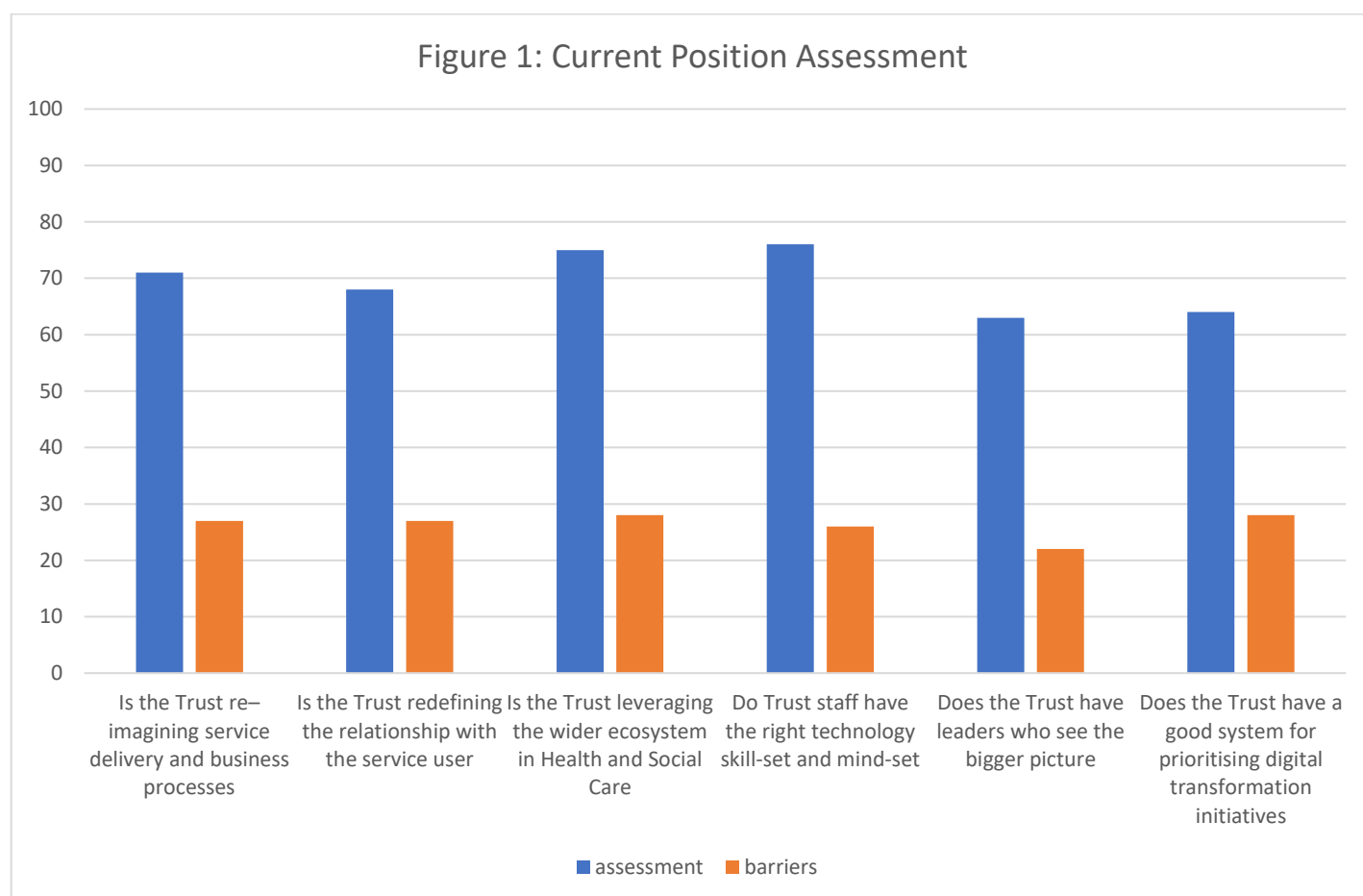
4. Summary of Findings

Is the Trust re–imagining service delivery and business processes?

The Trust is well placed for reimagining service delivery with opportunities for funding and innovation presented by the ongoing cancer services modernisation work. Both the Transforming Cancer Services (TCS) and Velindre Futures (VF) Programmes include requirements for service redesign and digital aspects of this are included, with the TCS business case including digital aims and the programme structure including digital workstreams as do the NVCC and other related business cases.

The Trust is planning for the future with the Smart Hospital concept for the new cancer centre and radiotherapy satellite by building in the digital infrastructure to maximise the future potential use of integrated digital systems.

The intent of the Velindre Futures work is to challenge the existing process and redesign for the future, with staff involved in the process. The ownership of processes is with the services and the redesign work is lead and undertaken by development and delivery groups. The terms of reference of these note a requirement for inclusion of staff from the Digital Department. There is an acknowledgement of the risk of silos and the Velindre Futures work is trying to break these with the delivery groups required to consider interdependencies, although we note that completely breaking down silos is likely to be challenging.

A revised change process is being developed within VCC to further enable the redesign work to have impact and to prioritise and coordinate change outputs.

Work has also been undertaken within WBS as part of the Blood Supply Chain 2020 (BS2020) programme. This included service redesign and the increased use of digital services. This process was staff led with protected time provided for staff to consider and redesign services. Going forward the intent within WBS is a laboratory modernisation programme which will utilise the same concepts.

There is work ongoing by the Chief Digital Officer (CDO) to raise awareness of digital possibilities and encouraging staff to look at relevant material.

Although the Trust is redesigning services, the culture required to embed digital is not fully developed within the organisation and the services do not fully understand the potential and the need for digital to be user led. As such the Digital Department are seen as leading on the digital aspects as opposed to enabling services ideas.

> Recommendation 1 - Further work on raising the awareness of the possibilities of Digital and seeking service user input to design and digital enabling work should be undertaken to ensure services can maximise the potential.

Is the Trust redefining the relationship with the service user (staff and patients)?

The Trust is developing the structures for engagement with staff service users. There has historically been a good relationship between the IT teams and the services in which they are based. Staff are also being included within the Velindre Futures design work and were included in the Blood Supply Chain 2020 programme and the intent is to involve staff in the WBS laboratory modernisation work. These actions should help to change the culture from digital being something that is "done to" staff to something that is "done by" and for staff. There is a Chief Clinical Information Officer and a Chief Nursing Information Officer in place to act as a link to the clinical side. However, there are minimal support structures underneath this, such as a network of digital champions from the services.

Recommendation 2 - A support network for the Clinical Information Officers should be developed, with a network of champions from the service which will enable the drive from the service side, identifying possible digital developments and leading on pilots and implementations. Further clinical sessions apportioned to digital transformation are required to support the Trust progressing this work.

In terms of changing the patient service user culture, there is a recognition of the need to redefine the relationship with the service users in order to make the most out of digital technology. The TCS, nVCC and other business cases note that the future vision is that patients are informed and empowered and that modern technology enables a 2-way relationship. It further notes the need to enable patient responsibility to look after their own wellbeing, undertake health transactions and access their records online. The Blood Supply Chain 2020 work also included service user relationships as it explicitly included reviewing the use of technology to improve the donor experience.

There is a framework in place to enable this change of culture with various mechanisms for engagement with patients in place including a Patient Liaison Group and Engagement Manager within VCC. The functions of these are currently being reassessed to ensure they are fit for purpose. The Velindre Futures work also includes specific mention of engagement with the terms of reference for the programme including this, and a specific engagement work-stream being developed.

Recommendation 3 - The Engagement Strategy should ensure a process by which service users can feed their needs and ideas into the service design work and that patient culture and involvement in the digital management of their care can change.

There are also examples where the Trust can demonstrate the changing relationship such as the use of an app for patients to monitor their health with daily questionnaires, increased digital connectivity with donors within WBS, an app for

post-surgery breast cancer patients physiotherapy and a mindfulness app for mental health. However, overall the engagement structures are not fully integrated and do not fully feed into the redesign work. Without an integrated structure and vision there is a risk of digital fragmentation with digital aspects developing in an uncoordinated and inconsistent manner. The Trust has recognised this and is working with an external organisation to develop a full Engagement Strategy.

Part of this strategy development process includes the identification of patient cohorts, including both the current and future patient cohorts, and notes the differences in thinking in generations. This will enable the Trust to ensure that its services are appropriate for all patients going forward.

The risks of digital exclusion are being considered with various actions underway to mitigate this, such as inclusion in a recent request for resource, ongoing discussions with the Older Peoples Commissioner and work with the Community Health Council (CHC). Information is also being provided in hardcopy format in VCC and other hospitals to try and reach patients without access to digital equipment.

Is the Trust leveraging the wider ecosystem in Health and Social Care?

Cross boundary working is subject to a cultural barrier with each organisation traditionally having their own systems, processes and information which has led to silos. There is recognition of this across Wales and work is ongoing to break these down.

The TCS programme includes consideration of collaboration and partnerships, both internationally and with Digital Health & Care Wales (DHCW) and Health Boards. The digital section of the TCS business case notes that cancer services cross boundaries and so silos need to be removed between organisations and legacy systems and that information has to be available across organisational boundaries. This intent is evidenced by the cross organisational involvement in the Radiotherapy Satellite Project which will enable a flow of information and processes across organisational boundaries.

The VF programme also considers the wider ecosystem with a note that wider engagement with Health Boards and the third sector is to be pursued. We noted that the current level of information flowing across the system could be improved and the replacement of CaNISC by a national product will assist in information flow.

As such Transforming Cancer Services, Velindre Futures and the new Cancer Centre present an opportunity to enable the wider health and digital ecosystem to be engaged with the Trust. The building of the new hospital, together with the associated funding and service redesign presents an attractive proposition for corporate involvement to demonstrate new ways of working.

The Trust is trying to realise this potential with the emplacement of a Director of Partnerships, although we note that the post holder is currently on sabbatical and the role is not specifically being covered.

> Recommendation 4 - The structures for developing partnerships with industry and academia should be coordinated.
>
> An education programme to enable the opportunities presented by partnerships should be created to enable resource and funding to be freed up to maximise offers.

There are various examples of partnerships and relationships being built such as building relationships with academia to link to PhD programmes, linking with industry e.g. Dell / Blue Prism. However, this work is slightly unstructured and not properly coordinated, in particular with the focus on VCC with little work on developing partnerships within WBS. In addition the existence of systemic barriers in terms of lack of funding, lack of capacity and resistance to change and experimenting have impacted on the development of partnerships.

Do Trust staff have the right technology skill-set and mind-set?

There has been work within the Digital Department to quantify the numbers and skills of staff needed to develop the use of digital technology and some recruitment has occurred, along with some restructuring to try to maximise the use and development of staff already in place. The IT / Digital Departments within the Divisions have been combined into a single Digital Department and there has been work to identify the level of resources required to operate business as usual and move forward with digital transformation. This has led to a request for resource in being made to ensure that the appropriate skills in modern technology products and resources are available as the current position will not properly allow the Trust to take the digital agenda forward.

> Recommendation 5 - The staff resource within the Digital Department should be increased to enable both capacity for business as usual and digital transformation, and ensure that modern, digital skills are available.

From the staff perspective, in general the results of our user survey (Appendix B) show that staff across the Trust have a positive outlook on digital, recognise the benefits and have an appetite to move forward. In addition, staff are generally confident in their skills for working with technology, particularly within the current paradigm.

The user survey we undertook further showed that staff are comfortable using technology and that there was an appetite for increased use along with an understanding of the benefits. There was a minority of staff who don't fully understand the benefits of digital technologies and who have concerns over the impact of increasing use of technology on face to face care time together with a lack of understanding of how choice can be improved using digital technologies. This staff group also self identified as not being fully confident in working in new ways. If this minority staff group are not fully engaged and upskilled the Health Board will encounter resistance to the introduction of new technology solutions and will not gain the benefits of these.

Recommendation 6 - The organisation should increase the communication of the benefits of digital technologies and how care can be improved without increased risk to confidentiality.

Related to this work, a series of training sessions should be offered to staff to ensure they are comfortable in working with technology.

Does the Trust have leaders who see the bigger picture?

There are defined leads for digital on the Trust Board (Director of Planning, Strategic Transformation and Digital and an Independent Member) and although we note that neither of these are from a technical background they display a good understanding of the potential impact of digital technology. The Chief Digital Officer has a technical background and takes the lead on digital matters.

We note that the Board does not need to be from a technical background, but it should understand what can be accomplished at the intersection of business and technology and must be prepared to help shape how technology can transform the organisation. As such the Board should sufficiently understand emerging technology well enough to see opportunities for a better operating model for the business. Without this understanding and of the transformative potential of digital technology the Board may not be maximising the use of digital.

Recommendation 7 – Training and development work should be undertaken with Board members to ensure they understand the possibilities of digital technologies and have the appropriate knowledge and skills to take their priority areas forward.

From a leadership perspective, there is insufficient discussion of digital at the Board level, and the discussions that do take place are focussed on implementation progress for systems. There is insufficient discussion of how digital can change and enable the organisation. In addition the IG/IT Committee has been withdrawn with digital now being governed by two committees (Quality and Safety and Strategic Planning), neither of which evidences substantial discussion over digital

transformation. As such the Trust cannot visibly demonstrate to staff the importance of digital transformation from the top down.

> Recommendation 8 - Senior governance and Committee level leadership should be demonstrated. Either by the establishment of a Digital / Transformation Committee or by setting out specific time within the Strategic Development Committee as a defined, prioritised agenda item.

Although we note that there is no current Digital Strategy and vision in place, work is well underway to develop this with an initial outline having been completed. The vision for digital is also included in other aspects of the Trusts strategic framework such as within the TCS business case, IMTP and the Digital Case for Change paper that was presented to Executives.

in addition, currently there is no "roadmap" or programme for the implementation of the Digital Vision, without this in place the mechanisms by which the Trust can embed and continue the progress towards digital are not sufficient to ensure successful delivery of the Digital Strategy.

> Recommendation 9 - The vision for digital technologies should be fully articulated within a finalised Digital Strategy and a communication plan for this developed to ensure staff engagement.
>
> As part of this a Digital Transformation Programme should be established at a Trust level to continue the progress made to date and a "roadmap" for delivery of the Digital Vision should be set out.

Linked to this, the various strands of service redesign and digital enabling are slightly disconnected in terms of governance with each having its own reporting route and this may lead to conflicting decisions and misaligning of limited resources.

> Recommendation 10 - Consideration should be given to establishing a Digital Delivery Board/Group to lead and coordinate the delivery of the Digital Strategy and Digital Transformation Programme.

The issues noted in this section and the barriers noted later are cyclically linked, with a lack of full understanding of the potential for digital impacting on the development of a vision and strategy for digital. This then impacts on access to funding for transformative projects which acts as a drag on service redesign and delivery of a digital vision.

Does the Trust have a good system for prioritising digital transformation initiatives?

The Trust is developing a concept of a 'digital first' organisation and can demonstrate that mechanisms are being developed to enable this, such as the inclusion of digital

workstreams in the VF programmes and requirement for the development and delivery groups to include digital staff. The revised change structure being established in VF will also aid this as it will act as a gatekeeper for proposed service changes and can push back to ensure digital consideration.

However, the current position is that the digital first concept is not in place yet, as in many cases business cases are for replacing or improving what is already in place as opposed to changing the model with digital enabling and there is not always consideration of how technology can change and redesign a process. Without the digital first culture being embedded in the organisation the Trust may not be able to maximise the use of digital and of the opportunities presented by TCS and the new cancer centre.

> Recommendation 11 - The Executive Team / Director of planning should formally state the requirement to consider the use of digital as a transformation enabler within each service strategy and business case to drive integration and alignment.

There is a good basis for staff involvement in service redesign and developing ideas for change. The basis of the Blood Supply 2020 programme was that it was done with staff and not to staff, so a culture exists of welcoming ideas. The Velindre Futures work is based within the services, with staff asked to be part of the redesign process and an engagement and ideas process is being formalised within the Cancer Centre with regular meetings to present themes to staff along with a suggestions channel.

There are barriers to the digital first concept in terms of lack of understanding and vision and lack of funding. Opportunities to move forward are not always being taken as funding is not provided due to perceived risk of the investment due to a lack of understanding of the potential, or a perception that the investment is a Digital Department product as opposed to a service transformation and service owned product.

> Recommendation 12 - Training and awareness should be developed to change the culture over ownership of digital technologies in order to change the perception that digital is a Digital Department product to a transformation and service delivery funding stream owned by services.

Barriers

This section discusses the current status of the Trust against identified barriers to adoption of digital technology.

Need for a corporate vision for digital

As noted above, although a vision is taking shape, and there is are digital aims within TCS, IMTP and VF, the Digital Strategy has not been completed, communicated to staff and publicised.

Need to strengthen the digital culture to ensure service users own and challenge the status quo

As noted previously the culture within the Trust is still one where staff do not own the digital enablers and rely on the Digital Department developing technology and processes. There are indications that this is starting to change and work is being done within the VF work to try and overcome this. However, at present the culture of ownership of digital is not in place and service users are not seeing the opportunities and challenging the extant processes.

Ability to experiment quickly

The Trust is starting to enable a process for staff to experiment with new ideas. The BS2020 programme allowed time for staff to experiment as part of the redesign and the Velindre Futures programme is embedding Research, Development and innovation (RDI) in each directorate to try and free up time. The move towards Office 365 has also assisted this with Power Apps being available. However, we were informed that the service is running at close to capacity which reduced the time for staff to experiment and innovate and there is no protected area set aside for experimentation / prototyping.

> Recommendation 13 - The Trust should consider setting up a development area for staff to experiment with ideas. This should be supported by a process for assessing and prioritising those ideas to move forward and providing protected time.

Legacy systems

Given the nature of the Trust and of the NHS in Wales, legacy systems are inevitably going to be an issue, and will likely remain so for some time. There are a large number of systems in place, with control of these being spread across the Trust and DHCW. These systems are older, often using inflexible technologies that were emplaced to meet the previous demands. They often have long lifespans and can be difficult to integrate with new cloud and web-based services.

The Trust is replacing the core legacy system (CaNISC) with national NHS Wales products, but these are themselves legacy. The impact of legacy systems is not only as a barrier to new technology introduction, but also as time and money is spent

maintaining these and managing associated risks this means that Trust Board attention is taken up with legacy and not the future.

Securing Talent / Skills

There is a shortage of digital staff with the right skills, which we note is an issue faced by organisations across Wales. However, the issue has been highlighted and there are plans to bring in additional resource. The lack of digital staff is impacting on the ability of the Trust to move forward with its digital ambition as the capability and capacity is lacking. We note that the VF development and delivery groups require input from the digital team. However, the capacity within the team is insufficient to enable both this and involvement within the new Cancer Centre project.

This issue is compounded by the historical use of fixed term contracts for digital staff which increases staff churn. The Digital Department has set out its case for additional resource and this has made clear the need for staff to enable business as usual as well as digital transformation, it also notes the need for modern skills such as Office 365 and for resources to enable digital inclusion.

In terms of user skills, staff in general feel confident in taking up digital technologies and there appears to be a large appetite for increasing the use of technology within the Trust. There is a subset of staff who, as previously noted are not so supportive and these should be addressed as per the previous recommendation.

Budget

The move to digital technologies will need increased funding, and this is a key barrier to moving forward with digital technologies. The Trust spends a relatively low amount on digital, with a value equating to less than 1.5% of the budget, which compares unfavourably with average spend of approximately 3% for companies. The budget for digital is mainly spent on legacy systems and business as usual with little finance available for digital transformation.

As the Trust does not have sufficient allocated budget to progress all of its identified digital projects it operates on a case by case basis with funding obtained from various sources such as Welsh Government monies, Transformation monies, discretionary capital etc. The TCS programme also affords an opportunity to unlock

Recommendation 14 - The Trust should consider increasing the proportion of its expenditure on Digital. We note that there is a requirement for expenditure on the legacy systems and current state, however a secure funding stream for digital transformation should be established.

Related to this, work to change the culture regarding the ownership of digital should be undertaken to ensure that the transformative nature is understood.

Additional resource streams should also be built, such as partnering with industry and SMEs in order to alleviate some pressures.

funding for digital transformation although we note that lack of funding is identified within the risk log for the programme. The lack of a current Digital Strategy is linked to the funding aspect as it is difficult to link funding requests to a defined strategy and the Board will not always understand the need for digital investment in each case.

We note that the funding for digital within the NHS in Wales is generally not up to date and the funding and budgeting mechanisms have not kept up with developments in technology, in particular with the move from a capital funding requirement to a revenue one. In addition digital budgets are separate from service delivery budgets and there is a lack of reliable funding streams for digital transformation.

Cybersecurity

It is vital to ensure that the move towards digital technologies is accompanied by appropriate security and, in order to protect the organisation, the Trust has opted to establish its own cybersecurity team which will help remove this barrier and allow new technologies to be implemented in a secure manner. However we note that our recent IM&T Control & Risk Assessment Audit identified that the delivery of the Trusts Cyber work plan has been impacted due to a lack of resource.

Ability to work across silos

There are silos in place, both within the Trust and external to the Trust. The use of digital technologies will require a greater flow of information and collaboration across silos. The Trust has recognised this as an issue and is working on breaking down some of these silos. The digital teams within VCC and WBS have been combined to ensure greater consistency.

As part of the BS2020 programme there was activity to merge the North and South teams to enable consistency and cross working. The issues of silos in VCC have also been identified and work is ongoing to alleviate these, with the VF delivery groups being required to liaise with the other groups. The move from CaNISC to the national product, alongside the TCS programme will also assist in breaking down silos and allowing information to flow.

Collaboration between IT and lines of business

The relationships between the services and Digital Department are strong, due to having dedicated teams within the services and this has lead to good collaboration. The intent is to keep and build on these collaborations with the inclusion of digital team members in the VF delivery groups. However, at present the capacity is not sufficient to fully enable this.

Risk-averse culture

In order to take advantage of new technology, the Trust has to have a certain appetite for risk, in particular the risk of project or product failure. The Trust is naturally highly risk averse in terms of harm to patients and this risk aversion is manifesting in other areas. The Board tends to be conservative and accepting of

already proven systems without an appetite for experimentation. This aversion is linked to a lack of full understanding of digital transformation and can impact on funding opportunity, with recent refusals for investment into robotic process automation (RPA) being an example. This barrier may be alleviated to some extent by greater education and awareness raising and the provision of a protected area and time for experimentation to prove ideas.

Change management capabilities.

The move to new ways of working with new technology will, by necessity, involve change and users can be highly resistant to change. The Trust has recognised this barrier and has established an integrated Programme Management Office and this includes change managers. In addition, the Trust routinely utilises change managers within projects in order to facilitate the introduction of new way of working.

Appendix A: Recommendations

Recommendation 1
Further work on raising the awareness of the possibility of digital and seeking service user input to design and digital enabling work should be undertaken to ensure services can maximise the potential.

Recommendation 2
A support network for the Clinical Lead should be developed, with a network of champions from the service which will enable the drive from the service side, identifying possible digital developments and leading on pilots and implementations. Further clinical sessions apportioned to digital transformation are required to support the Trust progressing this work.

Recommendation 3
The Engagement Strategy should ensure a process by which service users can feed their needs and ideas into the service design work and that patient culture and involvement in the digital management of their care can change.

Recommendation 4
The structures for developing partnerships with industry and academia should be coordinated.
An education programme to enable the opportunities presented by partnerships should be created to enable resource and funding to be freed up to maximise offers.

Recommendation 5

The staff resource within the Digital Department should be increased to enable both capacity for business as usual and digital transformation, and ensure that modern, digital skills are available.

Recommendation 6

The organisation should increase the communication of the benefits of digital technologies and how care can be improved without increased risk to confidentiality.

Related to this work, a series of training sessions should be offered to staff to ensure they are comfortable in working with technology.

Recommendation 7

Work should be undertaken with Board members to ensure they understand the possibilities of digital technologies and have the appropriate knowledge and skills to take their priority areas forward.

Recommendation 8

Senior governance and Committee level leadership should be demonstrated. Either by the establishment of a Digital / Transformation Committee or by setting out specific time within the Strategic Development Committee as a defined, prioritised agenda item.

Recommendation 9
The vision for digital technologies should be fully articulated within a finalised Digital Strategy and a communication plan for this developed to ensure staff engagement. As part of this a Digital Transformation Programme should be established at a Trust level to continue the progress made to date and a "roadmap" for delivery of the Digital Vision should be set out.

Recommendation 10
Consideration should be given to establishing a Digital Delivery Board/Group to lead and coordinate the delivery of the digital strategy and digital transformation programme.

Recommendation 11
The Executive Team / Director of planning should formally state the requirement to consider the use of digital as a transformation enabler within each business case.

Recommendation 12
Training and awareness should be developed to change the culture over ownership of digital technologies in order to change the perception that digital is a Digital Department product to a transformation and service delivery funding stream owned by services.

Recommendation 13
The Trust should consider setting up a development area for staff to experiment with ideas. This should be supported by a process for assessing and prioritising those ideas to move forward and providing protected time.

Recommendation 14
The Trust should consider increasing the proportion of its expenditure on digital. We note that there is a requirement for expenditure on the legacy systems and current state, however a secure funding stream for digital transformation should be established. Related to this, work to change the culture regarding the ownership of digital should be undertaken to ensure that the transformative nature is understood. Additional resource streams should also be built, such as partnering with industry and SMEs in order to alleviate some pressures.

Staff opinion of digital technology

Staff Self Assessment of Skills

Legend: ■ Very Confident ■ Reasonably Confident ■ Not Very Confident ■ Not at all Confident

Staff Perception of the Organisations Vision for Digital
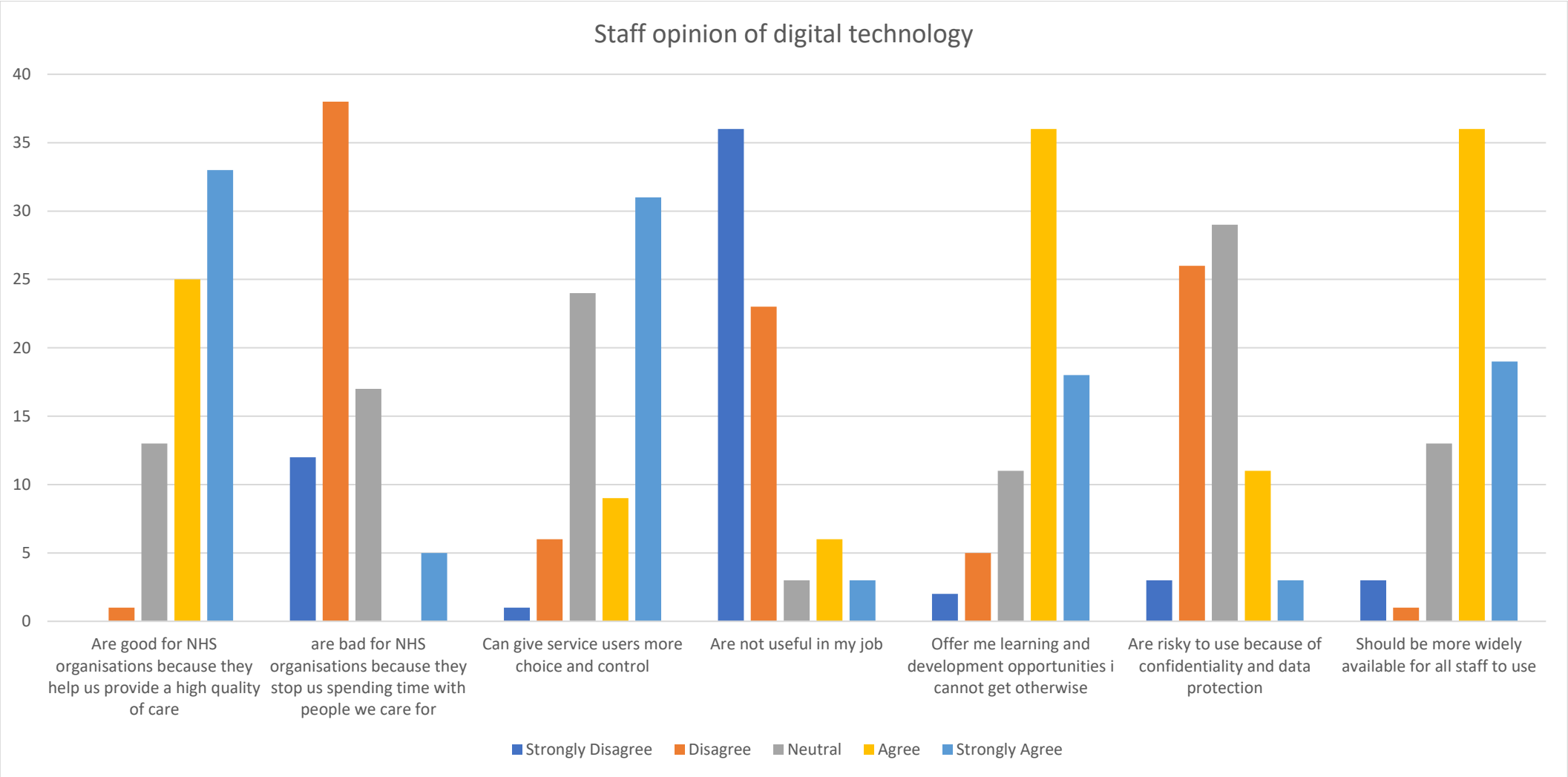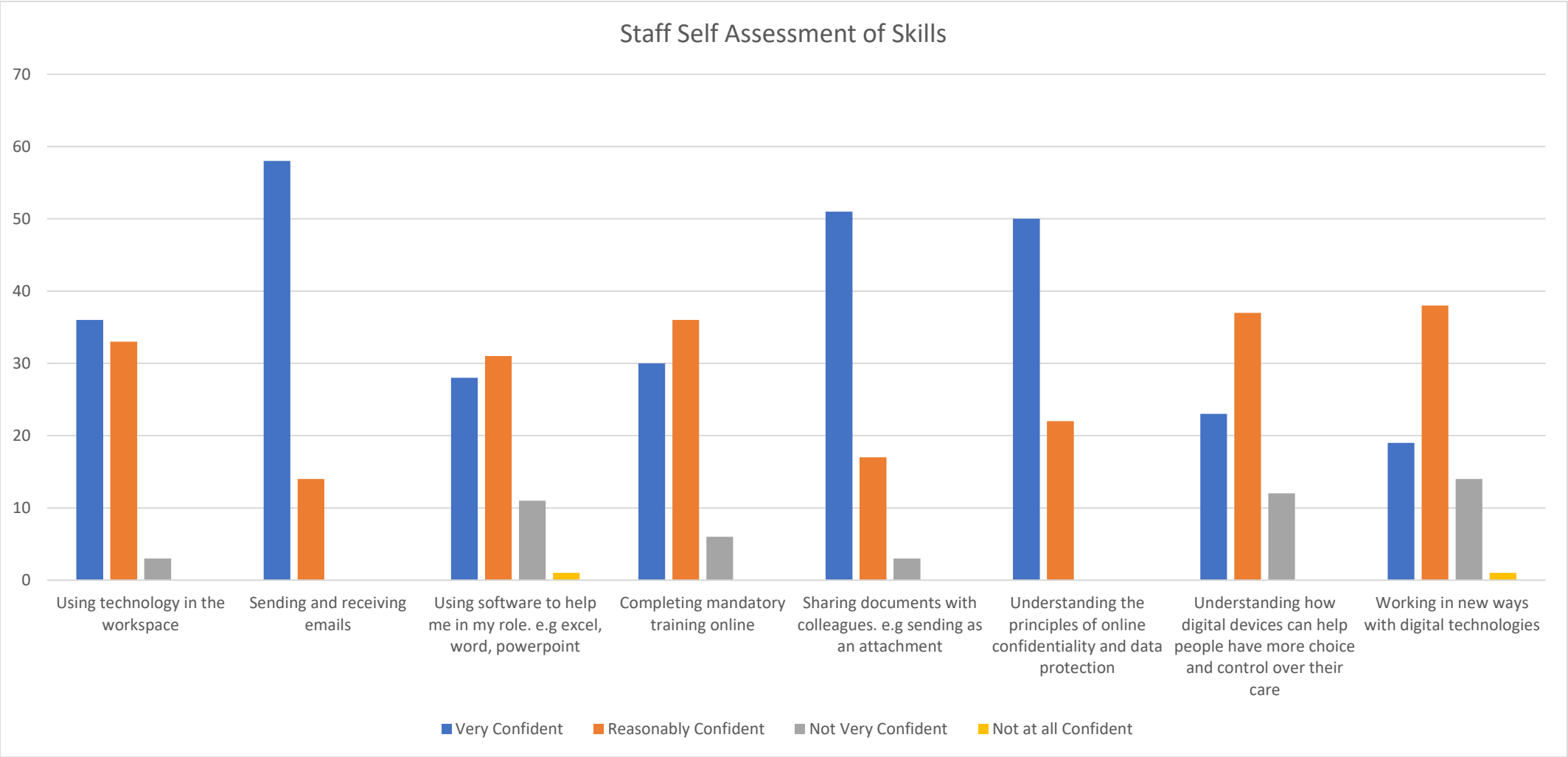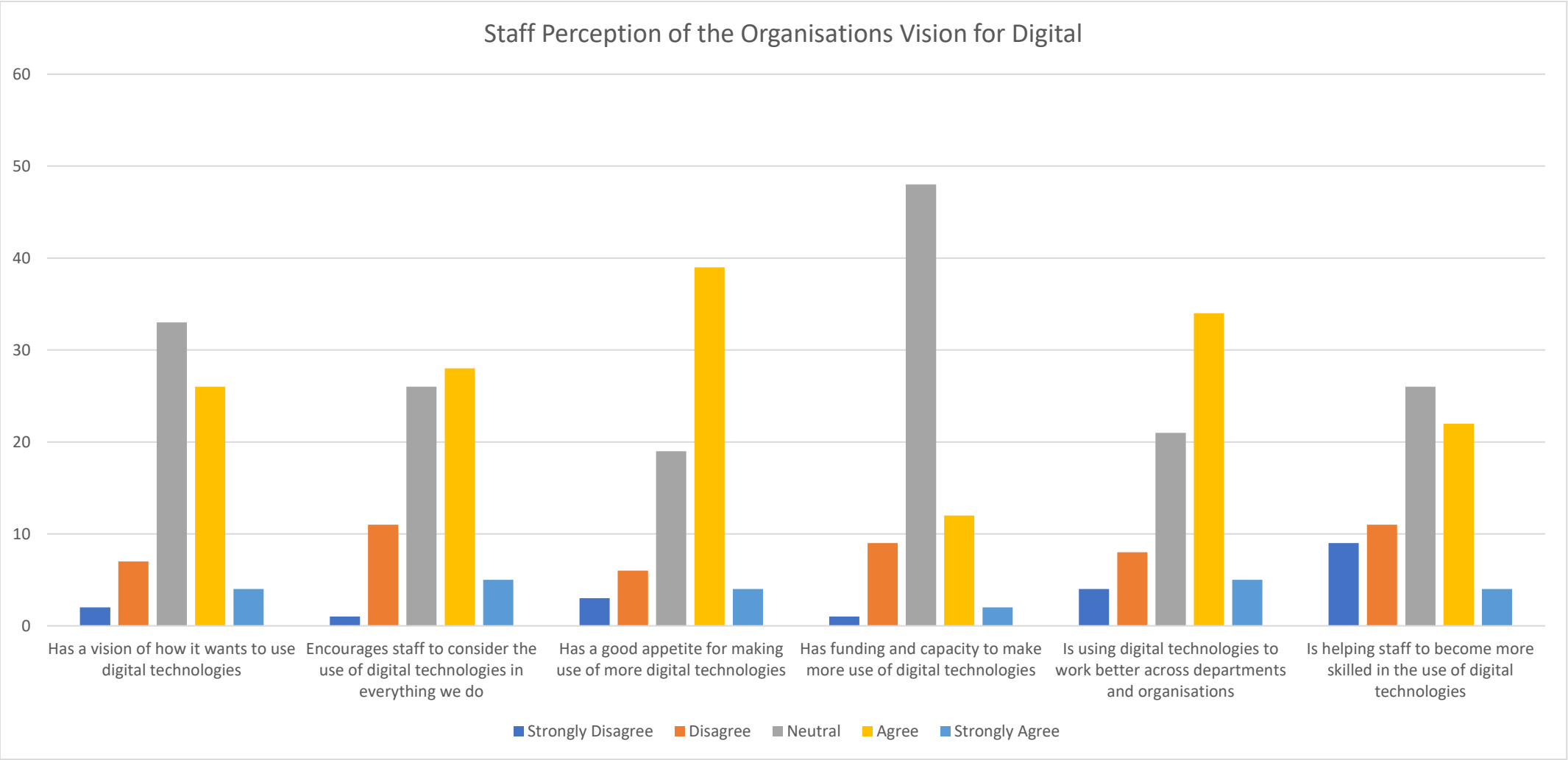
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Board Committee Effectiveness

Final Internal Audit Report

January 2022

Velindre University NHS Trust

Contents

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	Emma Rees, Audit Manager
	Philip Lewis-Davies, Principal Auditor
Executive sign-off:	Lauren Fear, Director of Corporate Governance & Chief of Staff
Distribution:	Emma Stephens, Head of Corporate Governance
Committee:	Audit Committee
	Trust Board

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.

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Executive Summary

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance over the:

- effectiveness of the new Board Committee structure; and,

- the adequacy and effectiveness of controls in operation.

Overview

The Trust is committed to improving effectiveness and efficiency in its accountability and decision-making at Board level through the September 2020 committee restructuring and ongoing development work in this area. We concur with the actions taken to date and acknowledge that, via its own development work, the Trust has plans in place or is already acting to address many of the matters we identified throughout our review (see section 2).

We have identified some recommendations to further ensure robustness in the process and support the Trust in maximising efficiency and effectiveness:

- clearer alignment of committee cycles of business and agendas with the Trust's objectives and risks (matter arising (MA) 1);

- developing a robust process to ensure all required reports are included in agendas (MA1); and

- clearly defining what success looks like for the new structure, identifying key performance measures to objectively assess benefits realisation going forward and developing robust action plans to support realisation (MA2).

All 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	Defined Board and committee governance and assurance structures	Substantial
2	Structures that support effective and efficient decision-making and scrutiny	Reasonable
3	Cycles of business – alignment with objectives and risks	Reasonable
4	Clear reporting and triangulation of business activity	Reasonable
5	Assurance over benefits realisation	Reasonable

Key matters arising		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Cycles of Business and Committee Agendas	2, 3	Design	Medium
2	Benefits Realisation	2, 5	Design	Medium

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

1.   Introduction

1.1   Following a benchmarking exercise against NHS Wales Health Boards / Trusts and Canterbury Health in New Zealand, Velindre University NHS Trust (the Trust) Board approved a new Board Committee structure.

1.2   Effective from October 2020, the Trust moved from nine to five Board committees: Quality Safety & Performance (QSPC); Strategic Development (SDC); Audit & Assurance; Remuneration & Terms of Service and Charitable Funds.

1.3   There are two sub-committees under these committees: Transforming Cancer Services Programme Scrutiny and Research, Development & Innovation.

1.4   The expected benefits of the new structure were identified as:

- better delivery, planning and triangulation of business activity;
- plans considered and implemented in a local and partnership context;
- clear decision-making process on areas of accountability;
- enhanced collaborative working given the increasing agenda with local stakeholders; and
- defined governance and assurance structures.

1.5   To support the new committee structure, the Trust is in the process of developing a new Performance Management Framework (PMF) which will triangulate reporting on quality, safety, workforce and finance. The aim is that the PMF will harmonise floor to Board reporting across the Trust.

Purpose

1.6   Our review sought to provide the Trust with assurance over the:

- effectiveness of the new Board Committee structure; and,
- the adequacy and effectiveness of controls in operation.

1.7   We took into consideration:

- the process undertaken by the Trust to develop the new committee structure and its ongoing work on the Performance Management Framework;
- work undertaken on committee effectiveness by Audit Wales in their Structured Assessment and review of Quality Governance arrangements; and
- the impact of the Covid-19 pandemic in our assessment of the arrangements in place.

1.8   Our work was predominantly focused around the QSPC and SDC as the two newly created committees.

1.9   The audit excluded governance arrangements over hosted bodies.

<u>Associated risks</u>

1.10 The key risk considered in this review was an ineffective committee structure, potentially resulting in:

- failure to deliver strategic objectives;

- failure to effectively manage risk; and,

- financial or reputational damage.

<u>Context</u>

1.11 Through the September 2020 committee restructuring and ongoing development work, the Trust is seeking to optimise efficiencies in accountability and decision-making at Board level. A recent area for improvement it identified is further streamlining of committee cycles of business.

1.12 The new committee structure had been in place for just over twelve months at the time of our audit, during which the first annual committee reviews for the two newly formed committees (QSPC and SDC) were also being undertaken.

1.13 At the time of writing, the QSPC Annual Review had been completed and reported to the November 2021 QSPC meeting. The Annual Review also identified areas for development and improvement in terms of efficiencies that could be gained from the new committee structure (see paragraphs 2.14-2.16).

1.14 Our audit was undertaken within the context of the Trust's journey, and our conclusions and recommendations provide assurance over progress to date and identify further areas where there is opportunity to improve robustness and maximise efficiency.

2.   Detailed Audit Findings

Audit objective 1: the Trust has clear, defined Board and committee governance and assurance structures

2.1 The Trust has defined Board and committee governance and assurance structures which were reviewed and approved by the Board.

2.2 The restructure process was managed by the Corporate Governance team, led by the Director of Corporate Governance & Chief of Staff.

2.3 Under the revised structure, each committee (and sub-committee) has approved Terms of Reference and Operating Procedures (ToR) and a cycle of business.

2.4 The Board was presented with the new committee structure in September 2020 and noted the draft new and updated ToR and cycles of business. The Board supported these documents to be finalised through the inaugural meetings of each of the committees and sub-committees, prior to being brought back to the Board

for approval in November 2020. At that point, the Board also approved revisions to the Trust Standing Orders to reflect the new committee structure.

2.5   Whilst the new committee ToR have been published on the Trust's public website, we noted that the Standing Orders on the site do not reflect the new committee structure. See matter arising 7 in Appendix A.

Conclusion:

2.6   The Board has defined governance and assurance structures in place. No significant matters for reporting were identified in this area. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 2: the new committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability

2.7   The committee ToRs follow a standard format that details delegated powers, committee authority, and reporting and assurance matters.

2.8   To ensure all previous committee activity was captured, and nothing was lost under the new structure, the Corporate Governance team undertook a detailed activity mapping exercise. This also aimed to ensure there was no duplication in reporting.

2.9   The mapping exercise was a starting point for refining the committee cycles of business. The Trust has undertaken further streamlining work throughout 2021 in this area, particularly at the QSPC due to the amount of business it inherited from the predecessor committees. Changes to the QSPC cycle of business have included amalgamation of several reports and removal of items from the cycle, where considered appropriate (see also paragraph 2.24). The Trust recognises there is further opportunity to streamline committee agendas and we understand it intends to continue this work going forward.

2.10   We concur with the Trust's approach in this area and have identified recommendations to support in this process in matter arising 1 in Appendix A.

2.11   During our attendance at committee meetings, we noted that allocated agenda timings are often not adhered to, potentially limiting time available for appropriate scrutiny of other agenda items. This impacts the QSPC particularly, due to the large volume of items on its agendas and where time allocated for each agenda item is often not adhered to in the meetings. A recent example is where discussions at the November 2021 QSPC meeting about significant matters arising in Radiotherapy overran the allocated time, resulting in the remaining agenda items being rushed. We recognise the importance of discussions around significant matters arising and have provided recommendations to support the management of this in matter arising 1 in Appendix A.

2.12   Through our discussions with Independent Members, we identified there remains some concern about the risk of duplication or gaps in reporting to committees.

Members identified areas of concerns in general terms as being where a sub-committee reported to more than one committee (for example, the Research Development & Scrutiny Sub-Committee) and where a subject matter is being reported to more than one committee (for example, digital matters are presented to SDC and QSPC). We also identified a specific example where the annual Clinical Audit report was presented to the Audit Committee, QSPC and the Board. See matter arising 4 in Appendix A.

2.13   Scrutiny over committee performance is provided in a range of ways including the delivery of an annual report to the Board. This includes:

- a self-assessment of performance;

- an annual survey of committee members / attendees; and

- a review of the committee's ToR and cycle of business.

2.14   The QSPC Annual Report was discussed at its November 2021 meeting. In particular, the annual survey reiterated our findings around:

- the large agendas and level of detail in reports, and the impact that this has had on the efficiency of meetings; and

- the potential for duplication of activities between the committees and the Board.

2.15   Survey respondents also requested further clarity around the role of the QSPC.

2.16   The QSPC Annual Report identified high-level actions to address concerns raised in the survey, including:

- establishing of an operational Quality & Safety Group in early 2022 to feed into the QSPC and streamline the level of detail and quality of information received at QSPC – we were informed this action is captured as part of the Trust's development work on its new Quality & Safety Framework;

- training for report writing for assurance and escalation – we understand the Trust was due to deliver its first cohort of training in this area in mid-December 2021, but the training was postponed due to the escalation of the Covid-19 pandemic (command and control structures were stood back up due to increasing case numbers and concerns about the Omicron variant);

- review of quality and level of detailed of reports to the QSPC to enhance and engineer more effective triangulation – we were informed that reporting quality will be covered as part of the above training; and,

- flow of operational and divisional reporting to the QSPC – see paragraph 2.26 for work ongoing in this area.

2.17   Whilst we recognise action is being taken, we identified that the Trust has not developed a formal action plan with identified responsible individuals and deadlines

to ensure the actions and improvements are implemented effectively. See matter arising 2 in Appendix A.

2.18 The SDC Annual Report (including the Committee Annual Survey) was due to be discussed at its December 2021 meeting. However, we were informed committee members are to be given additional time to complete the survey, therefore the report will be taken to the February 2022 meeting.

2.19 We understand the Trust intends to undertake a formal Trust-wide review of the restructured committees through feedback from Independent Members and Executive Directors, supported by the committee annual reports and feedback from Audit Wales and ourselves (via this report). The review was initially planned to be presented at the January 2022 Board meeting. However, due to the impact of the developing position resulting from the prevalence of the Omicron variant, this review will now be concluded and presented at the March 2022 Board meeting. This will also ensure the findings and outcomes of the SDC Annual Report and Effectiveness survey are able to be incorporated into the overarching review.

Conclusion:

2.20 The new committees have clearly documented ToRs, and their performance is subject to scrutiny in a structured manner. The Trust is continuing its development work to fully optimise the effectiveness of the QSPC. We have identified recommendations to support and enhance this process. We have provided **reasonable assurance** over this area.

Audit objective 3: Board and committee cycles of business are aligned to strategic objectives and risks

2.21 Cycles of business are in place for each committee and are linked to the committee ToR.

2.22 With the development of the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) (subject to a separate audit during 2021/22), the Trust has an opportunity to clearly demonstrate the link between its cycles of business and its objectives and risks. This may also help to further drive efficiency in agenda setting and reporting. See matter arising 1 in Appendix A.

2.23 We were informed that committee chairs are engaged in agenda setting. However, we identified instances (set out in matter arising 1 in Appendix A) where required reports (for example, on the cycle of business, or requested by members) should have been included within Board or committee agendas but were missing.

2.24 The cycles of business are subject to review by each committee on a continuing basis:

- the QSPC made changes to its cycle of business in March and September 2021 and proposed further changes at its November 2021 meeting; and

- the SDC made changes to its cycle of business in November 2021.

2.25 Supporting cover reports provided explanations for the proposed changes to both committees' cycles of business.

2.26 We were informed these changes are being identified through ongoing work by the Corporate Governance team in conjunction with service leads and report authors to ensure the right information is being reported at Board / committee level and to determine where efficiencies could be achieved (for example, where reports can be amalgamated or are no longer needed at this level).

Conclusion:

2.27 The committees' cycles of business have been defined and subject to regular review, although the Trust has an opportunity to clearly demonstrate the link between its committee ToR and cycles of business and its objectives and risks. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: Board and committee reporting is clear and concise and provides effective triangulation of business activity

2.28 The new committee structure brings performance reporting on all aspects of the Trust (for example, operational, quality & safety, finance, workforce, etc) together into the QSPC, with the intention of triangulating performance more effectively through:

- triangulation within committee reports, where appropriate: we note this is a new approach for report writers and, as such, will take time to become embedded and fully effective. We understand triangulation is included in the report writing training (see paragraph 2.16) and that the new Performance Management Framework will further support triangulation in reporting.

- time allocated at the end of each agenda to discuss triangulation: we understand the main purpose for this is to identify triangulation for inclusion in the QSPC highlight report, although we note that this time can be limited due to the size of the QSPC agenda (see matter arising 1 in Appendix A).

2.29 We identified that there is some variability in the quality of the content of reports at the committees. Issues include high levels of operational information, reports not always tailored to the audience and purpose of report and a lack of effective executive summaries. Similar points were identified by respondents to the QSPC Annual Survey.

2.30 Whilst this was not the case for all committee reports, these issues may impact the Trust's ability to optimise efficiencies in the committee structure and ensure effective triangulation of performance. We were informed this will be addressed

through the report writing training (see above). We have identified further recommendations to support this in matter arising 3 in Appendix A.

2.31   We also noted that whilst agendas have been issued on a timely basis (i.e., seven days before the meeting), committee papers are often issued after this. This may impact on Independent Members' ability to undertake appropriate pre-meetings scrutiny and review, potentially causing inefficiencies in committee meetings. See matter arising 5 in Appendix A.

Conclusion:

2.32   Committee reporting is evolving but requires further refinement to maximise the potential for efficient monitoring and scrutiny. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 5: the Trust has assurance that the expected benefits of the new structure are being realised

2.33   The Trust identified the expected benefits of the Board committee restructure during the development phase. The expected benefits are set out in paragraph 1.4. We were informed that the Trust-wide review of the restructured committees is to be reported to the March 2022 Board meeting (paragraph 2.19) will include consideration of benefit realisation to date.

2.34   However, the identified benefits are not SMART (Specific, Measurable, Achievable, Realistic, and Timely) and the Trust has not clearly defined what success looks like in terms of the new structure. Therefore, it will be difficult to objectively assess whether the benefits have been realised.

2.35   The QSPC annual committee review process (paragraph 2.13-2.16) identified that, whilst progress has been made, further development is required to achieve the intended benefits (we note earlier that action is already underway to address the areas for development).

2.36   We recognise that the new committee structure has only been in place for just over twelve months and that the Trust has further to go to fully achieve the intended benefits. The Trust now has the opportunity to revisit the intended benefits to ensure they remain appropriate, identify performance measures to better assess realisation and clearly define what success will look like. The Trust could use the annual committee review process to support ongoing assessment of benefits realisation.

2.37   See matter arising 2 in Appendix A.

Conclusion:

2.38   The annual committee review process has identified further actions required to realise the intended benefits of the committee restructure. The Trust needs to

ensure it defines performance measures to allow clear monitoring of benefits realisation going forward. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Cycles of Business and Committee Agendas (Design)	Impact
Cycles of Business With the development of the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) (subject to a separate audit during 2021/22), the Trust has an opportunity to clearly demonstrate the link between its cycles of business and its objectives and risks. This may also help to further drive efficiency in agenda setting and reporting. We acknowledge that the QSPC is aware of the impact of the high volume of items on its cycle of business / agendas, as highlighted in its 2021 Annual Survey results. It is actively reviewing its cycle of business and has identified actions for improvement (see matter arising 3). We have identified further opportunities to optimise efficiencies below. **Committee Agendas** A review of committee agendas indicated that it is not clear why each item is included, for example, as a standing item, required by the cycle of business, as a significant matter arising, etc. During our attendance at committee meetings, we noted that allocated agenda timings are often not adhered to, potentially limiting time available for appropriate scrutiny of other agenda items. This impacts the QSPC particularly, due to the large volume of items on its agendas and where time allocated for each agenda item is often not adhered to in the meetings. For example, at the November 2021 QSPC meeting, the Committee overran the allocated timing for the Velindre Cancer Centre divisional performance report due to discussions about significant matters arising within Radiotherapy and also issues noted in Outpatients. This led to the remaining agenda items being rushed. We were informed that further discussions about Radiotherapy at the subsequent Board meeting also overran the allotted time, although a decision was taken to hold further discussions at a future meeting. We recognise the importance of the discussions held on these matters and have provided recommendations to support the management of this below. **Capturing Required Agenda Items** We identified instances where reports should have been included within agendas, as demonstrated in the table below. We were informed during the debrief that Independent Members have requested the relevant committee's cycle of business be included as a consent item at every meeting. We concur with this to ensure members are aware of items that should be considered within that meeting.	Potential risk of: • committee reporting and scrutiny may not focus on key objectives or risks; and • inefficient committee scrutiny.

Report subject	Board or committee	Expected on the agenda	Comment
Private Patient Debt	Audit Committee	October 2021	On action log from July 2021. Item was on the October 2021 agenda, but as a verbal update (no report was provided). The Audit Committee Chair stated at the meeting that they were expecting a written report.
Trust Assurance Framework (TAF) dashboard	Board	November 2021	Not on action log or cycle of business, but the September 2021 TAF cover report stated the full TAF dashboard would be provided in November. No explanation for the delay was provided at the November meeting. Note: it was presented at the December 2021 SDC meeting as a consent item and is also to be received at the January Trust Board as a main agenda item.
Committee Annual Report	SDC	December 2021	Not on action log or scheduled on cycle of business for this meeting. We were informed report was being drafted for this meeting due to the Trust-wide review of the restructure planned for the January 2022 Board. However, the report was delayed allowing committee members / attendees further time to complete the survey. This was not mentioned at the December 2021 meeting.

Recommendations	Priority

1.1 The Trust should:
 	
    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

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;

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;

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

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);

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

g. consider whether the NWIS transfer provides opportunity for the Audit Committee to support the cycles of business of other committees.

	Management response	Target Date	Responsible Officer
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.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
	b. Relevant sections of the TAF/TRR will be included at the beginning of all Committee meetings.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
	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 against this accordingly.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

d. Committee members may bring forward agenda items for earlier discussion if required.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
e. We will consider using a 'questions in advance' approach for committee papers.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
f. As per above captured under point 1.1 (c)	See 1.1 (c)	See 1.1 (c)
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.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 2: Benefits Realisation (Design)	Impact
Our review of the benefits of the committee restructure identified that: • the benefits are not SMART (i.e., Specific, Measurable, Achievable, Realistic, and Timely); and • the Trust has not defined what success would look like, or when it should be achieved by. Therefore, going forward, it will be difficult to objectively assess whether the benefits have been realised. The QSPC Annual Report identifies areas for improvement and focus and action is underway to address this. However, we found that there is no formal action plan with responsible individuals and deadlines to ensure the improvements are implemented to support the realisation of the identified benefits.	Potential risk of: • inability to objectively measure benefits realisation; • inability to effectively deliver the defined benefits; and • committee restructuring may not reach its full potential.

Recommendations	Priority

2.1 The Trust should:
 	
   a. revisit the identified benefits to:
 	
      i.   ensure they remain appropriate;
 	
      ii. establish what success in the committee restructuring looks like;
 	
      iii. identify key milestones and performance measures to objectively measure benefits realisation; and
 	
   b. develop action plans with identified responsible individuals and deadlines to support achievement of success (including actions identified through committee reviews), ensuring progress against the action plans is monitored by the Board. Any changes to deadlines (for example, due to the pandemic) should be clearly identified and explained.
	Medium

Management response		Target Date	Responsible Officer
2.1	The established annual review process for each committee will form the baseline against which all actions / recommendations will be formally reviewed and assessed following the conclusion of the second year of operation for both the QSPC and SDC.	N/a	N/a

There is not a requirement for an additional layer to be introduced over and above this process which has proven effective across all of the Board Committees

Matter arising 3: Committee Reporting (Design)	Impact
We recognise that the Trust has developed training for committee report authors, although has had to stand down the training due to the escalation of the Covid-19 pandemic and concerns around the Omicron variant. We concur with the intended training and have identified further mechanisms to support the quality of committee reporting below.	Potential risk of: • key issues not appropriately identified and considered; • inefficient committee oversight and scrutiny; • inefficiency in report writing / presenting; and • failure to reap the benefits of triangulation that the QSPC offers.

Recommendations	Priority
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 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

Management response	Target Date	Responsible Officer
3.1 a. Report authors will be informed of the purpose of committee reports and the level of detail required.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
b. A mechanism to review reports in advance of issue will be developed to ensure the points in recommendation 3.1 (b).	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 4: Gaps or Duplication in Reporting (Design)	Impact
We identified that there remains some concern about the risk of gaps or duplication in reporting to committees. Members identified areas of concern in general terms as follows: • the Research Development and Innovation Sub-Committee (RDISC), which reports to multiple committees. Independent Members interviewed feel the reporting process is well controlled. However, the process is reliant on key individuals rather than a defined process to ensure information is reported effectively; and • members noted that some topics are discussed at more than one committee, for example digital matters (QSPC, SDC and Audit Committee). We also identified that the annual Clinical Audit report was presented to the Audit Committee, QSPC and Board.	Potential risk of: • inefficiencies in the committee restructure due to duplication of effort or gaps in reporting.

Recommendations	Priority

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
 	
    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

Management response	Target Date	Responsible Officer
4.1 a. The RDISC reporting lines will be reviewed and defined to minimise the risk of gaps or duplication.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
b. Clarity will be provided on the purpose for reporting where a subject matter is reported to more than one committee.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 5: Timeliness of Committee Paper Availability (Operation)	Impact
Through discussions with Independent Members and our attendance at committee meetings, we identified that committee agendas are issued on a timely basis (i.e., seven days in advance of the meeting). However, often, some of the supporting papers are issued after this. We understand that committee members pre-allocate time to review papers and lateness in delivery may limit their time available to undertake appropriate pre-meeting scrutiny and review. This may cause inefficiencies in committee meetings. We understand action has been taken to address this, for example, earlier calls for agenda items and papers. However, this remains an issue despite action taken.	Potential risk of: • inefficient committee scrutiny.

Recommendations	Priority

5.1   The Trust should:
 	
    a. remind staff reporting into the committees of the importance of timely submission of their reports; and
 	
    b. monitor delays in the lateness of delivery of papers and provide challenge where appropriate.
	Low

Management response	Target Date	Responsible Officer
5.1 a. Staff will be reminded of the importance of timely submission of committee reports.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
b. The Corporate Governance team will monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 6: Record of meetings (Operation)	Impact
In our review of committee minutes, we identified: • instances where individuals were listed as in attendance and as having provided apologies; • it was difficult to understand whether all required attendees (i.e., required by the ToR) were present, especially if no apologies had been noted; and • the minutes did not clearly establish why individuals were present at meetings, for example, as a required attendee, presenter, observer, etc.	Potential risk of: • confusion as to quorum status of meetings; • inadequate record keeping.

Recommendations	Priority
6.1 The Trust should accurately record those present at committee meetings in the minutes, including the status in which individuals attend.	Low

Management response	Target Date	Responsible Officer
6.1 Management will ensure committee minutes accurately record those present at meetings, including the status of individuals in attendance.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 7: Standing Orders (Operation)	Impact
The Trust updated and approved its Standing Orders to reflect the new committee structure in November 2020. However, the new Standing Orders have not been uploaded to the Trust's public website.	Potential risk of: • public confusion over the legitimacy of the Board restructure.

Recommendations	Priority
7.1 The Trust should update its website with the revised Standing Orders.	Low

Management response	Target Date	Responsible Officer
7.1 The revised Standing Orders will be uploaded to the Trust website.	January 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

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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Trust Assurance Framework
Final Internal Audit Report

January 2022

Velindre University NHS Trust

Contents

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	Emma Rees, Audit Manager
	Philip Lewis-Davies, Principal Auditor
Executive sign-off:	Lauren Fear, Director of Corporate Governance
Distribution:	Emma Stephens, Head of Corporate Governance
Committee:	Audit Committee
	Trust Board

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 agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre 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 the Trust Assurance Framework (TAF) is robust, and that Velindre University NHS Trust (the Trust) is managing its principal risks.

Overview

We have provided **reasonable assurance** over this area. The significant matters which require management attention include:

- completing the development of the TAF dashboard by the agreed deadline to ensure it is effective in the oversight of strategic risk;

- ensuring planned refinement to operational risk reporting via the Trust Risk Register (TRR) is completed by the planned deadline; and

- ensuring key decisions and supporting justifications are clearly demonstrated in Board and Committee papers / minutes.

These matters are set out in Appendix A.

Whilst not raised as a matter arising (the issue was resolved at the time of the audit), we also note that there was no formal risk reporting to Board level during the period under review (from September 2020 until September 2021).

Report Classification

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

Assurance summary[1]

Assurance objectives		Assurance
Trust Assurance Framework		
1	Development of the TAF and supporting process	Substantial
2	Identification of principal strategic risks and assurance mechanisms[2]	Reasonable
3	Action plans to address control deficiencies for strategic risks[2]	Limited
Risk Management		
4	Risk Management Framework	Substantial
5	Review and scrutiny of operational risk	Limited
6	Linkage between the TAF and TRR[2]	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Completion of the TAF dashboard	2, 3	Operation	High
2	Operational risk reporting (TRR)	5	Operation	Medium
3	Transparency in decision-making	5	Operation	Medium

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

[2] Due to the time of our review in relation to the stage of development of the TAF dashboard and TRR, it was too early to fully test the operating effectiveness of controls in this area. The assurance rating is based on the design of the controls and the limited operating effectiveness testing undertaken.

1.   Introduction

1.1   Velindre University NHS Trust (the Trust) approved new Risk Management and Trust Assurance Frameworks in September 2020.

1.2   Work on populating the Trust Assurance Framework (TAF) dashboard and the Trust Risk Register (TRR) was delayed due to the re-prioritisation during the Covid-19 second wave.

1.3   Full reporting to the Trust Board on the TAF dashboard and TRR commenced in September 2021.

Purpose

1.4   Our review sought to provide the Trust with assurance that the TAF is robust, and that the Trust is managing its principal risks.

1.5   Our assessment considered the Trust's work on the development of the TAF and the impact of the Covid-19 pandemic.

1.6   The audit excluded:

- testing of the monitoring and scrutiny of the TAF – this process was newly implemented at the time of our review. We reviewed the design of the process but were unable to test the process in operation; and

- risk management activity at a divisional level, including escalation from the divisional risk registers to the Corporate Risk Register – this was covered in our 2020/21 Divisional internal audit review.

Associated risks

1.7   The key risk considered in this review was poor management of strategic risk, potentially resulting in:

- failure to deliver strategic objectives;

- financial or reputational damage; and

- patient or donor harm.

Timeline

1.8   In January 2020, the Trust Board confirmed its sponsorship for a significant review of the Trust's Risk Management Framework (RMF). This included the creation of a Business Assurance Framework, known in the Trust as the TAF.

1.9   Development of the RMF and TAF was undertaken over the subsequent nine months, with the Framework documents setting out the approach to risk management and Trust assurance being approved by the Board in September 2020.

1.10 Due to the Covid second wave in late 2020, the Trust reappraised its priorities, resulting in the following work being stood down or delayed:

- populating the TAF dashboard (i.e., the document outlining strategic risks and related controls / assurance mechanisms); and

- Trust-wide review and refresh of operational risks within Datix and the transfer from Datix v12 to v14.

1.11 Work recommenced in summer 2021, with progress updates being provided to the Strategic Development and Audit Committees in June and July 2021, respectively.

1.12 The first iteration of the TAF dashboard and TRR were presented to the Board in September 2021.

2. Detailed Audit Findings

Audit objective 1: the Trust has developed a TAF and supporting process which clearly set out: accountability, roles and responsibilities; reporting requirements to ensure the TAF is regularly scrutinised and updated; and integration with risk management and other management arrangements

2.1 The TAF, which set out the Trust's approach to assurance over strategic risks, was approved by the Board in September 2020.

2.2 Prior to its approval, the Corporate Governance team led development work which involved:

- engagement with Independent Members, Executive Directors and Trust senior management; and

- external consultation and advice from Ernst and Young.

2.3 The TAF was updated to reflect process improvements identified during the development of the TAF dashboard in summer 2021. The revised document was approved at the September 2021 Board meeting.

2.4 The TAF clearly sets out:

- accountability, roles and responsibilities;

- reporting requirements to ensure regular update and scrutiny of the TAF dashboard; and

- how the TAF dashboard interacts with risk management and other management arrangements.

2.5 Additionally, the TAF dashboard (detailed further in paragraph 2.7 below) identifies the responsible Committees and individuals for each of the strategic risks and actions required. The dashboard is designed to effectively inform the Board of principal strategic risks and an assessment of the related assurance mechanisms.

Conclusion:

2.6   No matters for reporting were identified under this audit objective, therefore we have provided **substantial assurance** over this area.

Audit objective 2: the TAF dashboard has been approved by the Board and enables the Board to identify and understand the principal risks and identifies the assurance mechanisms.

2.7   The template TAF dashboard provides individual risk schedules for each of the principal strategic risks. Each risk schedule covers:

- risk description;

- link to the related strategic objective(s);

- principle risk ownership (Executive lead);

- risk scores (inherent, residual, target);

- gaps in control and assurance;

- action plan for addressing the above gaps (including action, owner, progress update and due date); and

- detailed key controls (including owner and effectiveness rating) and sources of assurance (considering first, second and third lines of defence and assurance ratings).

2.8   The template format supports the identification and understanding of the principal risks and their related control and assurance mechanisms.

2.9   The Trust identified ten principal strategic risks through engagement with the Independent Members, Executive Directors and senior management via a series of workshops.

2.10   The Trust's intention was to present a complete populated TAF dashboard to the Board in September 2021. However, the first iteration of the dashboard presented at this meeting was not complete, particularly:

- three of the ten principal risks were excluded; and

- sources of assurance had not been fully identified for the key mitigating controls.

2.11   This was highlighted in the cover report, alongside the intention to deliver a complete TAF dashboard to the November 2021 Board meeting. However, we note that the TAF dashboard was not presented in November as intended, although we acknowledge an updated (but still incomplete) version was taken to the December 2021 Strategic Development Committee (SDC) as part of the consent agenda (i.e., for noting, not discussion).

2.12 We appreciate the work has been delayed due to the pandemic and other pressures faced by the Trust. Whilst we understand the Independent Members were informally aware of the delays, there was no formal decision (i.e., recorded in Board or Committee papers / minutes) to stand down or put a revised timeframe in place for this important work.

2.13 The Trust needs to ensure the TAF dashboard is completed for it to be an effective tool in the oversight and management of strategic risk. We were informed that the intention is to have a complete TAF by the end of March 2022, recognising that the document will be subject to ongoing refinement and improvements as it is used in practice.

2.14 See matters arising 1 and 3 in Appendix A.

Conclusion:

2.15 The template TAF dashboard is designed to effectively inform the Board of principal strategic risks and an assessment of the related assurance mechanisms. Whilst it had received an early iteration of the TAF dashboard, at the time of writing, the Board had yet to receive a fully complete version. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: the Trust has developed action plans to address control deficiencies identified in the TAF and progress against these plans is monitored

2.16 The template TAF dashboard includes space for an action plan for addressing control or assurance gaps against each principal strategic risk. This includes identifying the action owner, progress updates and a due date.

2.17 Actions plans were included in the TAF dashboard presented to the Board in September 2021. However, due to the incompleteness of the dashboard, the completeness of action plans was variable. This remained the case with the updated version presented at the December 2021 SDC.

2.18 The Executive leads are still at the stage of collating control and assurance information and assessing the gaps and deficiencies. Therefore, the action plans focus on wider information gathering rather than a response to addressing specific gaps or deficiencies identified.

2.19 See matter arising 1 in Appendix A.

2.20 As noted in paragraph 1.6, we did not undertake any further testing on monitoring of progress against the action plans, due to it being too early to undertake further verification. However, the action plans are contained within the TAF dashboard and, therefore, will be monitored at Board and Committee level via the overarching monitoring of the TAF dashboard.

Conclusion:

2.21 The TAF dashboard and intended monitoring process provides a mechanism to enable the Board to provide effective oversight of action plans and the monitoring of their implementation. However, due to the incompleteness of the risks, controls and assurances in the TAF dashboard, these action plans remain. Therefore, we have provided **limited assurance** over this audit objective.

Audit objective 4: the Trust has a risk management framework which clearly sets out accountability, roles and responsibilities and reporting requirements

2.22 The Trust's new RMF was approved by the Board in September 2020. As with the TAF, the RMF review and update process included engagement within the Trust and consultation with external advisors (see paragraph 2.2).

2.23 Accountabilities, roles and responsibilities are defined in the Risk Management Framework. This included specific reference to the Board, Audit Committee, Executive Directors, the Senior Responsible Officer, Risk Owners, Executive Management Team, Divisional Risk Leads, Specialists, the Corporate Governance Team, Service Directors, and all managers and staff.

2.24 The RMF document is supported by an RMF Process document. Both documents comment on reporting across the Trust. This includes reporting of selected risks to the Board in the form of a Trust Risk Register (TRR) linked to individual risk scores criteria and the risk appetite of the Trust, as defined at risk category level.

2.25 The reporting process in the RMF includes monthly divisional reporting on risk to the Corporate Governance team. However, the RMF documents do not define a monthly cut-off date for updating Datix to ensure risks are reported on a timely basis. See matter arising 2 in Appendix A.

Conclusion:

2.26 No significant matters for reporting were identified, therefore we have provided **substantial assurance** over this audit objective.

Audit objective 5: the Trust Risk Register is regularly scrutinised at Board and Committee meetings

2.27 The new TRR was first presented to the Board at its September 2021 meeting. The TRR was not completely in the newly defined format, as not all risks had been migrated across to Datix v14. We understand this is due to Welsh Blood Service requirements not yet being reflected in v14 and that the Trust is engaged with the Datix Once for Wales team to resolve this matter. No issue is raised as this matter is in hand and the intention is to move all risks to v14 as soon as possible.

2.28 Additionally, the number of risks included in the September 2021 TRR was high (111 risks), which could potentially result in ineffective monitoring and scrutiny. We were informed that the Trust intends to refine the TRR such that it identifies the key overarching operational risks (between 10-25 risks) that genuinely require reporting to Board level. As with the TAF, the intention is to complete this work by the end of March 2021. See matter arising 2 in Appendix A.

2.29 The RMF requires that the Audit Committee reviews the TRR in advance of Board meetings and reports to the Board on any significant matters. In the case of the November 2021 Board meeting, the Audit Committee reviewed the TRR outside the meeting setting due to the alignment of meeting dates. This matter has been reviewed by the Director of Corporate Governance to ensure that dates of Board and Audit Committee meetings for 2022 are appropriately aligned (therefore, no issue has been raised in our report).

2.30 Prior to September 2021, no risk register was presented at Board level during the period under review (i.e., from September 2020). We were informed this was due to pressures of the second wave of Covid-19, resulting in delays in the refresh of risks in Datix and the roll-out of Datix v14. We were further informed that the gap in risk reporting was mitigated by:

- the Covid-19 command and control structures (out of scope for this review, therefore no testing undertaken on these structures);

- reporting on the number and scoring of open risks within Datix and progress in developing the new TRR;

- informal discussions on risk between Independent Members and Executive Directors, namely the Director of Corporate Governance; and

2.31 Through review of the Board and Committee minutes in this period, we also identified that:

- the Chair's and Chief Executive's reports to the Board included commentary on significant risk matters;

- a summary of the Trust's risk profile was presented at the July 2021 Board meeting – this covered a high-level summary of significant risks under the risk domains (it did not cover mitigating controls or action being taken).

2.32 This was not in line with the Audit Committee cycle of business, which requires the risk register to be considered at every regular meeting. Whilst we understand the decision not to present the risk register was considered and discussed with the Independent Members, no formal decision or justification was recorded in the Board or Committee minutes. See matter arising 3 in Appendix A.

2.33 Due to the more informal nature of the mitigating controls, it is difficult to provide assurance over the completeness of reporting of significant operational risks during the period under review. The new TRR will be regularly reported to the Audit

Committee and Board going forward, therefore no issue has been raised. However, the matter has been considered in determining the assurance rating for this audit objective.

Conclusion:

2.34   The TRR has been presented to Board meetings since September 2021, although further refinement of the TRR is needed. Prior to this, the gap in formal operational risk reporting to Board and the informal mitigating controls in place mean we can provide **limited assurance** over this audit objective.

Audit objective 6: the Trust Risk Register is clearly linked to the TAF dashboard and the Trust's strategic objectives

2.35   The delivery of the TAF dashboard and the revised TRR are part of the overarching review of the Trust's RMF. The RMF clearly set out the links between the TAF dashboard and the TRR reporting principles and provides details for when movement of risks between the two reporting mechanisms should be considered and approved by the Board.

2.36   As both the TAF dashboard and TRR are new documents, and further work is required to complete the TAF dashboard, it was too early for us to undertake testing on the link between the TAF dashboard and TRR in practice.

Conclusion:

2.37   The RMF clearly set out the link between the TAF dashboard and TRR, although it was too early for us to verify this link in practice. Based upon the design of the control in place only, we have provided **substantial assurance** over this audit objective.

2.38   It is important that the Trust ensures the effectiveness of the TAF dashboard – TRR links in practice once these documents are fully operational.

Appendix A: Management Action Plan

Matter arising 1: Completion of the TAF dashboard (Operation)	Impact

The Trust's intention was to present a complete TAF dashboard to the September 2021 Board meeting. However, the first iteration presented at this meeting was incomplete. A completed TAF dashboard was scheduled for presentation at the November 2021 Board meeting. However, no TAF dashboard was subsequently presented at that meeting, although we acknowledge an updated (but still incomplete) version was taken to the December 2021 SDC meeting.
 	
A review of the TAF dashboard presented in September 2021 identified that:
 	
• there was no risk schedule for strategic risks 4, 5, and 6, although the cover report provided reasons and the planned work in hand for these risks (including that they would be presented in full in November 2021); and
 	
• for the risk schedules included in the dashboard, the following elements were in development or yet to be completed in full for all risks presented:
 	
   − sources of assurance (i.e., first, second and third lines of defence); and
 	
   − assessment and rating of the sources of assurance.
 	
We also noted that action plans to address gaps or deficiencies in controls / assurance had not always been developed. Additionally, where action plans had been developed, they often focused on wider information gathering to inform the understanding of controls and assurance, rather than to address identified gaps or deficiencies.
 	
The papers presented to the Board commented on further work in hand to populate the TAF dashboard more fully. We understand the target date for the completion of this work is the end of March 2022. We appreciate the work has been delayed due to the pandemic and other pressures faced by the Trust. However, the Trust needs to ensure the TAF dashboard is completed as planned for it to be an effective tool in the oversight and management of strategic risk.
	Potential risk of:
	
	• failure to identify and address control / assurance deficiencies over strategic risks; and
	
	• poor oversight and management of strategic risk.

Recommendations	Priority
1.1 The Trust should ensure the TAF dashboard is completed as planned by the target date (March 2022), including sources of assurance and action plans to address control / assurance gaps and deficiencies.	High

Management response	Target Date	Responsible Officer
1.1 To complete, taking into account current service pressures, still aim for March, given high priority	March 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 2: Operational risk reporting (TRR) (Operation)	Impact
Our review of the TRR presented to the September 2021 Board meeting identified that the TRR contained a high number (111) of risks. We were informed that the Trust intends to refine the TRR such that it identifies the key overarching operational risks (between 10-25 risks) that genuinely require reporting to Board level. As with the TAF, the intention is to complete this work by the end of March 2021. The reporting process in the RMF includes monthly divisional reporting on risk to the Corporate Governance team. However, the RMF documents do not define a monthly cut-off date for updating Datix to ensure risks are reported on a timely basis.	Potential risk of: • lack of timeliness in risk reporting; • inability to provide focused and effective oversight of operational risk; and • poor oversight and management of operational risk.

Recommendations	Priority
2.1 The Trust should: 　　a. ensure the review and refinement of the risks on the TRR is completed as planned by the end of March 2021; and 　　b. update the Risk Management Framework process documentation to provide a monthly timetable of actions for departments/divisions/projects 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

Management response		Target Date	Responsible Officer
2.1	a. To complete, taking into account current service pressures, still aim for March, given medium priority	March 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
	b. To complete	March 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 3: Transparency in decision-making (Operation)	Impact
Whilst we were informed that discussions were held with Independent Members, the decision not to present the risk register at Board level whilst the Datix review and transfer was ongoing was not formally recorded in Board or Committee papers / minutes. Additionally, there was no formal decision (i.e., recorded in Board or Committee papers / minutes) to stand down or put a revised timeframe in place this important work.	Potential risk of: • lack of transparency in decision-making; • inability to provide focused and effective oversight of operational risk; and • poor oversight and management of operational risk.

Recommendations	Priority
3.1 The Trust should ensure that all key decisions and supporting justifications are clearly recorded in Board or Committee papers / minutes, including those which represent a change to: • Board or Committee cycles of business; and • timeframes for significant projects or work streams.	Medium

Management response	Target Date	Responsible Officer
3.1 Agree with action and will be implemented with immediate effect	Immediately	Lauren Fear, Director of Corporate Governance & Chief of Staff

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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Client Organisation	Velindre University NHS Trust
Audit title	Trust Assurance Framework
Audit reference	VT-2122-01
Final Report Date	7th January 2022
Auditor(s)	Philip Lewis-Davies

I would be very grateful if you would please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	Yes	No	Partially	n/a	Any further comments
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial e.g. providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Thank you very much for taking time to complete this questionnaire. Please return by email: **simon.cookson@wales.nhs.uk**.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Counter Fraud Annual Report 2020/21	

AUDIT COMMITTEE BOARD	

DATE OF MEETING	11th January 2022
PREPARED BY	**Nigel Price - Counter Fraud**
PRESENTED BY	**Nigel Price – Counter Fraud**
EXECUTIVE SPONSOR	**Matthew Bunce (Finance Director)**

REPORT PURPOSE	For Noting and Discussion

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING:		
NAME OF COMMITTEE OR GROUP	DATE	OUTCOME
n/a	n/a	n/a

ACRONYMS	NHS - National Health Service LCFS - Local Counter Fraud Specialist NHSCFA - NHS Counter Fraud Authority NWSSP - NHS Wales Shared Services Partnership NFI - National Fraud Initiative POCA - Proceeds of Crime CPS - Crown Prosecution Service IUC - Interview under Caution

1. SITUATION/BACKGROUND

The purpose of the Counter Fraud Annual Report is to provide the Audit Committee with details of the counter fraud work during 2020/21.

2. ASSESSMENT

The purpose of the Counter Fraud Annual Report is to provide the Audit Committee with a report of the counter fraud work during this reporting period. Any changes that may occur in the year will be reported as part of the regular progress reports that are submitted to the Audit Committee.

2.1   Impact Assessment:

QUALITY AND SAFETY IMPLICATIONS/IMPACT	None Identified.
RELATED HEALTHCARE STANDARD	27
EQUALITY IMPACT ASSESSMENT	n/a
LEGAL IMPLICATIONS / IMPACT	Where there is any evidence of prima facie fraud identified then advice as to how best to proceed and whether there is sufficient evidence to support a criminal prosecution is sought from the CPS Specialist Fraud Division.
FINANCIAL IMPLICATIONS / IMPACT	Fraud committed against the NHS has a financial impact, since the Health Body would have suffered an initial financial loss as a result of the subject's actions. The work of the Health Body's Counter Fraud staff is undertaken in order to attempt reduce the level of fraud and/or corruption within Velindre NHS Trust to a minimum and keep it at that level in order to free up resources for patient care.

3. RECOMMENDATION

Any negative publicity received as a result of media reports may have an effect on the reputation of the Health Body. However, by publicising any action taken against the individual(s) would also show that fraud committed against the NHS will not be tolerated and this may also serve as a deterrent to others.

The Committee is, therefore, asked to:

- **RECEIVE** and **DISCUSS** the Counter Fraud Annual Report for the period 2020/21.

COUNTER FRAUD & CORRUPTION

ANNUAL REPORT 2020/21

Nigel Price
Counter Fraud
Cardiff and Vale University Health Board

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1. Management Summary

1.1 This Annual Report is written in accordance with the provisions of the Welsh Assembly Government Directions on Fraud and Corruption; which require Local Counter Fraud Specialists (LCFS) to provide a written report, at least annually, to the organisation on Counter Fraud work. The report content and style comply with the model prescribed by NHS Counter Fraud Authority (formerly NHS Protect) and is in the same format as those that have been previously submitted

1.2 The Velindre University NHS Trust together with NHS Wales Shared Services Partnership (NWSSP) appointed as their nominated Lead LCFS, Craig Greenstock, Counter Fraud Manager at the Cardiff and Vale University Health Board. Since January 2021 Nigel Price has been the acting manager due to Craig Greenstock being on long-term sick leave.

1.3 During 2020/21, no new referrals were received that were directly linked to Velindre University NHS Trust but two cases were carried over from the previous year and two cases were under investigation by the Counter Fraud Service (Wales).

1.4 Civil recovery would also be sought for any monies fraudulently obtained that were identified during the course of the various investigations. Included as part of the civil recovery would be claims, by the Trust, for all costs identified as a result of not only the proven fraud but also the LCFS costs (e.g. court attendance, salary, travel expenses) in carrying out the criminal investigations.

1.5 If required, advice is sought on cases from NHS CFS (Wales) and when an investigation has been concluded, legal opinion would also be taken from the Specialist Fraud Division Crown Prosecution Service if there was sufficient evidence to support a criminal prosecution.

1.6 Regular progress reports of investigations have been presented to the Trust's Audit Committee and where system weaknesses have been identified and recommendations made, these have been sent to the relevant Service Group and/or Directorate Managers.

1.7 The mix of cases investigated to date are summarised in **Appendix 2** and a full index of the cases reported/referred to the LCFS are listed in **Appendix 3**.

1.8 Velindre University NHS Trust's policies and procedures (e.g. Human Resources, Finance etc) have been reviewed and commented upon in relation to the Counter Fraud Policy.

1.9 A good working relationship was established with the NHS Counter Fraud Service (Wales) following its establishment by Welsh Government and it becoming operational in October 2001, and this relationship continues to develop and strengthen.

2.   Inform and Involve (Developing an Anti Fraud Culture)

2.1   The LCFSs have a continuing work programme with the NHS Counter Fraud Service (Wales) to develop an Anti-Fraud Culture within the NHS.

Examples of work carried out to develop an Anti Fraud Culture include:

- Distribution of relevant Counter Fraud reports, newsletters and Counter Fraud Authority Fraud Prevention Notices.

- Submission of comments on draft Trust policies/protocols as appropriate relating to any Counter Fraud issues

- Fraud awareness presentations, 10 during 2020/21 to 116 members of staff, and more are in the process of being arranged for 2021/22.

- Analysis of staff feedback questionnaires is carried out following the fraud awareness sessions in order to gauge how much knowledge the attendees had of the counter fraud work that is being undertaken within the NHS Trust and also to assist in forming the content of future sessions. The feedback received to date shows that 100% of the staff who attended a presentation feel more comfortable discussing their concerns with the counter fraud service.

Examples of work currently planned/being considered in developing an Anti-Fraud Culture:

- Additional fraud awareness presentations to other various staff groups as outlined in the Velindre University NHS Trust and the NWSSP Counter Fraud Work-Plans for 2021/22.
- Carrying out a further staff survey within the Trust's various Divisions and also hosted organisations to gauge the level of knowledge of fraud in the NHS which can then identify any key areas to be targeted in relation to providing awareness sessions.
- Developing the quarterly Counter Fraud Newsletter which currently provides Velindre University NHS Trust, Hosted Bodies' and NWSSP staff with real examples of fraud and the successful outcomes from such investigations.

2.2   In accordance with the Secretary of State Directions, as in **Appendix 1**, the LCFS will:

- Proactively seek and report to NHS Counter Fraud Authority any opportunities where details of Counter Fraud work (involving action on prevention, detection, investigation, sanction or redress) can be used within presentations or publicity in order to deter Fraud and Corruption in the NHS.

- Report all allegations of fraud to NHS Counter Fraud Authority and develop a good working relationship to ensure that all information is available for presentations and/or publicity.

- Also share information with other LCFS throughout Wales in order to build on good practice and identify areas where fraud may be prevented.

3.   Prevent Fraud

3.1   The LCFS will liaise with Velindre University NHS Trust Communication and Corporate Departments when reporting prosecution cases that may attract media attention to ensure that a consistent approach is taken and the message is sent out that fraud will not be tolerated within Velindre University NHS Trust.

The LCFS will regularly liaise with Velindre University NHS Trust and NWSSP Senior Managers and other staff on all allegations of fraud and it has been identified that this work by the

LCFS continues to have a positive impact in identifying and reporting any fraudulent activity.

The deterrence effect is always difficult to measure, however, there are still a number of referrals being made, but in the main these have been from the NHS Student Awards Service. It is hoped that, following the planned fraud awareness sessions in conjunction with the quarterly newsletter articles, more Trust staff will become aware of the potential areas for fraud and, as a result of advice and further guidance from Velindre University NHS Trust LCFS, they will be more prepared to act against any suspected fraudsters by reporting the outcome of any subsequent investigation to the remaining staff.

3.2   To be effective locally, publicity needs to have local relevance and it is important for the LCFS to communicate local successes, particularly around Sanctions and Redress and so it is also important that outline details of all successful prosecutions continue to appear in Velindre University NHS Trust and NWSSP staff related publications.

3.3   The LCFS will, in conjunction with NHS Counter Fraud Authority, NHS CFS (Wales) and Velindre University NHS Trust's Corporate Department, consider publicity in any case of fraud, where a successful outcome is achieved as a result of action taken via any of the disciplinary, criminal and/or civil routes. This helps to reinforce the messages about action being taken to reduce fraud and will be carried out through the appropriate channels.

4.   Deter Fraud

4.1   LCFS will provide reports on systems weaknesses in each case where fraud is identified to:

- NHS Counter Fraud Authority
- NWSSP Internal Audit
- Wales Audit Office (External Audit)

Examples where this has occurred are:

- Submission of new case notifications and intelligence information via NHS Counter Fraud Authority FIRST Case Management System. From the 1st April 2021all referrals and investigations will be recorded on the new CLUE system.
- Providing regular reports and/or presentations to Velindre University NHS Trust, NWSSP Audit Committee and Senior Managers.
- Regular liaising with Internal and External Auditors with reference to investigations for assistance and previous reports held by them.
- Where, as a result of Counter Fraud work, any system weaknesses have been identified then the LCFS have provided potential solutions and/or recommendations as part of closure reports to the relevant managers.

4.2   The LCFS provide reports on policy weaknesses in each case where fraud is identified to NHS Counter Fraud Authority, Velindre University NHS Trust and NWSSP's Finance Director.

4.3   Where policy and/or system weaknesses are identified, the LCFS will notify the appropriate staff such as Velindre University NHS Trust's Finance Director, Director of Workforce & OD, Senior Managers, Internal and External Audit and/or NHS Counter Fraud Authority.

5.   Hold to Account (Detection)

5.1   The LCFS will take account of:

- Information from the Internal and External Audit functions regarding System Weaknesses (e.g. interpreter services and overseas/private patients).

- NHS Counter Fraud Authority Risk Management exercises in order to prioritise other areas of detection work.

- The LCFS own enquiries and analysis of data, reports (including Whistle Blowing) and trends (e.g. sickness absence).

- National Fraud Initiative Data Matching Exercise

6.   Hold to Account (Investigating Fraud)

6.1   The LCFS will investigate cases in accordance with the Secretary of State Directions. All investigations have, therefore, been carried out in accordance with the directives outlined in **Appendix 1.**

The LCFS will refer cases to NHS CFS (Wales) in accordance with the Welsh Assembly Government Directions and all cases have been reported using the NHS Counter Fraud Authority FIRST Case Management System. From January 2010, all NHS LCFS have been required to electronically record all information regarding their investigations onto the NHS Counter Fraud Authority FIRST Case Management System, which is held within a restricted area within the NHS Counter Fraud Authority internet webpage.

6.2   Five cases were formally referred to counter fraud during 2020/21 via the FIRST Case Management System and there were two cases brought forward from 2019/20. Most referrals received are not necessarily and/or automatically reported on the NHS Counter Fraud Authority FIRST Case Management System, due to the fact that many are isolated instances and very low in terms of monetary value.

Each case is judged on the individual merits before proceeding with an investigation and in the majority of cases it has been found to best suited for the individual(s) to be dealt with under Velindre University NHS Trust's Disciplinary Policy rather than as part of a full-scale criminal investigation and/or prosecution due to the small monetary amounts involved in the alleged fraud in addition to the cost of taking a case to court.

6.3   The LCFS will and do provide NHS Counter Fraud Authority, Internal Audit and External Audit, both Velindre University NHS Trust and NWSSP's Finance Director and the respective Audit Committees, with regular update reports on significant movements with particular cases.

7.   Hold to Account (Applying Sanctions and Seeking Redress)

7.1 The LCFS will consider the different sanctions available to them and have regard to the "Triple Track" approach to investigations, i.e. Criminal, Civil and Disciplinary action. To ensure that correct, prompt action is taken in each case, a close working relationship has been developed with various Velindre University NHS Trust and NWSSP's Workforce and Human Resource Managers.

7.2 The LCFS will supply NWSSP Accounts Receivable Department with information where fraud is established in order to enable them to recover the lost resources. A full file is maintained on each of the investigations carried out to provide information that will assist in the recovery of funds.

8.   Annual Assessment Declaration

8.1 Since 2013/14 and following a review of the practice whereby NHS Counter Fraud Authority would determine how effective a Health Body's Counter Fraud arrangements were when

compared to other NHS Bodies, a significant change was introduced into the way in which Health Bodies were to report and then be assessed.

8.2 From the 1st April 2021 the reporting process has changed to comply with the new Government Functional Standards GovS: 013 Counter Fraud which comprises 12 'Components'. The Return is assessed by the Counter Fraud Authority and a report is sent to the Trust.

<div align="right">**Appendix 1**</div>

WELSH ASSEMBLY GOVERNMENT DIRECTIONS

The following grid identifies the key requirements under Welsh Assembly Government Directions and outlines current activity within each section.

Paragraph	Instruction	Action by Health Board
2 (1)	Chief Executive and Director of Finance to Monitor and ensure compliance with these Directions and any other instructions on countering fraud and corruption against the NHS	Regular meetings are held between the Finance Directors for Velindre University NHS Trust and NWSSP together with the Nominated Lead LCFS.
	Action to be taken in accordance with the NHS Counter Fraud and Corruption Manual and in accordance with the Table annexed to the Directions	Where possible the Manual has been referred to for guidance and appropriate action taken. An updated Manual has previously been issued following a revision, by Welsh Government, after considering changes in legislation

		within the NHS in England.
2 (2)	Each health body shall facilitate, and co-operate with NHS Counter Fraud Authority's Quality Inspection work giving prompt access to staff, workplaces and relevant documentation	Good close working relationship has been established with NHS CFS (Wales). To date there has never been an issue over access to staff or workplaces. NHS Counter Fraud Authority Quality & Assurance Unit carried out a Focused Assessment in October 2016, with full co-operation, and their report was received and then accepted by Velindre University NHS Trust.
2 (3)	Endeavour to agree an SLA with NHS Counter Fraud Service (Wales).	The current SLA was signed in March 2010, but will be reviewed to incorporate any changes which may take place within the NHS in Wales.
3 (1)	Nomination of a suitable officer to act as LCFS. Notify NHS Counter Fraud Authority of replacement LCFS within three months of the need becoming apparent	Velindre University NHS Trust and NWSSP Nominated Lead LCFS, until January 2021, is Craig Greenstock. After that date the role has been temporarily filled by Nigel Price
3 (2)	A trained and accredited LCFS in post by 1 February 2002	Velindre University NHS Trust and the NWSSP's Nominated Lead LCFS was accredited in 2014 and is employed at another NHS Body, but undertakes the counter fraud work as part of a separate contracted-out service.
4 (a)	LCFS reports to Director of Finance	The Nominated Lead LCFS reports directly to the Finance Director, informs him of all cases as they are received, and keeps him updated on any progress/closure.
4 (b)	LCFS provision of written report at least annually	An Annual Report was submitted in respect of 2001/02 (1st year of LCFS arrangements), and the practice has continued.
4 ©	Attendance at Audit Committee meetings	Velindre University NHS Trust and NWSSP's Nominated Lead LCFS or at least one of the health body's other LCFS has attended all Audit Committee meetings that have taken place up to and including March 2021.
	Right of access to all Audit Committee members.	The LCFS have access to all Audit Committee members.
	Right of access to Chairman and Chief Executive	The LCFS have not required access during the year but are confident that, if required, right of access is available (as detailed in the health body's Counter Fraud Policy)

4 (d)	Undertake Pro-Active work to detect cases of Fraud and/or Corruption as specified by Chief Executive and Director of Finance, particularly where systems weaknesses have been identified	The LCFS have made 10 Fraud Awareness Presentations to 116 Velindre University NHS Trust, Hosted Bodies and NWSSP staff in a variety of staff groups. The LCFS also undertake Pro-Active Exercises and follow up all incidents of a potential fraudulent nature received via the NHS Counter Fraud Reporting Line, Velindre University NHS Trust's Whistle Blowing facilities and/or any Internal or External Audit reports.
4 (e)	Proactively seek and report opportunities for publicity to NHS Counter Fraud Authority (includes instances for inclusion in presentations) involving action to prevent, detect, investigate, impose sanctions and seek redress	One particular successful fraud related case appeared on National TV and also in a number of National and Local newspapers and has also been widely publicised across Velindre University NHS Trust, Hosted Bodies and NWSSP via the quarterly CF newsletter.
4 (f)	Investigate cases of suspected fraud in accordance with division of work outlined, the LCFS will not investigate (unless there is prior agreement) LCFS will investigate where it is clear that they will be under £15k. Cases where it is clear they will be over £15,000 in value will be referred to NHS CFS (Wales). There is evidence that fraud extends beyond the Health Body. GDS and/or prescription fraud are involved There is evidence of corruption involving a public official The LCFS will assist when required in investigation of cases involving their Health Body where the investigation falls within the remit of NHS Counter Fraud Authority.	All cases investigated to date have followed the guidelines. Only cases less than £15,000 are investigated, and above £15,000 the cases are referred to, and investigated by/in liaison with, NHS CFS (Wales). There have been no cases identified during the year which extended beyond the organisation. There have been no alleged frauds reported that involved any altered documentation for prescribed drugs. There have been no cases of alleged corruption reported during 2020/21. There have been no matters reported that would have fallen within the remit of NHS Counter Fraud Authority.
4 (g)	Refer cases to NHS Counter Fraud Authority teams as appropriate	All cases appropriate to NHS CFS (Wales) have been referred.

4 (h)	Inform the appropriate NHS Counter Fraud Authority team of all cases of suspected fraud investigated by the Health Body.	Entries on the FIRST Case Management Systems, for intelligence purposes, have been completed for all cases of suspected fraud investigated during the year.
5	Co-operate with investigative work: Chief Executive and Director of Finance to ensure access is given as soon as possible and not later than 7 days from the request to the LCFS or NHS Counter Fraud Authority Operational Service staff to: Premises, records and data owned or controlled by the health body relevant to detection/investigation of fraud and corruption All staff who may have relevant information.	The LCFS and NHS Counter Fraud Authority rights and responsibilities, as set out in the SLA, SFIs and the Counter Fraud Policy, have been fully complied with and both have received co-operation from all levels throughout the health body. As above
6 (1)	LCFS to complete relevant forms when Director of Finance believes fraud or corruption to be present, so that NHS Counter Fraud Authority may supply advice on appropriate sanctions. LCFS and Director of Finance to consider further action in accordance with the NHS Fraud & Corruption Manual.	Investigations have complied with NHS Fraud & Corruption Manual and completed forms as appropriate.
6 (2)	Director of Finance to liaise with NHS CFS (Wales) concerning prosecutions prior to taking such action.	Investigations have complied with the NHS Fraud & Corruption Manual
6 (3)	Director of Finance to liaise with NHS CFS (Wales) prior to reaching a decision to refer cases to the police or other body for investigative action, if required.	Appropriate liaison took place in any cases to date where investigations have required referral to police or any other third party organisation for example The UK Immigration and Enforcement Team.
6 (4)	Non-disclosure of information, except for purposes of investigation or subsequent proceedings; no disclosure to anyone who may be implicated	There has been no disclosure of information to anyone who may be implicated in any of the investigations unless required under Police & Criminal Evidence Act.
6 (5)	LCFS to report details of any identified system weakness which would allow fraud or corruption to occur, to the internal auditors	The LCFS liaise with Internal & External Auditors and provide information regarding system weaknesses. Managers are also

		informed of system weaknesses and advised accordingly.
6 (6)	LCFS to ensure investigations focus on obtaining information to ensure recovery of funds can take place.	A full file is maintained on each of the investigation carried out to provide information to assist the recovery of funds.
	Director of Finance responsible for ensuring financial redress is sought where losses identified	Recovery of losses is considered in all cases and would be sought where appropriate.

Further Information

1.   **Reporting lines**

Trust Chief Executive (Velindre University NHS Trust)	Steve Ham Chief Executive's Office Corporate Headquarters Unit 2, Charnwood Court Parc Nantgarw, Nantgarw Nr.Cardiff. CF15 7QZ Email: Steve.Ham2@wales.nhs.uk
Executive Director of Finance (Velindre University NHS Trust)	Mark Osland Finance Director's Office Corporate Headquarters Unit 2, Charnwood Court Parc Nantgarw, Nantgarw Nr.Cardiff. CF15 7QZ Email: Mark.Osland@wales.nhs.uk
Director of Finance (NWSSP)	Andy Butler NHS Wales Shared Services Partnership (NWSSP) 4-5 Charnwood Court Heol Billingsley Parc Nantgarw Cardiff CF15 7QZ Email: Andy.Butler@wales.nhs.uk
Nominated Lead Local Counter Fraud Specialist	Nigel Price Counter Fraud Department Cardiff and Vale UHB Headquarters 1st Floor, Woodland House Maes-y-Coed Road Cardiff CF14 4TT Email: nigel.price@wales.nhs.uk

2.   Mix of cases

Number of cases in 2020/21, including those brought forward from previous years:

Area (based on initial reported category)	Number of cases	Closed	Ongoing
Workforce Issues (e.g. Recruitment/DBS Checks)	0	0	0
Timesheet/False Sickness Absence	0	0	0
Reimbursement of Costs (Student Awards)	7	5	2
Miscellaneous (Use/Theft of NHS Property)	1	1	0
Total	**8**	**6**	**2**

3.   NHS Counter Fraud Authority Website

Information about NHS Counter Fraud Authority and the NHS Counter Fraud Strategy can be found at www.cfa.nhs.uk

INDEX OF LCFS INVESTIGATIONS 2020/21

Ref. No	Subject	Status	Open/Closed
SSP14.05	Unauthorised Sale of NHS Property	Crown Court Hearing (Suspended Sentence) Civil Recovery (5k) still being made at £50 per month	closed – January 2021 Balance £2424.25 paid in full
SSP19.04	False Representation	Initial investigation started	Closed July 2019 An advice file was submitted to the CPS. After reviewing the evidence, it was decided the evidence would not support a criminal trial.
SSP20.03	False Representation	Claiming for bursary funding	Closed July 2019 No evidence to support the allegation
SSP20.04	False Representation	Allegation of fraudulent bursary application	Closed July 2029 No bursary awarded
SSP20.07	False Representation	Failure to pay for childcare costs after receiving payment from the NHS	Closed November 2020 Referred for civil case recovery
WARO/20 /00086	False Representation	The allegation is that the subject gave false information about a holiday destination to avoid self-isolation.	Open Pending a disciplinary hearing
WARO/21 /00033	Over payment of salary	The allegation is that the subject received payments to which he was not entitled	Open Repayments are being negotiated.

AREA OF ACTIVITY	DAYS USED
STRATEGIC GOVERNANCE	15
INFORM AND INVOLVE	15
PREVENT AND DETER	25
HOLD TO ACCOUNT	20
TOTAL DAYS USED	75

COST OF ANTI-FRAUD, BRIBERY AND CORRUPTION WORK	
PROACTIVE COSTS	£15,400.00
REACTIVE COSTS	£5,600.00
TOTAL COSTS	£21,000.00

Declaration

I declare that the Anti-Fraud, Bribery and Corruption work carried out during the financial year 2020/21, within the Velindre University NHS Trust, has been further self reviewed against the NHS Counter Fraud Authority Standards for Providers - Fraud, Bribery and Corruption/NHS Standard Contract and the rating as detailed in Appendix 4 has been achieved.

Organisation Name

Velindre University NHS Trust

Executive Director of Finance

Matthew Bunce

Date

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

Counter Fraud Progress Report

AUDIT COMMITTEE BOARD

DATE OF MEETING	11th January 2022
PREPARED BY	Nigel Price - Counter Fraud
PRESENTED BY	Nigel Price – Counter Fraud
EXECUTIVE SPONSOR	Matthew Bunce (Finance Director)

REPORT PURPOSE	For Noting and Discussion

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING:		
NAME OF COMMITTEE OR GROUP	DATE	OUTCOME
n/a	n/a	n/a
ACRONYMS	NHS - National Health Service LCFS - Local Counter Fraud Specialist NHSCFA - NHS Counter Fraud Authority NWSSP - NHS Wales Shared Services Partnership NFI - National Fraud Initiative POCA - Proceeds of Crime CPS - Crown Prosecution Service IUC - Interview under Caution	

1. SITUATION/BACKGROUND

The purpose of the Counter Fraud Progress Report is to provide the Audit Committee with details of the counter fraud work during the reporting period including a summary of investigations and outcomes. It forms part of the quarterly updates presented to the committee for its assurance.

2. ASSESSMENT

The purpose of the Counter Progress Report is to provide the Audit Committee with a report of the days spent on counter fraud work during this reporting period. Any changes that may occur in the year will be reported as part of the regular progress reports that are submitted to the Audit Committee.

2.1 Impact Assessment:

QUALITY AND SAFETY IMPLICATIONS/IMPACT	None Identified.
RELATED HEALTHCARE STANDARD	27
EQUALITY IMPACT ASSESSMENT	n/a
LEGAL IMPLICATIONS / IMPACT	Where there is any evidence of prima facie fraud identified then advice as to how best to proceed and whether there is sufficient evidence to support a criminal prosecution is sought from the CPS Specialist Fraud Division.
FINANCIAL IMPLICATIONS / IMPACT	Fraud committed against the NHS has a financial impact, since the Health Body would have suffered an initial financial loss as a result of the subject's actions. The work of the Health Body's Counter Fraud staff is undertaken in order to attempt reduce the level of fraud and/or corruption within Velindre NHS Trust to a minimum and keep it at that level in order to free up resources for patient care.

3. RECOMMENDATION

Any negative publicity received as a result of media reports may have an effect on the reputation of the Health Body. However, by publicising any action taken against the individual(s) would also show that fraud committed against the NHS will not be tolerated and this may also serve as a deterrent to others.

The Committee is, therefore, asked to:

- **RECEIVE** and **DISCUSS** the Counter Fraud Progress Report for the period 1st October 2021 to 30th December 2021

VELINDRE UNIVERSITY NHS TRUST

Audit Committee 11th January 2022

**Counter Fraud Progress Report for the period
1st October 2021 to 30th December 2021**

Nigel Price
Counter Fraud
Cardiff & Vale University Health Board

VELINDRE UNIVERSITY NHS TRUST

AUDIT COMMITTEE 11th January 2022

COUNTER FRAUD PROGRESS REPORT

1.	**Introduction**
2.	**Current Case Update**
3.	**Progress and General Issues**

Appendix 1 **Summary Plan Analysis**
Appendix 2 **Assignment Schedule**

<u>Mission Statement</u>
To provide the Trust with a high-quality NHS Counter Fraud Service, which ensures that any report of fraud is investigated in accordance with NHS Secretary of State Directions and all such investigations are carried out in a professional, transparent and cost-effective manner.

1. INTRODUCTION

1.1 In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report details the Counter Fraud and Corruption work carried out, by the Trust's Local Counter Fraud Specialists, for the period ended 30th December 2021.

The report's style has been agreed, in consultation with the Trust's Director of Finance, with the objective of informing, the Audit Committee of referrals of suspected fraud, investigations and any operational issues.

The Annual Work-Plan has 110 days allocated to the Trust for counter fraud work. At 30th December 2021, 90 days have been completed and reported in Appendix 1. The days have been used in conducting investigations into the NHS Counter Fraud Authority's Fraud Prevention Guidance Impact Assessment 2020-21; reviewing policies; preparing, and delivering fraud awareness sessions and analysing the feedback on those presentations; preparing reports for and attending audit committee meetings.

Any significant changes in the progress of the work, since the last report to the Audit Committee are outlined in point 2 below. An index of all referrals that have been or are still being investigated during this period is attached at Appendix 2.

2. CURRENT CASE UPDATE

During this reporting period two investigations have been closed, one new investigation has started and one remains open. The investigations are listed in appendix 2.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

Face-to-face presentations have been severely reduced due to the COVID-19 restrictions. However, during this reporting period 1 presentation to 8 members of staff has been delivered through Microsoft 'Teams'. Feedback from all the presentations so far this year shows that 100% "strongly agreed" that, after the presentation, they are more comfortable discussing their concerns with counter fraud.

3.2 Counter Fraud Resources Update

After interviewing suitable candidates for the role of an investigator, one was successful and a provisional start date for January 2022 is planned.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2020/21		
AREA OF WORK	**Velindre Planned Days**	**Days to Date**
General Requirements		
Production of Quarterly Reports to Audit Committee	5	5
Attendance at Audit Committees	5	3
Planning/Preparation of Annual Report and Work Programme	5	7
Annual Activity		
Creating an Anti Fraud Culture	8	5
Presentations, Briefings, Newsletters etc.	16	10
Other work to ensure that opportunities to deter fraud are utilised	4	4
Prevention		
The reduction of opportunities for Fraud and Corruption to occur	6	4
Detection		
Pro-Active Exercises (e.g. Procurement)	6	6
National Fraud Initiative 2020/21	10	10
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	25	21
Ensure that Sanctions are applied to cases as appropriate	2	1
Seek redress, where fraud has been proven to have taken place	3	2
Pooled days to be used on "as and when" basis	15	12
TOTAL VELINDRE UNIVERSITY NHS TRUST	**110**	**90**

APPENDIX 2

COUNTER FRAUD ASSIGNMENT SCHEDULE 2021/22

Case Ref	Allegation	information	Current Situation
INV/21/000 12	Providing false information to obtain a bursary	The allegation is that a student nurse withheld information to obtain more bursary funding than they were entitled.	**Opened 09/04/2021** Interview under caution planned for 6th October 2021
INV/21/003 19	Abuse of position	The allegation in this case is that a senior manager gave preferential treatment to people not entitled to receive it.	**Opened 21/10/2021** Inquiries continuing

AUDIT COMMITTEE

AUDIT COMMITTEE ANNUAL REPORT 2020

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Claire Bowden, Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Trust's Standing Orders require each sub-committee of the Board to submit an annual review setting out its activities during the year and detailing the results of a review of its performance.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report provides the Committee with a summary of the work undertaken during the period 1st January – 31st December 2021.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the Trust's activities / functions.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Committee are asked to endorse the report prior to submission to the Trust Board for approval.

AUDIT COMMITTEE

ANNUAL REPORT 2021

Audit Committee
Annual Report 2021

1. Foreword

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee. It outlines the coverage and results of the Committee's work for the year ending 31 December 2021.

During the year, I was supported by Independent Members, Mr Gareth Jones and Mrs Jan Pickles, who offered considerable knowledge and wide-ranging experience to the Committee. I would like to take this opportunity to put on record my sincere thanks for the significant contribution made by both during the year.

I would like to express my thanks to all the Officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NHS Wales Shared Services Partnership, Local Counter Fraud Services and by Audit Wales.

Despite a very challenging year due to the pandemic, meetings have been well attended, and there was constructive dialogue and challenge throughout. All meetings have been held virtually and have generally worked well. A characteristic of the Committee's work and its related meetings has been the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Trust, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Martin Veale JP
Chair of the Velindre University NHS Trust Audit Committee
22 December 2021

2. Introduction

This report summarises the key areas of business activity undertaken by the Committee between January and December 2021 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

This report reflects the Committee's key role in the development and monitoring of the governance and assurance framework within which the Trust operates.

3. Role and Responsibilities

The primary purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Trust's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further.

The Trust operates a separate Audit Committee to provide assurance on the work of the NHS Shared Services Partnership (NWSSP). Whilst the same Independent Members sit on both committees, they are entirely separate, and the NWSSP Audit Committee produces its own Annual Report.

During the period ended 31st March 2021, the Committee also advised and assured the Board on those activities undertaken by the NHS Wales Informatics Service (NWIS) that were the responsibility of the Trust. NWIS left the Trust on 1st April 2021 and became a new Special Health Authority, Digital Health and Care Wales (DHCW).

4. Agenda Planning Process

The Chair of the Committee, in conjunction with the Trust's Executive Director of Finance, draws up the agenda for Committee meetings, which is based upon an agreed annual programme of work and clearly linked to the Committee's Terms of Reference.

The agenda and papers are disseminated to Committee members at least five working days before the date of the meeting.

5. Operating Arrangements

The Committee's Terms of Reference are reviewed annually, with the next review being considered at the January 2022 Audit Committee. A copy of the Terms of Reference extant at the point of writing this report is attached at the end.

The Audit Committee Cycle of Business for June 2021 to May 2022 was approved in March 2021 and will next be reviewed in April 2022. The agenda of each meeting, however, is sufficiently flexible to allow the committee to consider any emerging issues.

6. Membership, Frequency and Attendance

The Terms of Reference of the Committee state that the Committee should consist of a minimum of three Independent members of the Board. One of these members must also be a member of the Quality & Safety Committee.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. During 2021 this option was not exercised.

During the year the Committee met on five occasions with attendance as follows:

Name	Audit Committee (out of 5 possible meetings)
Mr Martin Veale JP (Independent Member) Chair	5 out of 5
Mr Gareth Jones (Independent Member)	5 out of 5
Mrs Janet Pickles (Independent Member)	4 out of 4 (tenure ended prior to 5th meeting)

During the year, the meetings were also regularly attended by the following:

- Mr Steve Ham, Chief Executive
- Mr Mark Osland, Executive Director of Finance (who left the Trust in September 2021)
- Mr Matthew Bunce, as Deputy Director of Finance until he took up the position of Executive Director of Finance in September 2021
- Ms Claire Bowden, Head of Financial Operations
- Mrs Lauren Fear, Director of Corporate Governance

- Mr Steve Wyndham, Audit Wales
- Mrs Kate Febry, Audit Wales

- Mr James Quance, Internal Audit
- Mrs Jayne Gibbon, Internal Audit

- Mr Nigel Price, Local Counter Fraud Specialist

Despite the continuing COVID-19 pandemic, the Audit Committee met as scheduled; albeit virtually through video conferencing. The Committee's 2nd meeting of the year which had previously been held in April was brought forward to March to review matters regarding the NWIS transfer prior to the effective date of 1st April 2021.

7. Audit Committee Activity 2021

The Audit Committee fulfilled its planned work for 2021 covering a wide range of activity. This work can be summarised under the following headings:

7.1 External Audit
- The Committee approved the Audit Wales plan for 2021 in March 2021. Updates from representatives from Audit Wales were given at each meeting.
- Audit Wales documentation was provided to the Committee during the year in relation to the:
  - Annual Audit Plan 2021;
  - Financial Audit 2020/2021;
  - Structured Assessment 2021;
  - Procuring & Supplying of PPE for the COVID-19 pandemic;
  - Test, Trace, Protect in Wales;
  - Audit Fee charged to the Trust.

- Audit Wales provided the Committee with a report entitled "Doing it Differently, Doing it Right?" that related to Governance in the NHS during the COVID-19 crisis and described key themes, lessons & opportunities.
- Audit Wales also shared with the Committee other relevant publications that were of relevance to the Trust.

7.2 Internal Audit
- The Committee received regular progress reports from the Internal Audit team during the calendar year following agreement of an Internal Audit Plan for 2021/2022 in March 2021, noting that it could be subject to change.
- During the year the Committee considered eighteen reports completed by Internal Audit: their assurance ratings are shown below, with a full list of the reports shown in appendix 1.

	Velindre	NWIS
Substantial	7	0
Reasonable	10	1
Limited	0	0
	17	**1**

- Internal Audit's annual assurance opinion for 2020/2021 was reported to the Committee in June 2021. It stated that "the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact** on residual risk exposure until resolved".

7.3 Annual Accounts, Annual Governance Statement & Accountability Report
- The Committee meeting in June 2021 received the audited 2020/2021 Annual Accounts, Annual Governance Statement, Letter of Representation and the Trust's response to Audit Wales regarding governance arrangements.
- The Annual Accounts were subject to a Qualified Audit Opinion by Audit Wales as a result of their non-attendance at stock takes, and therefore their inability to obtain sufficient appropriate evidence to support the inventory balance at the end of the financial year.
- The Committee, while expressing disappointment at the Qualified Audit Opinion, endorsed and recommended the approval of the Annual Accounts and other documents to the Trust Board.

7.4 Counter Fraud
- The Committee received the Annual Workplan for 2021/2022 in March 2021, and quarterly updates from the Counter Fraud Specialist.
- Information relevant to the National Fraud Initiative Exercise that the Counter Fraud Specialist leads on behalf of the Trust was also shared.

7.5 Internal Assurance & Risk Management Monitoring
- The Committee received details of the changes to the pro-forma and process for approval of expenditure over the Chief Executive's financial limit.
- A presentation was given to the Committee in March 2021 by the Head of Procurement detailing how the Well-Being of Future Generations Act is informing procurement in Wales.
- The Committee endorsed for Board approval a revised set of Standing Orders and Standing Financial Instructions, following a review conducted and revised model documents issued in accordance the Welsh Ministers' powers of delegation contained within certain sections of the NHS (Wales) Act 2006.

- Governance lessons that can be learnt from the response to COVID-19 were shared with the Committee.
- A Committee self-assessment questionnaire was issued in November 2021 for completion by Members and attendees, with findings to be reported in early 2022.
- Procurement Compliance was reported regularly to the Committee.
- The Trust Risk Register was presented at the July meeting for review by the Committee, noting that more detailed reviews took place in the relevant Committee and Divisional meetings.
- The Audit Action plan, which tracks the implementation of the recommendations of audit, was regularly reviewed by the Committee. The Committee at times expressed disappointment at a lack of updates provided or items overdue for implementation which were fed back to action leads accordingly.

7.6   Clinical Audit
- The Clinical Audit Annual Report was presented to the Committee by the Executive Medical Director in October 2021.

7.7   NHS Wales Informatics Service (NWIS)
- Regular updates on governance and financial matters were provided to the Committee prior to the transfer of NWIS to a new Strategic Health Authority, Digital Health and Care Wales (DHCW) on 1st April 2021.
- Specific items relating to the transfer were provided to both the January and March 2021 meetings, with closure reports provided where necessary, and offers of support to the new organisation given as appropriate.

8.   Reporting the Committee's Work

The Chair of the Audit Committee reports to the Board on the key issues discussed at each meeting by way of a written Highlight Report. These reports are supported by the more detailed Committee minutes. Committee papers and committee minutes are routinely published on the Trust's website.

9.   Conclusions and Way Forward

The work of the Audit Committee in 2021 has been varied and wide-ranging. The Committee's programme of work will continue to be reviewed to ensure that its contribution to governance, risk management, financial management, counter fraud and internal control is maximised.

This report demonstrates that the Audit Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of control in place and that where necessary has recommended improvements to controls.

Appendix 1

Levels of Assurance Assigned by Internal Audit

Substantial Assurance	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk exposure.**
Reasonable Assurance	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited Assurance	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

List of Internal Audits Undertaken and Assurance Ratings

Velindre University NHS Trust

Internal Audit Assignment	Assurance Rating 2021
Financial Systems	Reasonable
Nursing Staffing Levels Act (Wales) 2016	Substantial
Velindre Cancer Centre	Reasonable
Welsh Blood Service	Reasonable
*Workforce Planning **Follow Up***	*Reasonable*
*IM&T Control & Risk Assessment **Baseline Review***	*N/A*
New Contracting Model	Substantial
New Velindre Cancer Centre Development Advisors	Reasonable
New Velindre Cancer Centre Development Contract Arrangements / Project Agreement	Substantial
New Velindre Cancer Centre Development Governance & Financial Management	Substantial
New Velindre Cancer Centre Development Planning	Substantial
Radiotherapy Bookings	Substantial
Health & Care Standards	Substantial

Welsh Language Standards	Reasonable
Digital Health & Care Record for Cancer (CANISC Replacement)	Reasonable
Waste Management	Reasonable
Infection Prevention & Control	Reasonable
Divisional Review – Incident Management	Reasonable
Divisional Review – Risk Management	Reasonable
SUMMARY (excluding advisory & follow up reports)	
Substantial	7
Reasonable	10
Limited	0
Total	17

NWIS (to 31st March 2021)

Internal Audit Assignment	Assurance Rating 2021
*General Data Protection Regulation **Follow Up***	*Substantial*
Organisational Resilience	Reasonable
*Governance Arrangements during the COVID-19 Pandemic **Advisory Review***	*N/A*
SUMMARY (excluding advisory & follow up reports)	1
Substantial	0
Reasonable	1
Limited	0
Total	1

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Approved:	November 2020
Next Review Due:	October 2021

1.	INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2.	PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- *Advise* and *assure* the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3.	DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives,

  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

  - the reliability, integrity, safety and security of the information collected and used by the organisation,

  - the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6   The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate.   It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7   The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8   The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9   The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10   The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11   The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12   The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4.	MEMBERSHIP

Members

4.1   A minimum of three (3) members, comprising:

Chair   Independent member of the Board (Non-Executive Director)

                             Two independent members of the Board (Non-Executive Directors)

                             [one member should be a member of the Quality, Safety & Performance Committee]

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2   In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.*)
Executive Director of Finance
Director of Corporate Governance
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation   The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation
  to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3   Secretary   As determined by the Director of Corporate Governance

Member Appointments

4.4   The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5   Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.6   The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Workforce & Organisational Development.

5.	COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.	RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7.	REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable

Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8.   APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum *[as per section on Committee meetings]*
- Notice of meetings
- Notifying the public of Meetings
- Admission of the public, the press and other observers

Cross reference with the Trust Standing Orders.

9.   REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10.   CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

AUDIT COMMITTEE

TECHNICAL UPDATE

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Claire Bowden, Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS
FRAB	Financial Reporting Advisory Board
IFRS	International Financial Reporting Standard(s)
TAG	Technical Accounting Group

1.   SITUATION/BACKGROUND

1.1   This report has been prepared to provide the Committee with an update on the new International Financial Reporting Standard (IFRS) 16 for leases that has previously been advised will affect the financial statements prepared for 2022/2023 and future years.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

IFRS 16 – Leases

2.1   This IFRS will replace the current leases standard: most notably largely removing the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. This will lead to some additional previously recognised operating leases being added to the Statement of Financial Position as an asset, with a corresponding liability for future rentals.

2.2   This IFRS was originally expected to be applied to the 2019/2020 financial statements, however, in November 2018, the Financial Reporting Advisory Board (FRAB) made the decision to defer implementation of this standard to 1st April 2020.

2.3   The Committee were advised in October 2020 that implementation had been deferred again until 1st April 2021. A further decision was then made to defer implementation until 1st April 2022, and the Committee were informed of this in January 2021.

2.4   The Finance team continue to work with the Welsh Government, Estates & Procurement staff, and the All Wales Capital TAG group to ensure implementation of the standard from the 2022/2023 financial year.

3.   IMPACT ASSESSMENT

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

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As they can be quantified at this stage, they have been included in section 2.

4. RECOMMENDATION

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