1.0.0 STANDARD BUSINESS

Led by Martin Veale, Chair of the Audit Committee

1.1.0 Apologies

Led by Martin Veale, Chair of the Audit Committee

1.2.0 In Attendance

Led by Martin Veale, Chair of the Audit Committee

1.3.0 Declarations of Interest

Led by Martin Veale, Chair of the Audit Committee

1.4.0 Action Log

Led by Martin Veale, Chair of the Audit Committee

1.4.0 Audit Committee Action Log updates folllowing May 2022 Meeting.pdf

2.0.0 CONSENT AGENDA

Led by Martin Veale, Chair of the Audit Committee

2.1.0 FOR APPROVAL

Led by Martin Veale, Chair of the Audit Committee

2.1.1 Draft Minutes from the Public Part A Audit Committee meeting held on 03 May 2022

Led by Martin Veale, Chair of the Audit Committee

2.2.0 FOR NOTING

Led by Martin Veale, Chair of the Audit Committee

2.2.1 Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

2.2.1 Procurement Compliance Report July 22 v1.2 (003) Final.pdf

2.2.2 Losses and Special Payments Report (Oral Update)

Led by Claire Bowden, Head of Financial Operations

2.2.3 NHS Wales – Health Boards and NHS Trusts All Wales Chairs of Audit Committee Minutes

Led by Martin Veale, Chair of the Audit Committee

2.2.3 Draft AWACC Minutes 19.05.2022 final draft.pdf

2.2.3a ARAC Update re AWACC 19.05.2022 FINAL.pdf

3.0.0 PRIVATE PATIENT SERVICE REVIEW

Led by Matthew Bunce, Executive Director of Finance

3.1.0 Private Patient External Review Oversight and Action Plan

Led by Matthew Bunce, Executive Director of Finance

3.1.0 Private Patient External Review Oversight & Acion Plan Report Audit Committee 19.07.2022.pdf

4.0.0 GOVERNANCE OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS AND MANAGEMENT ACTIONS TRACKING

Led by Matthew Bunce, Executive Director of Finance

4.0.0 Audit Committee Governance of Audit Action Tracker 06.07.22.pdf

4.0.0a Governance of Audit Action Tracker Appendix A Audit Engagement Lessons learned.pdf

4.0.0b Governance of Audit Action Tracker Appendix B Procedure for the Mangement of Audit Recommendations Actions.pdf

4.0.0c Governance of Audit Action Tracker Appendix C Audit Action Tracker Summaries Oversight Tables and Detailed Tracker.pdf

4.0.0d Governance of Audit Action Tracker Appenix D IA proposals for scenarios for recording actions in tracker.pdf

4.0.0e Governance of Audit Action Tracker Appendix E 2021 22 Internal Audit Follow up audit Audit Action Tracking.pdf

5.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

5.1.0 Trust Risk Register

Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff

5.1.0 Audit Committee Risk Paper -19.07.2022 -vfinal.pdf

5.1.0a VUNHST Risk Management Policy FINAL DRAFT FOR EMB.pdf

5.2.0 Trust Assurance Framework

Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff

5.2.0 Audit Com SDC Final Paper - 19.07.22.pdf

5.2.0a V7 TAF DASHBOARD - UPDATED 01.07.2022.pdf

5.3.0 Audit Action Tracker – Overdue and Completed Recommendations

Led by Matthew Bunce, Executive Director of Finance

5.3.0 Cover Paper - Red and Green Audit Action Tracker July 2022 Meeting Final.pdf

5.3.0a MB 07.07.22 Review Master Audit Action Tracker - Updates following May 2022 Red and Green Actions.pdf

5.4.0 Legislative & Regulatory Compliance Register

Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff

5.4.0 Legislative and Regulatory Compliance Register.pdf

5.4.0a Appendix 1_Legislative Regulatory Compliance Register.pdf

6.0.0 EXTERNAL AUDIT

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

6.1.0 Audit Position Update

Led by Katrina Febry and Steve Wyndham (Audit Wales)

6.1.0 Covering paper AW Audit Committee Update July 2022.pdf

6.1.0a VUNHST Audit Position Statement 2022 07 July.pdf

6.2.0 21-22 accounts memorandum report

Led by Steve Wyndham (Audit Wales)

6.2.0 Covering paper AW ML July 2022.pdf

6.2.0a Velindre_2021-22_Audit_of_Accounts_Addendum_Management_Letter - final.pdf

7.0.0 INTERNAL AUDIT

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

7.1.0 2022/23 Internal Audit Progress Update Report

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

7.1.0 VUNHST Audit Committee Progress Update Cover Paper - Jul-22.pdf

7.1.0a VUNHST Audit Committee Progress Update - Jul-22.pdf

7.2.0 Final 2021/22 Internal Audit Reports from the 2021/22 Core Internal Audit Plan

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

7.2.1 Wellbeing of Future Generations Act Advisory Review Report

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

7.2.1 VT 2122-06 - Final Advisory Review Report - WBGFA - Trust issue v2.pdf

7.2.2 Follow Up: Previous Recommendations

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

7.2.2 VT 2122-16 - Final Follow-up Internal Audit Report - Trust issue.pdf

7.3.0 nVCC Integrated Audit Plan 2021/22

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

7.3.1 Financial Reporting – Final Report

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

7.3.1 Velindre nVCC 2122 Financial Reporting Final Report.pdf

7.3.2 MIM Procurement – Final Report

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

7.3.2 Velindre nVCC 2122 MIM Procurement Final Report.pdf

7.4.0 Enabling Works Integrated Audit Plan 2022/23

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

7.4.1 Security Contract – Final Report

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

7.4.1 VUT_2223_IAP_Security Contract_Final Report.pdf

8.0.0 COUNTER FRAUD

8.1.0 Annual CF Report 2021-2022

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

8.1.0 VEL Annual Report 21-22 FINAL.pdf

8.2.0 Counter Fraud Progress Report Quarter 1

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

8.2.0 VELINDRE Period 1 2022 Progress Report.pdf

9.0.0 FINANCE

9.1.0 Private Patient Service Debt Position

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

9.1.0 Private Patient Service Debt Position- Audit Committee Paper July 2022v2.pdf

9.1.0a Appendix 1 PP Debt Positon July.pdf

10.0.0 ADMINISTRATION

10.1.0 Agreement of Committee Cycle of Business

Led by Emma Stephens, Head of Corporate Governance on behalf of Lauren Fear, Director of Corporate Governance & Chief of Staff

10.1.0 Audit Committee Cycle of Business 2022-2023 Cover Paper.pdf

10.1.0a Audit Committee annual plan 2022 2023 Draft for June 2022 Committee-LF.pdf

11.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

12.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

13.0.0 ANY OTHER BUSINESS

By prior approval of the Chair of the Committee

14.0.0 DATE AND TIME OF THE NEXT MEETING

Tuesday 04 October 2022, 2:00pm-5:00pm

15.0.0 CLOSE

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 22 March 2021 Meeting			
07/2021 3.1.0	**Legislative & Regulatory Compliance Register** **ACTION: Lauren Fear and Matt Bunce to discuss the inclusion of procurement compliance in this document.**	**ACTION: Lauren Fear and Matt Bunce**	**UPDATE JULY 2022: CLOSED** Report to be received which is included in July 2022 Audit Committee**.**	LF/MB
	Actions from 14 October 2021 Meeting			
10/2021 4.5.0	**Update on review of Private Patients debts (Verbal Update)** Matthew Bunce as mentioned will do piece of work on age debt and can have a discussion with Martin Veale and Gareth Jones and share 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	**UPDATE MAY 2022: CLOSED** The Committee noted that all Private Patient actions would be addressed on the Agenda 03 May 2022. The Committee proposed to get an ongoing review of the Aged Debts.	MB

	Actions from 03 May 2022 Meeting			
05/2022 2.2.1	**Procurement Compliance Report** **ACTION: Matthew Bunce to confirm with Helen James, Head of Procurement to raise the importance of grouping items and adding narrative to provide oversight of the process within the Procurement Compliance Report.**		**UPDATE JUNE 2022: CLOSED** Matthew Bunce had a meeting with Helen James and Paul Thomas 30 June 2022 to discuss recommended changes to the Procurement Compliance Report. Some changes have been made for the report presented at the July Committee with further improvements to be made going forward.	MB
05/2022 3.0.0	**Private Patient Service Review** **ACTION: Private Patient Service Review to be a standing item on the agenda with a process for each element of the report and how they are going to be reported governance wise in Audit. Audit Committee only to look at finance governance sections. Decide on agenda items going forward and to consider the need for agenda items going forward to make sure this is engaged in a committee.**		**UPDATE JUNE 2022: CLOSED** Item on Agenda 19 July 2022.	MB / LM
	Paper to be received in the July 2022 Audit Committee to articulate the oversight arrangements of the Private Patient Service process going forward.		**UPDATE JUNE 2022: CLOSED** Paper on Agenda 19 July 2022.	**MB / LM**

05/2022 4.1.0	**Trust Risk Register** Following the timing of the paper and the fact it has been to Trust Board and the overall framework and development **ACTION: Lauren Fear to look at how the risks taken from Trust Board can be represented clearly in the Audit Committee report cover paper.**		**UPDATE JULY 2022: CLOSED** The Trust Risk Register cover paper will ensure that the governance route and specific role of Audit Committee on each occasion is explained clearly.	**LF**
05/2022 4.2.0	**Trust Assurance Framework** Gareth Jones highlighted that in paragraph 3.7.3 in the cover paper refers to a discussion in Strategic Development Committee about reverse stress testing and questioned the timing of this as it was requested this exercise be completed promptly? **ACTION: Lauren Fear will work through the reverse stress testing element with Emma Stephens to see how this can be brought forward.**		**UPDATE JULY 2022: CLOSED** Timescales, in response to GJ's comments, reflected in the paper.	**LF**
05/2022 4.2.0	**Trust Assurance Framework** **ACTION: To receive further updated version of the Trust Assurance Framework at the July 2022 AUDIT Committee.**		**UPDATE JUNE 2022: CLOSED** Paper on agenda 19 July 2022.	**LF**
05/2022 4.3.0	**Audit Action Tracker – Overdue and Completed Recommendations** **ACTION: Martin Veale requested the Audit Action Tracker be included as an Alert in the Highlight Report at next Board Committee to make sure all Executives are sighted on this, and the Committee agreed with this.**		**UPDATE MAY 2022: CLOSED** The Audit Committee Action Tracker was placed at the front of the Highlight Report in the ALERT / ESCULATE section.	**AH**

05/2022 5.1.0	**Audit Plan 2022** July 2022 final audit report requested to have narrative included to state the reason why there is a different route to be taken in Wales as opposed to England regarding Clinicians Scheme Pays. **ACTION: Steve Wyndham to include the reason why there is a different route to be taken in Wales as opposed to England in the July 2022 final audit report.**		**PROPOSE TO CLOSE.** **UPDATE JULY 2022:** The AGW has simply taken a different view on Clinicians Scheme Pays to his counterpart in England, the C&AG. The AGW needs to consider whether an item of income or expenditure is irregular and, if so, whether the item is material (by value and/or by nature). Where the AGW considers that an item of income or expenditure is both irregular and material, he will modify his regularity opinion.	**SW**
05/2022 6.6.0	**Internal Audit Report: DBS Checks** In relation to Management response 2.1.a. (i) DBS Policy target date of September 2022 is too far away. ****ACTION: Matthew Bunce to feedback to Sarah Morley that the Trust should develop it's DBS Local Policy as a matter of priority and consider the points raised in the recommendations/findings.**		**OPEN** **Update JULY 2022:** DBS Policy is on track to be developed by September 2022. The policy has to go through its internal consultation phase and be signed off. It is not possible to do this within any shorter timeframe. The Trust currently has a clear procedure for the use of DBS Checks which is being followed for all appointments.	**SM**

05/2022 8.1.0	**Audit Committee Effectiveness Survey** **ACTION: Lauren Fear, Claire Bowden can discuss with Emma Stephens in terms of this general point could look at an extra meeting for next year. Need to make sure schedule better to not have papers that have already been to Board as can't evidence the scrutiny when it's already been someone else to another meeting and the process in which Committee Papers could be shared longer in advance of the meetings.**		**OPEN** **Update JULY 2022:** Approach to 2023/24 schedule to be agreed in principle with Audit Committee Chair. This will be completed in readiness for the September 2022 Board Committee Schedule Planning Arrangements.	**CB / LF / ES**
05/2022 9.2.0	**Private Patients Debt Position** The document is missing a general oversight of policy in terms of overseas patients and questions have we got guarantees insurance company would pay before we start spending money to reduce the risk. ****ACTION: Lisa Miller responded that they could include a summary around how seek authorisation pre-payment and preapproval up front for each of the categories.** Process information attached in the appendix should be included in the overall report.		**UPDATE JULY 2022: CLOSED** There are a range of SOP's in place which demonstrate the pre-authorisation requirements for each category of private patient. These have been reviewed and will be approved at the next Management Group meeting in August 2022. However, the process for pre-authorisation has been embedded for many months in line with best practice.	**LM**

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT
1st April 2022 – 20th June 2022
(Reporting Deadlines)

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Helen James, Head of Procurement & Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR 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	STA - Single Tender Action
SFIs	Standing Financial Instructions

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 1st April 2022 – 20th June 2022 and whether it was in accordance with Standing Financial Instructions (SFIs) Chapter 11 Procurement and Contracting for Goods and Services, Procurement Manual, and the Contract Notification Arrangements, included as Schedule 1 of the SFIs.

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

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

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

[1] subject to the existence of suitable suppliers

[2] in accordance with the requirements set out in SO 11.6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SFI Reference	SFI Description	Description	Items
11.13	Single Quotation Application or Single Tender Application	Single Quotation Actions	9
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	5
11.13	Single Quotation Application or Single Tender Application	Single Tenders for consideration following a call for an OJEU Competition	0
11.17	Extending and Varying Contracts	Contract Extensions and Contract Change Note (CCN) or Variation of Terms)	5
10.4		Award of additional funding outside the terms of the contract (File notes)	1

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Compliance Assurance

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

Repeat Submissions

It has been recognised that there are repeated SQA/STA requests for the same service/providers and it has been agreed that future reports will contain information in relation to the total value of expenditure to date, based on the historical contract information retained by the Procurement Department, and in accordance with its document retention policy.

Information will also be provided as to when the same request was 'Last Reported' to Audit Committee and the associated value. It has not been possible to provide this information for the July meeting however, this will be provided from the next committee meeting onwards.

Non-Compliance

Appendix 1.2 highlights where service areas have engaged with providers to supply goods and/or services without Procurement involvement. These activities have a value in excess of £5,000 so they are in breach of SO's/SFI's and File Notes are completed and a record maintained.

All Wales Contracts

Appendix 1.3 summarises for information purposes the All Wales Contracts that are currently being progressed by NWSSP.

Legislative Regulatory Compliance Register

The Trust Legislative Regulatory Compliance Register does not currently include reference to procurement regulation. NWSSP has confirmed that it doesn't currently have a register This report provides assurance in relation to the Trust compliance with procurement legislation and regulation which has been reflected in the Trust Register.

2.2 **General Observations**

Having recently been assigned management responsibility of the Velindre Procurement function, the Head of Procurement has made several observations in respect of current procurement practices and processes as follows:

SQA/STA Requests

The initial assessment is there are a high volume of SQA/STA submissions that potentially alternative procurement routes could have been used. Initial review has identified a number of requests are in relation to maintenance/servicing of equipment that cannot be undertaken by any supplier other than the original equipment manufacturer (OEM). These requests are justified however, rather than submit

a request for an annual maintenance contract, it would be more cost effective to agree a longer-term arrangement, which would also reduce the volume of STA/SQA requests.

A review of available frameworks will be undertaken to establish whether they can be accessed as an alternative compliant route to market, negating the requirement for an SQA/STA. Furthermore, liaising with NWSSP's Maintenance Team to identify existing Health Board/Trust contracts for similar equipment with a view of amalgamating the Trust's requirements, will again negate the SQA/STA request.

Publication of Contract Awards

Following receipt of a Procurement Policy Note, Public Sector organisations are mandated to publish all contracts awarded above £25,000 via competition/direct award/STA, utilising their Tendering Portal and these will be publicly available. In view of this, there may be an increased interest in the contracts awarded by the Trust which may result in an increase in the number of FOI requests. Consequently, it will be necessary to alert Audit Committee of any associated or perceived risks that may emerge in the event that a provider disputes the approach adopted, regardless of the approach adopted from the Public Procurement Regulations 2015.

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

It appears that the previous Head of Procurement did not have sufficient capacity to undertake the majority of procurement activity valued at between £5k and £25k, which resulted in the previous Trust DoF agreeing to the Trust service leads managing their own procurement requirements, obtaining quotations and agreeing contractual terms.

This is not normal practice and should cease as soon as is practicable, as it places the Trust at a disadvantage in relation to their contractual position and risk. From discussions with the current Director of Finance, arrangements will be put in place for all procurement activity to be channelled through the Procurement Team as this will ensure greater compliance with SO's/SFI's.

As an indication of the annual requirement (1st July 2021 to 1st July 2022) of contracts between £5k and £25k the table below identifies the volume of all contracts for VCC and Corporate. Further analysis will be provided for WBS in the next report to provide the total picture.

Spend Range	Volume
Over £100k	38
£25k to £99k	125
£5k to £25k	230
Under £5k	2,554
Grand Total	**2,947**

Future Audit Committee Reports

The Head of Procurement is reviewing the content of the current Audit Committee Procurement compliance Report and is seeking to improve the information provided to give the required assurance. It is anticipated that the revised report will be available at future meetings. This report already includes in the situation / background section a reminder for members of the assurance framework for procurement the Trust works to which is contained within the SFIs Chapter 11 Procurement and Contracting for Goods and Services, Procurement Manual, Contract Notification Arrangements and statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	All policies are equality impact assessed prior to approval.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As indicated in Appendices 1.1 (Summary Information of Compliant Arrangements) and 1.2 (Further Matters / Non-Compliant Arrangements)

4. RECOMMENDATION

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

Velindre University NHS Trust - Audit Committee Report – July 2022

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Alan Prosser	Welsh Blood Services	WBS-SQA-986	01/07/22 – 30/06/24	Single Quotation Action	Maintenance of equipment	Terumo	£21,362	Sole OEM	Endorsed	No further actions required.	Repeat Submission – last reported March 2020
Alan Prosser	Welsh Blood Services	WBS-SQA-988	06/01/22 – 05/01/24	Single Quotation Action	Maintenance of equipment	Horiba Medical UK Ltd	£10,710	Sole OEM	Endorsed	No further actions required.	First Submission
Alan Prosser	Welsh Blood Service	WBS-SQA-992	01/07/2022 – 30/06/2024	Single Quotation Action	Maintenance of Spectra Optia apherisis stem cell collection machines	Terumo	£21,362	Sole OEM	Endorsed	No further actions.	Repeat Submission last reported March 21
Alan Prosser	Welsh Blood Service	WBS-SQA-1002	01/07/2022 – 31/03/2023	Single Quotation Action	Software Contract to provide transfusion E-learning package for NHS Wales staff	Learnpro Efire Service Ltd	£9,110	Bespoke package created by supplier	Endorsed	No further actions.	First Submission

Velindre University NHS Trust - Audit Committee Report – July 2022

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Alan Prosser	Welsh Blood Service	WBS-SQA-1004	04/05/2022 – 31/01/2024	Single Quotation Action	Ongoing supply of Bovine Serum Albumin Solution (Probumin)	Merck Life Science UK	£10,300	Only supplier to pass WBS validation	Endorsed	No further actions.	Repeat Submission last reported January 21
Alan Prosser	Welsh Blood Service	WBS-SQA-1006	01/04/2022 – 31/03/2025	Single Quotation Action	'Organisational Membership (Digital Services)	The British Computer Society	£20,850	Only supplier that can offer membership	Endorsed	No further actions.	First Submission
Alan Prosser	Welsh Blood Services	WBS-STA-982	01/01/2022 – 31/03/2025 (option to extend +1+1 years)	Single Tender Action	WBMDR Stem collections	Nuffield Health, The Vale Hospital	£ 61,200 (Value includes option to extend)	Site to act as contingency for WBMDR service	Endorsed	No further actions.	Repeat Submission last reported January 21
Alan Prosser	Welsh Blood Service	WBS/CCN/056	30/05/2022 - 31/10/2025	Change Control notice	Microbiology Testing	Abbott	£65,000	Increased scope of contract	Endorsed	No further actions.	First Submission
Paul Wilkins	Velindre Cancer Centre	VCC-SQA-989	04/05/2022	Single Quotation Action	Annual maintenance test of device	Touch Point	£6,432	Sole OEM	Endorsed	No further actions.	First Submission
Paul Wilkins	Velindre Cancer Centre	VCC-SQA-990	24/04/2022	Single Quotation Action	Thermoplastic mask systems	Oncology Imaging Systems	£14,100	Sole OEM	Endorsed	No further actions.	Repeat Submission last reported March 21
Paul Wilkins	Velindre Cancer Centre	VCC-SQA-1000	31/05/2022	Single Quotation Action	Provision of support writing and submission of a Primary Manuscript	Huntsworth Health Ltd	£16,215	Only supplier available to provide work	Endorsed	No further actions.	First Submission
Paul Wilkins	Velindre Cancer Centre	VCC-STA-1010	01/05/2022 – 30/04/2023 (Option to extend +1 +1 years)	Single Tender Action	Ongoing renewal of annual software Licence & Support for Medical Device asset Manage system	Real Asset Management	£55,954 (Value includes option to extend)	Sole OEM	Endorsed	No further actions.	Repeat Submission last reported March 21

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Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Paul Wilkins	Velindre Cancer Centre	VCC-STA-991	24/04/2022	Single Tender Action	Masks for Stereotactic Radiotherapy Brain Patients	Brainlab Ltd	£35,645	Sole OEM	Endorsed	No further actions.	Repeat Submission last reported March 21
Paul Wilkins	Velndre Cancer Centre	VCC-STA-995	01/04/2022 – 31/03/2023	Single Tender Action	Storage of Velindre University NHS Trust records	The Maltings Document Storage Group Limited	£30,819	Measure to ensure that records are stored in a site that is compliant	Endorsed	Procurement exercise to be completed	First Submission
Matthew Bunce	Corporate	VCC-STA-999	01/05/2022 – 30/04/2023 (option to extend +1 +1 years)	Single Tender Action	Ongoing renewal of annual software Licence & Support for Finance asset Manage system	Real Asset Management	£30,899 (Value includes option to extend)	Sole OEM	Endorsed	No further actions.	Repeat Submission last reported March 21
Matthew Bunce	Corporate	VEL/CORP/CCN/ 049	01/01/2022 – 31/12/2022	Change Control notice	Investment Tender	Brewin Dolphin	£23,000	Increased scope of contract	Endorsed	No further actions.	First Submission
David Powell	TCS	VCC-STA-1012	05/04/2022	Single Tender Action	Installation of electricity connection on the MIM site and therefore the new Velindre Cancer Centre (nVCC) is needed	Western Power Distribution	£2,006,986	Sole OEM	Endorsed	No further actions.	First Submission
David Powell	TCS	VCC/CCN/052	12/05/2022 – 11/09/2022	Change Control notice	Technical Advisor and specialist support - in relation to the environmental, ecological and carbon ambitions of the Trust in Support of the nVCC project	Professor Phillip Jones.	£11,000	Increased scope of contract	Endorsed	No further actions.	First Submission
David Powell	TCS	VCC/CCN/053	02/03/2022 – 31/03/2023	Change Control notice	Procured as an M&E adviser with significant	Hulley and Kirkwood	£16,878	Increased scope of contract	Endorsed	No further actions.	First Submission

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Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
					experience of design in a sensitive ecological site; implementation of preferably Health Care related						
David Powell	TCS	VCC/CCN/055	19/05/2022 - 13/04/2023	Change Control notice	Provision of planning consultancy service for the new Velindre cancer centre and associated enabling works	The Urbanist	£23,800	Increased scope of contract	Endorsed	No further actions.	First Submission
David Powell	TCS	VCC/CCN/057	40 day extension with affect from 01/05/2022	Change Control notice	Extension to the Provision of Technical Project Management	Archus Ltd	£14,448	Increased term of contract	Endorsed	No further actions.	First Submission

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Appendix 1.2 - Further Matters / Non-Compliant Arrangements

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
David Powell	Velindre Cancer Centre	VCC-FN-148	07/06/2022	File Note	Mott MacDonald Section 73 Phase 1 and 2 works	Mott MacDonald	£39,662	Works undertaken by agreement with supplier, at supplier's risk, prior to full quote being provided for services. The Project could not afford time delays, and expressed the urgency of the pricing being confirmed by the supplier prior to SLA being signed.	Late contract signing	No further actions	First time submission

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Appendix 1.3 – NWSSP All Wales Contracts in progress

No.	Contract Title	Doc Type	Total Value	Director of procurement Services (Jonathan Irvine) approval <£750k	Welsh Government approval >£500k	Managing Director (Neil Frow) approval £750k-£1M	Chair (Tracy Myhill) approval £1M+
1.	Electricity Electricity supply - over & sub 100kW sites Contract period 1/4/15 – 30/9/22 extension 1/10/22 - 31/3/25	extension	£404,193,000	16/03/2022	original approval applies 26/2/14	06/04/2022	06/04/2022
2.	Construction Frameworks for SBU HDDA these frameworks will fulfil the Health Board business case submissions based on each contracting authority's long-term strategic plan, and the need to react to urgent minor works projects Contract period: April 22-March 25	ratification	£44,000,000	17/03/2022	04/05/2022	06/05/2022	06/05/2022
3.	Printer Consumables The supply of various printer consumables such as toner cartridges throughout NHS Wales Contract period 01/04/2022 - 31/03/2023	ratification	£1,500,000	CS 22/03/22	12/04/2022	21/04/2022	21/04/2022
4.	General Waste & Recycling Services collection and disposal of non-hazardous general waste including food waste for Swansea Bay UHB, Cwm Taf Morgannwg UHB, Velindre University NHS Trust, HEIW and Welsh Blood Service sites. Contract period 5 years (+ 3 yr extension option)	briefing	£24,000,000	CS 25/03/22	03/05/2022	n/a	n/a
5.	Cardiology Radiology Endoscopy Surgical urology consumables A Framework Agreement covering all NHS Wales bodies for the supply of the following Interventional products to four specialist areas Cardiology, Radiology, Endoscopy and Surgical Urology Contract period – 4 years (1/4/22-31/3/26)	ratification	£127,324,916	25/03/2022	13/04/2022	21/04/2022	21/04/2022
6.	Provision of Post Graduate Modules in Genomics Education and Training Services Develop internationally recognised medical and public health genomics services in Wales – that are innovative, responsive and well-connected to the major genetics and genomics initiatives that are evolving worldwide Contract period 1/11/22 – 31/7/26 (2 yr extension option)	briefing	£1,169,600	12/04/2022	04/05/2022	n/a	n/a
7.	MVCs & IP5 Clin waste collection Clinical Waste Collection & Disposal at South Wales & North Wales Field Hospitals, Mass Vaccination Centres/Testing Centres & Pathology Laboratories at IP5 Contract period 01/06/2022 – 31/05/2023 (+2 yr extension option)	ratification	£ 2,643,549	13/04/2022	12/05/2022	13/05/2022	sent to TM 13/5
8.	Proprietary Drugs Proprietary Drugs to purchase for use by All Wales hospital pharmacy departments, as requested by the All Wales Drug Contracting Committee Contract period 01/07/2022 to 30/06/2024 (+2 years extension)	ratification	£385,849,378	13/04/2022	10/05/2022	20/05/2022	sent to TM 20/5
9.	Provision of Rating Consultants for 2023 Non-Domestic Rating Revaluation to secure specialist professional services to support the 2023 Non-Domestic Rating Revaluation on behalf of NHS Wales. The intention is to appoint an all-Wales rating consultant(s) in time for when the new list is published in October 2022 so that rateable values can be checked, manifest errors corrected and	briefing	nil	12/04/2022	08/06/22	n/a	n/a

No.	Contract Title	Doc Type	Total Value	Director of procurement Services (Jonathan Irvine) approval <£750k	Welsh Government approval >£500k	Managing Director (Neil Frow) approval £750k-£1M	Chair (Tracy Myhill) approval £1M+
	allow and any appeals to be prepared and submitted in an expeditious manner following the 1st April 2023. Contract period 1/10/22-30/9/27 (+2 yr extension option)						
10.	Pest control services The provision of both regular and ad-hoc pest control services as required by the Health Boards/Trusts in NHS Wales. Contract period 01/05/2022 – 30/04/2024 +1yr extension)	ratification	£555,000	12/04/2022	06/05/2022	n/a	n/a
11.	Laundry detergent The five Laundry Processing Units (LPU's) were previously operated by Local Health Boards and as such made their own provisions for products used within the laundry such as soap and detergent. The creation of the All-Wales service allowed synergy and standardisation in service provision and delivery in areas such as procurement of goods and services Contract period 1/9/22-31/8/27 (+2yr extension option)	briefing	£1,960,000	12/04/2022	06/05/2022	n/a	n/a
12.	Electrosurgical Instrumentation Provision of Electrosurgical Instrumentation products Contract period 1/5/22 – 31/5/26	ratification	£3,130,957	26/04/2022	25/05/2022	25/05/22	Sent to TM 25/5
13.	Proton beam therapy. commission Proton Beam Therapy (PBT) from the Rutherford Cancer Centre in Newport for the population of south west, mid and south east Wales. The procurement exercise was completed between May and October 2018. In November 2018, the Joint Committee approved a recommendation that the Rutherford Cancer Centre (RCC) could be commissioned by WHSSC to provide PBT for adult patients (aged 25 years and older) in Wales referred via the approved pathway. Contract period 9/4/19 – 8/4/23	extension	£700,000	28/04/2022	original approval applies 18/12/18	n/a	n/a
14.	Haulage set up and maint of specialist vehicles The contract is for the Haulage, Set Up and Maintenance of specialist Vehicles, owned or leased by participating Health Boards/Trusts Contract period 01/05/19-30/4/23	extension	£1,265,290	21/04/2022	original approval applies 19/2/19	27/04/2022	28/04/2022
15.	Electricity supply Electricity supply - over & sub 100kW sites Contract period 1/4/15 – 30/9/22 extension 1/10/22 - 31/3/25	Extension amended	£404,193,000	06/05/2022	original approval applies 26/2/14	09/05/2022	sent to TM 9/5
16.	Culture Media and Consumables For the provision of culture plated and bottled media as well antibiotic sensitivity testing discs for Microbiology Laboratories Contract period 1/6/22-31/5/24 (2 year extension option)	ratification	£3,860,300	17/05/2022	08/06/22	Sent to NF 8/6	
17.	E-Expenses Management System deliver an all-Wales E-expenses Management System for NHS staff in Wales. The system integrates with ESR, enables NWSSP to provide Duty of Care checks on registered vehicles and allows users to submit expenses through an app on their mobile phones Contract period 5/8/19-4/8/23	extension	£888,480	18/05/2022	original approval applies		n/a
18.	Generic Drugs Injections infusions Generic Drugs - Injections/Infusions Items to purchase for use by All Wales hospital pharmacy departments, Contract period 01/07/2022 to 30/06/2024 (2 years)	ratification	£33,199,632	26/05/2022	09/06/22	Sent to NF 9/6	
19.	Heparins Heparins & Anticoagulants purchased by hospital Pharmacy Departments Contract period 1/7/20-30/6/23	extension	£23,131,266	08/06/22	Original approval applies 15/4/20	Sent to NF 9/6	

NHS Wales – Health Boards and NHS Trusts
All Wales Chairs of Audit Committees

Notes of the meeting held on 19th May 2022 via MS Teams

Present:
Paul Newman, Hywel Dda University Health Board (Chair)
Martin Turner, Welsh Ambulance Services NHS Trust
Gill Lewis, Health Education and Improvement Wales
John Union, Cardiff and Vale University Health Board
Marian Wyn-Jones, Digital Health and Care Wales
Tony Thomas, Powys Local Teaching Health Board
Martin Veale, Velindre University NHS Trust
Patsy Roseblade, Cwm Taf University Health Board
Dyfed Edwards, Public Health Wales
Richard Clark, Aneurin Bevan Local Health Board

In attendance:
Jo Wilson, Hywel Dda University Health Board
Paul Dalton, Internal Audit, NWSSP
Carwyn Lloyd Jones, Digital Health and Care Wales
Jamie Graham, Digital Health and Care Wales
Anne Beegan, Audit Wales
Andrew Doughton, Audit Wales
Clare James, Audit Wales
Sonja Wright, Hywel Dda University Health Board (Minutes)

Apologies
Shelley Bosson, Aneurin Bevan Local Health Board (Vice-Chair)
Nuria Zolle, Swansea Bay University Health Board
Medwyn Hughes, Betsi Cadwaladr University Health Board

Minute Reference	Item	Action
AWACC (22) 12	**Welcome & Introductions** Paul Newman welcomed everyone to the meeting.	
AWACC (22) 13	**Apologies for Absence** Apologies for absence were noted as above. Richard Clark advised the group that he was attending on behalf of Shelley Bosson to represent Aneurin Bevan Local Health Board.	
AWACC (22) 14	**Minutes of Meeting Held on 9th February 2022** The minutes were accepted as a true and accurate record of the meeting. **Matters Arising:** No matters arising. **Table of Actions:** It was confirmed that all actions had been completed or were included on the agenda.	

AWACC (22) 15	**Cyber Security** Carwyn Lloyd Jones, Director of ICT, DHCW and Jamie Graham, Interim Head of Cyber Security, DHCW provided a presentation highlighting the critical importance to business continuity of effective cyber security arrangements and outlining the scale of the potential impact of a successful cyber-attack upon service provision (with specific reference to health bodies). The presentation included a video in which the effects of a ransomware attack in May 2021 targeting the Health Service Executive - HSE (which provides all public health services in Ireland) were described, together with containment and remedial action taken by HSE and lessons learned. Members noted that it took approximately 8 weeks following the 'Conti' ransomware attack to restore even a low level of IT service within HSE, and that the impact of the cyber-attack manifested across all areas of the organisation, from operational capability – eg. the delivery of elective care services and the loss of key patient information and diagnostics - to corporate functions – eg. payroll, with a tail of associated issues remaining outstanding for some months after the event itself. Members were advised that a report into the attack which was commissioned by HSE and prepared by Price Waterhouse Cooper (PWC) revealed that the initial 'infection' of the HSE system had arisen from a single workstation – probably as a result of an individual opening a malicious Excel file that was attached to a phishing email - which subsequently enabled wider systems to be compromised, paving the way for the attack itself. In this context, the importance of staff training was highlighted in order to raise awareness of such risks across within individual organisations. In regards to lessons learned, two key elements of cyber security planning were emphasised in relation to a potential attack: *how to prevent* and *how to prepare for*. Members noted recommendations made in the PWC report, including the establishment of clear responsibility and governance arrangements at executive level for IT and cyber security, organisational investment in IT and cyber security resources, and the development of a Business Continuity Plan (which should focus upon provision of care and services to patients rather than the restoration of IT services). Members were further advised by Jamie Graham that the establishment of *offline* IT backup systems was also critical to protect against the deletion or modification of data, notwithstanding challenges in maintaining these systems due to the amount of data which would need to be transferred on a regular basis. Members were informed that while NHS Wales comprises 12 legal entities, it operates via a single IT network (the 'Cymru' domain), and that this flexibility also represents a significant weakness in that a security failure anywhere within NHS Wales can affect every entity, notwithstanding firewalls which are in place around individual health bodies. Members noted that this risk is exacerbated by the existence of older legacy systems within individual organisations. The respective roles of the DHCW Cyber Security team and the NHS Wales Cyber Resilience Unit were outlined – the former in terms of providing IT leadership, security services and corporate incident management across	

	NHS Wales and the latter in regard to providing a support and challenge function to enable operators of essential services within Wales to understand cyber risk and increase the resilience of their systems to potential threat. Marian Wyn-Jones thanked Carwyn Lloyd Jones and Jamie Graham for a clear and informative presentation and advised Members that, as Audit Chairs, they must be aware of the risks posed by cyber-attacks (which had increased significantly during the COVID-19 pandemic) and of the need to raise the profile of cyber security within their respective organisations. Furthermore it was noted that DCHW had significantly increased the number of risk on the corporate risk register, with the suggestion that other bodies undertake the same action and that this be discussed In-Committee. It was noted that the loss of ability to undertake business is the main element of the risk linked to cyber-attacks. Gill Lewis suggested that the articulation of cyber risk in Corporate Risk Registers should be generic, both in the interests of maintaining a high-level and in keeping with the core purposes of a corporate risk register, with further detail being at 'directorate' level. Furthermore, organisations need to be mindful of publishing detailed information regarding potential system vulnerability within the public domain, recognising that Corporate Risk Registers are often included among papers for discussion at Board and Committee meetings and are, therefore, potentially uploaded to organisations' public-facing websites. Carwyn Lloyd Jones explained that within DHCW, while cyber security had been captured as a generic risk in the Datix main section, this had been broken down to a number of specific elements for discussion in private sessions, enabling a more detailed oversight of progress made in relation to targeting individual aspects of the overall risk. Marian Wynn Jones added that, without exception, all discussions relating to details of cyber-risks are held in private sessions, as agreed by DHCW Independent Members. Members agreed to review the submissions provided within their own organisations to ensure they have been scrutinised within the governance framework of the respective organisations. *Carwyn Lloyd Jones and Jamie Graham left the meeting.*	All
AWACC (22) 16	**Internal Audit Update** Members received a presentation summarising the work of Internal Audit under the following headings: • 2021/22 audit progress • Limited Assurance Reviews • 2022/23 audit plans – emerging themes • Changes to audit methodology • IMTP 2022-25 • Other areas of focus • Work plan with AWACC 2022/23 <u>Limited Assurance Reviews:</u> Members were informed that (at 15%) the number of Limited Assurance reports for 2021/22 conformed more closely to the norm, given that, due to the pandemic, 2020 was an exceptional year. Members were advised of key themes linked to Limited Assurance opinions,	

	namely workforce (particularly control of contractors, consultancy and temporary staff), which reflected common pressures impacting upon organisations, the wider clinical governance area (specifically around Mental Health) and specific aspects of governance - mainly relating to monitoring arrangements for specific projects. Audit Plans - Emerging Themes: Members were informed that key themes relate to quality, with emphasis laid upon the need to maintain a quality focus in service recovery and in the face of current workforce challenges. Reflecting messages expressed in the previous agenda item (AWACC (22) 15: *Cyber Security*), Members also noted that cyber risk was listed as another emerging theme in 2022/23 audit plans. Changes to Audit Methodology: Members were informed that a Business Manager had been appointed to the Internal Audit Team, whose remit would include identifying trends and emerging issues from different organisations and enabling more effective use and reporting of these themes. Paul Dalton explained that his aim was to ensure that Internal Audit's planning and annual reporting become more focused and easier to read, with reduced duplication across the various documents issued. Commenting that he was pleased to note that the development of meaningful quality Key Performance Indicators had been included on Internal Audit's workplan, Martin Veale queried how Members could learn lessons from each, based on findings from internal audits, particularly given a natural reticence among organisations in regard to publicising areas of positive development. Paul Dalton explained that this would be facilitated through the development of bespoke reporting which would present an All Wales view in relation to individual findings. Members also noted that individual Heads of Audit meet to discuss ongoing and emerging issues within their respective organisations, and that this networking is effective in enabling early identification of key issues which are then fed through to the Board Secretaries Group. With regard to sharing what has been identified through audit as good practice, Gill Lewis highlighted potential liability issues which may need to be considered by auditors and by organisations in adopting processes which subsequently prove to be detrimental or ineffective. Gill Lewis also highlighted the importance of using one auditor or audit team to work on the same area across different organisations to ensure the identification of good practice is based upon a consistent and comparative approach. Paul Newman suggested that it might be more helpful to take a simpler approach in sharing what works well, as opposed to becoming overly preoccupied with relative gradings of 'good' and 'best'. Jo Wilson highlighted the work that was being progressed with a sub group of the Board Secretaries group in relation to learning. The group, which has representatives from HEIW, NWSSP, Hywel Dda, Internal Audit and Audit Wales, is examining themes and identifying areas where it may be possible to apply learning to individual organisations, whilst recognising and being cognisant of the differences in each of the sovereign bodies. In summary, the Group have avoided using the word 'best practice' and have instead explored how organisations can learn from each other.	

AWACC (22) 17	**Audit Wales – External Audit Update** *Anne Beegan, Andrew Doughton and Clare James joined the meeting.* Members received an update on work in progress, together with an update on Public Accounts and Public Administration Committee (PAPAC) related developments and a summary of Audit Wales (AW) reports and outputs between January and April 2022. Members were advised that the consultation period for AW's forward programme had been extended slightly. Members were informed of delays in the publication of 2 pieces of work: NHS Waiting Times Tool and Planned Care Commentary (due to a delay in receiving WG responses) and NHS Finances Data Tool Update, which should be published around 17th June 2022. Members noted that, while the latter would be similar to that issued in 2021 in terms of focusing upon the impact of COVID-19, additional expenditure analysis would be introduced in the future. Anne Beegan advised Members that the quality governance work undertaken as part of AW's local audit programme would be integrated within a national report, providing a commentary on whether NHS bodies' quality governance arrangements are supporting good quality and safe care. This report would be reviewed at the All Wales Quality and Safety Chairs meeting. Responding to a query from Members as to whether the Welsh Government (WG) Workforce review would be replicated for the NHS Workforce, specifically with regard to operational workforce planning, Andrew Doughton confirmed that the 2022/23 audit plan includes a study of this area, adding that AW would also review care home staffing capacity. Members were assured that, as workforce issues are closely linked to many areas identified in future audit consultations, workforce planning would continue to feature significantly in audit programmes. Members were advised that AW would likely prepare a briefing later in 2022 based upon the findings from a review of workforce planning across all Welsh health bodies, noting that this review would incorporate the strategic role which Health Education and Improvement Wales has in workforce planning. In regard to the generic '*Other NHS Summary Reporting*' heading which is included in the work programme, Anne Beegan explained that this refers to short summary reports eg. 'compare and contrast' reviews, which have been discussed at Board Secretaries Group meetings. Members were informed that AW would consider Members' requests and suggestions in respect of areas for future summary reporting. Andrew Doughton provided a summary overview of findings from the '*Care Home Commissioning for Older People*' review (reported in December 2021). Members were informed that the report, which focused upon 6 Local Authorities (LAs) and 1 Health Board in North Wales, identified significant challenges in relation to workforce, commissioning and highlighted the need for a regional strategic approach. Recognising that many drivers resulted from national policy and guidance and funding mechanisms, members were	

	informed that a national report had been prepared and a discussion session with WG had been scheduled. Members were advised that the main issues identified by the report included poor pay and lack of career structure for care home workers and the need to better understand the experience of service users (recognising that the creation by WG of the *Citizen Voice Body for Health and Social Care,* which will operate from April 2023, would help to develop and support this understanding). Other key issues identified related to market stability and the need for a greater focus upon dementia. Members noted that while WG has issued a response to the report, issues are inherently complex and solutions will therefore require a longer period to implement. Gill Lewis commended the usefulness of the report, particularly as it relates to national issues, adding that the issues identified are long-standing – chief among these being under-resourcing and low rates of pay for staff. Given that these challenges are entrenched within the sector, Gill Lewis queried what could be done to address them. Andrew Doughton agreed the importance of staff pay and career path and drew Members' attention to the disparity in care home staff pay rates across different LAs, depending upon available budgets. Members were informed that some care homes have begun to negotiate their own pay rates and costs – taking legal action against LAs where necessary – and were advised that while WG is aware of these developments, it is currently undecided on how to address them. Andrew Doughton observed that an additional factor for consideration lies in whether it is preferable for LAs to allocate funds to domiciliary care services in order to support people in their own homes, or to increase funding to resource care homes. Members agreed that a shift in the value which the general population attributes to care home workers is a key element in improving both career opportunities and rates of remuneration for staff within the sector. Anne Beegan highlighted the role of regional pooled funds (as administered by Regional Partnership Boards (RPBs)) and Integrated Care funding in care home provision and advised members that the practical application of this funding would be included in planned work relating to Unscheduled Care. Highlighting the financial risks arising from inflation which would exacerbate existing problems within the care sector, Paul Newman observed that the current challenges were certain to increase. Anne Beegan summarised key points identified in the AW review '*Taking Care of the Carers?*' (published October 2021) - notably that all NHS bodies in Wales had placed a significant focus on safeguarding staff at risk of COVID-19 throughout the pandemic, that increased stress and exhaustion were experienced by staff, with a growing risk to staff of developing longer term physical and psychological problems without ongoing support, and that the pandemic has brought the need to focus upon staff wellbeing into sharper relief within organisations. Members noted that the report had made 6 recommendations for health bodies and were informed that, recognising challenges faced by these bodies in effectively disseminating and applying shared learning, AW had	

	highlighted its expectations to Board Secretaries in regard to how its findings would be taken through the workforce and audit committees of their respective organisations. The need to undertake self-assessments of support packages available to staff was also highlighted. Anne Beegan added that AW would maintain an oversight over the following 6-8 months in regards to the focus which health bodies apply to staff wellbeing. In respect of the implementation of learning and recommendations arising from AW reports, members were informed of general challenges in obtaining a coordinated response from partnership bodies in terms of agreeing the recommendations issued, which may impact upon the Unscheduled Care work which has been scheduled into the AW workplan. Members queried the local approaches and how reports were tracked through individual organisations. Jo Wilson explained that within HDdUHB, findings and recommendations arising from this work would feed through an Integrated Executive Group to the RPB and further confirmed that – in accordance with AW expectations communicated via Board Secretaries that reports be reviewed by relevant committees – the '*Taking Care of the Carers?*' review had been presented and discussed at the HDdUHB Audit and Risk Assurance Committee and People, Organisational Development and Culture Committee; and that the *'Care Home Commissioning for Older People'* and local review had been presented at the Audit and Risk Assurance Committee. Members agreed to review their own local arrangements. Members were informed that financial accounts work is progressing well in terms of meeting the deadline of 15th June 2022 and were assured that, so far, no significant issues had been identified.	All
AWACC (22) 18	**Sharing Approaches across NHS Wales** Members noted that this agenda item was included as directed via an action from the previous meeting (AWACC 22 08: [inclusion of] *Comparison of how audit trackers and the Board Assurance Framework are managed and populated at next meeting.*) Jo Wilson noted that included within the papers were the Audit Trackers and Board Assurance Frameworks for most NHS bodies for Members' information, recognising that there was not sufficient time to review these in detail at today's meeting. It was agreed that these two areas could be substantive discussion items for future meetings. Members discussed the approach to audit tracking within each organisation, in particular in a post-pandemic world, and the local arrangements being adopted. Jo Wilson noted that from a HDdUHB perspective, an action had been requested by the Chair of the Audit and Risk Assurance Committee to review all recommendations within the audit tracker to ensure these remained relevant and applicable. This had been an internal review with the recommendation owner, a regulator (Internal Audit or Audit Wales) and the Board Secretary reviewing all actions included on the Action Tracker and removing those which were identified as being no longer relevant or superseded. Jo Wilson commented that, while time-consuming, this had proved a very worthwhile exercise which would now be undertaken on an annual basis. Furthermore, Jo Wilson noted all organisations have their own approaches to audit tracking. Paul Dalton added that a key point in relation to action trackers is to ensure that service and department managers	JW

	maintain ongoing discussion with audit committees in regard to progress and key issues impacting upon their respective areas. Martin Veale highlighted the need to balance the aim of reducing the number of outstanding recommendations and actions listed on trackers as quickly as possible with the need to avoid placing undue demand upon staff who are already experiencing significant pressures.	
AWACC (22) 19	**Update of Key and Relevant Matters from the All Wales Board Secretaries Network** Updates from the AWBSN meetings held on 28th January 2022, and 8th April 2022 were shared with the meeting papers. Jo Wilson informed the Group that key issues discussed included accelerated cluster development and the approaches taken by health bodies in preparing for the forthcoming UK COVID-19 Public Inquiry.	
AWACC (22) 20	**Work Programme** Paul Newman invited Members' comments regarding areas it would be useful for the group to include in its work programme. Martin Veale suggested that some items which had been marked as previously covered be brought back for future meetings, given their continuing relevance, and highlighted counter fraud as an example. It was agreed that an invitation would be issued to Carwyn Lloyd Jones, Director of ICT, DHCW and Jamie Graham, Interim Head of Cyber Security, DHCW to present an update in relation to cyber-security issues at a future meeting.	JW
AWACC (22) 21	**Chair and Support Arrangements from May 20222 onwards** Paul Newman confirmed that Martin Turner (WAST) would now take over the AWACC Chair and that the Board Secretary support role currently undertaken by Jo Wilson would at the same time pass to the WAST Board Secretary (Trish Mills). Paul Newman thanked Jo Wilson for the outstanding support which she had provided during his tenure as Chair and also to Martin Sollis the previous Chair. Jo Wilson thanked Members for their kind comments, stating that it had been a privilege to work with the Group for the past two years.	
AWACC (22) 22	**Any Other Business** No other business.	
AWACC (22) 23	**Date of Next Meeting** 9.30 - 12.30pm, 13th October 2022	

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 June 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	All Wales NHS Audit Committee Chair's Meeting
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mr Paul Newman, Audit and Risk Assurance Committee Chair
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mr Paul Newman, Audit and Risk Assurance Committee Chair

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the paper is to present the Audit and Risk Assurance Committee with an update from the proceedings of the All Wales NHS Audit Committee Chairs' meeting held on 19th May 2022, chaired by Mr Paul Newman, Chair of Hywel Dda University Health Board (HDdUHB) Audit and Risk Assurance Committee.

Cefndir / Background

The All Wales NHS Audit Committee Chairs' meeting provides an opportunity to share information regarding common issues which arise within NHS bodies across NHS Wales and to share best practice. The forum is supported by attendance from a nominated Board Secretary from the All Wales Board Secretaries Network (AWBSN). In addition, meetings are attended by representatives from NHS Wales Shared Services Partnership Internal Audit (NWSSP IA), as providers of audit assurance through the independent and objective assessment of governance, risk management and internal control. Also in attendance are representatives from Audit Wales (AW), in their capacity as external auditors who also provide information and advice.

Asesiad / Assessment

The following is a summary of the main issues discussed at the meeting on 19th May 2022:

1. **Cyber Security**
   The Director of ICT, DHCW and the Interim Head of Cyber Security, DHCW provided a presentation highlighting the critical importance to business continuity of effective cyber security arrangements and outlining the scale of the potential impact of a successful cyber-attack upon service provision (with specific reference to health bodies, and using as an example the effects of a ransomware attack in May 2021 targeting the Health Service Executive – HSE - which provides all public health services in Ireland).

   It was noted that NHS Wales comprises 12 legal entities, it operates via a single IT network (the 'Cymru' domain) and this flexibility also represents a weakness, in that a security failure anywhere within NHS Wales can affect every entity - this risk being exacerbated by the existence of older legacy systems within individual organisations.

Key elements of cyber security planning were highlighted in relation to a potential attack, grouped under the generic heading '*how to prevent* and *how to prepare for*.' These included the establishment of clear responsibility and governance arrangements at executive level for IT and cyber security, organisational investment in IT and cyber security resources, and the development of a Business Continuity Plan (which should focus upon provision of care and services to patients rather than the restoration of IT services). The establishment of *offline* IT backup systems was also critical to protect against the deletion or modification of data, and the supporting roles of the DHCW Cyber Security team and the NHS Wales Cyber Resilience Unit were outlined.

Recognising that associated risks should be comprehensively identified and captured, members discussed the level of detail which should be included on risk registers, together with appropriate fora in which to discuss cyber risks and agreed to review the submissions provided within their own organisations to ensure they have been scrutinised within the governance framework of the respective organisations.

2. NWSSP Internal Audit Update

Members received a presentation summarising the work of Internal Audit (IA) in respect of: 2021/21 audit progress, Limited Assurance reviews, themes emerging in relation to 2022/23 audit plans, changes to audit methodology, the IMTP 2022-25 and IA's workplan with AWACC 2022/23. The main points raised relating to IA work included:

- Key themes linked to Limited Assurance opinions included workforce (particularly control of contractors, consultancy and temporary staff) - reflecting common pressures impacting upon organisations, the wider clinical governance area (specifically around Mental Health) and specific aspects of governance - mainly relating to monitoring arrangements for specific projects.

- Key themes emerging from audit plans relate primarily to quality, with emphasis laid upon the need to maintain a quality focus in service recovery, particularly in the face of current workforce challenges. Members noted that cyber-risk was also listed as an emerging theme in 2022/23 audit plans.

- As regards changes to audit methodology, it was noted that a Business Manager had been appointed to the Internal Audit Team, whose remit would include identifying trends and emerging issues from different organisations, enabling more effective use and reporting of these themes.

  Noting that the development of meaningful quality Key Performance Indicators had been included on Internal Audit's workplan, consideration was given to how lessons could be learned from other Welsh health bodies, based on the findings of internal audits. Members were advised that this would be facilitated through the development of bespoke reporting from IA which would present an All Wales view in relation to individual findings. In regard to identification and adoption of 'best practice', the potential liability issues which may need to be considered by auditors and by organisations in adopting processes which subsequently prove to be detrimental or ineffective was recognised. Furthermore, the importance of using one auditor or audit team to work on the same area across different organisations to ensure the identification of good practice is based upon a consistent and comparative approach, and the merits of sharing what works well, as opposed to becoming overly preoccupied with relative gradings of 'good' and 'best'.

3. Audit Wales Update - External Audit Programme.

An update on work in progress was provided, together with an update on Public Accounts and Public Administration Committee (PAPAC) related developments and a summary of Audit Wales (AW) reports and outputs between January 2022 and April 2022.

Summary overviews were provided of findings from two specific reviews undertaken by AW: '*Care Home Commissioning for Older People*' (reported in December 2021) and '*Taking Care of the Carers?*' (published October 2021). The review of care homes, while being focused upon 6 Local Authorities and 1 Health Board in North Wales, identified significant generic challenges which are applicable regionally and nationally in relation to workforce (poor pay and lack of career structure), the need to better understand the experience of service users, the need for a better developed regional response in relation to commissioning, market stability and the need for a greater focus upon dementia. The inherent complexity of these issues, which inhibits the implementation of solutions and recognised the shift in the value which the general population attributes to care home workers as a key element in improving both career opportunities and rates of remuneration for staff within the sector was noted. Furthermore it was acknowledged that the need for Local Authorities to balance the allocation of funding to domiciliary care services in order to support people in their own homes with increases in funding to resource care homes.

The findings from the '*Taking Care of the Carers?'* review, which pointed to short and long-term risks to staff health resulting from the pandemic, also highlighted the focus which all NHS bodies in Wales had placed upon safeguarding staff at risk of COVID-19 and brought the need to focus upon staff wellbeing into sharper relief. In order to structure this focus, members were advised that the review had made 6 recommendations for health bodies and that AW had highlighted its expectations to Board Secretaries in regard to how its findings would be taken through the workforce and audit committees of their respective organisations.

4. Sharing Approaches across NHS Wales

Members noted that this agenda item was included as an action from the previous meeting (AWACC 22 08: C*omparison of how audit trackers and the Board Assurance Framework are managed and populated at the next meeting*). The need to ensure that service and department managers maintain ongoing discussion with audit committees in regard to progress and key issues impacting upon their respective areas was highlighted, as was the need to balance the aim of reducing the number of outstanding recommendations and actions listed on trackers as quickly as possible with the need to avoid placing undue demand upon staff who are already experiencing significant pressures

5. Update of Key and Relevant Matters from the All-Wales Board Secretaries Network (AWBSN)

Updates from the AWBSN meetings held on 28th January 2022 and 8th April 2022 were shared with the meeting papers. Members were informed that key issues discussed included accelerated cluster development and the approaches taken by health bodies in preparing for the forthcoming UK COVID-19 Public Inquiry.

6. AWACC Work Programme

Recognising the continuing relevance of certain topics included on the work plan which had been discussed at previous meetings, it was suggested that these be re-tabled for future meetings – cyber-security being highlighted as an example.

7. Chair and Support Arrangements

Members were informed that Martin Turner (WAST) would now take over the AWACC Chair and that the Board Secretary support role would at the same time pass to the WAST Board Secretary (Trish Mills). The next meeting will take place on 13th October 2022.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to receive this report for information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	3.1 The Committee shall review the adequacy of the UHB'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) that supports the achievement of the organisation's objectives.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Assurance reports to Committees and Board aligned to relevant standards.
Rhestr Termau: Glossary of Terms:	AWBSN – All Wales Board Secretaries' Network DHCW – Digital Health and Care Wales IMTP – Integrated Medium Term Plan WAST – Welsh Ambulance Service NHS Trust

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Board Secretary Chair, Audit & Risk Assurance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no direct financial implications within this report.
Ansawdd / Gofal Claf: Quality / Patient Care:	There are no direct quality or patient care implications within this report.
Gweithlu: Workforce:	There are no direct workforce implications within this report.
Risg: Risk:	There are no direct implications within this report.
Cyfreithiol: Legal:	There are no legal workforce implications within this report.
Enw Da: Reputational:	There are no direct implications within this report.
Gyfrinachedd: Privacy:	There are no direct implications within this report.
Cydraddoldeb: Equality:	• Has EqIA screening been undertaken? No • Has a full EqIA been undertaken? No

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE REVIEW

DATE OF MEETING	19/07/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Lisa Miller, Head of Operational Services Matthew Bunce, Executive Director of Finance
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer 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
VCC SLT	07/07/22	NOTED & AGREED EXTENSION TO DEADLINES FOR STRATEGIC ACTIONS

ACRONYMS

TPW	Tom Pugh-Williams Ltd
SLT	Senior Leadership Team
SRO	Senior Responsible Officer

1. SITUATION/BACKGROUND

1.1 A high level overview of the Private Patient Service was provided to Executives Directors on the 2nd March 2021 as part of a 'Deep Dive' session. In that session a decision was made to commission an external review of the private patient service as an urgent priority.

1.2 Internal Audit had identified the Private Patient Service as part of their Audit Plan for 2021-22 which they agreed to defer to future years given the Trust decision to commission an external review. However, Internal Audit and the Audit Committee agreed this subject to the external report, its recommendations, management responses and actions being presented to Audit Committee.

1.3 A requirement was developed and agreed, TPW Consulting and Training Ltd were appointed. A cover paper, final report and management responses and action plan were circulated to the Audit Committee members for discussion at 3rd May 2022 Committee meeting.

1.4 The agreed areas for review were: -

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

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

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

1.5 At the Trust Board meeting on 26th May 2022 an updated cover paper proposing the governance arrangements for revieing progress against the actions in the plan and providing assurance around delivery to Independent Members was presented. These proposals were agreed by the Board and are set out in section 2.1.

1.6 This report provides an update on the full action plan (**Appendix 1 – circulated separately as includes detail of weaknesses in Trust processes which could be exploited**), whilst the process to allocate actions to the three Assuring Committees is finalised. Going forward the Audit Committee will only consider assurance around the Financial & Commercial actions

1.7 At the June EMB Run it was agreed that an Executive lead as SRO was required to oversee delivery of the Private Patient Improvement Plan. The Executive Director of Nursing, AHP's & Medical Scientists agreed to undertake this role, with the required resources to support delivery. The first meeting of the project Board has been arranged in July.

1.8 VCC SLT and EMB have agreed to procure specialist support to undertake a review of the private patient income base and identify opportunity for increasing income. This will be funded based on a % fee of the additional income achieved.

1.9 Depending on the additional income generated from the income review further external support may be procured to support the VCC Private Patient team in progressing certain of the service improvements identified in the management response and action plan.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The completion of the strategic actions has been delayed as the focus for the private patient team and VCC management is in relation to the operational, governance, financial & commercial actions. In addition, as identified in 1.7 the first private patient project board will take place in July from which the next steps regarding agreeing the strategic direction for the service will be developed. Alongside this, the procurement process will be agreed for the second phase of specialist input to support the Trust in shaping its strategy and delivery of aspects of the improvement plan. There are a small number of organisations on the National Procurement Frameworks that can provide such specialist support.

2.2 It is proposed that the action delivery dates be revised to quarter 3 or 4 2022/23 to reflect the position set out in section 2.1.

2.3 Operationally good progress has been made against the actions with some taking longer than anticipated due to high level of vacancies, in a very small team. Significant improvements have been made within the overall management of the service including, but not exhaustive to debt management, development of SOP's, capture of activity previously not charged and liaison with Insurance Companies.

2.4 A Private Patient Management Group has been established meeting monthly in the first instance.

2.5 Dedicated finance resource is required to develop and provide monthly income and expenditure reports, support assessment of income improvements that can be made to contribute to the Trust Savings Plan. The income review and procurement work will be delivered through the specialist external support commissioned with oversight by the Finance team.

2.6 As described in section 1.5 a governance and assurance process has been agreed to monitor actions in the Private Patient improvement plan through relevant meetings and committees as outlined in the table below.

2.7 VCC SLT will monitor & review progress against all actions with oversight by EMB. Assurance around delivery of the improvements will be monitored through the following committees:

	Action Area	**Assurance Committee / Meeting**
(i)	Strategic Business Management	Strategic Development Committee to develop future strategic direction which will then, at the appropriate time, brought to the Trust Board for approval.
(ii)	Financial & Commercial	Audit Committee will continue to have oversight of financial controls and the debt management position.
(iii)	Operational & Governance	Quality, Safety and Performance Committee assurance of the oversight of EMB on the action plan for current service performance

2.8 The DoF has allocate each of the actions within the Private Patient Improvement Plan to each of the three Committees based on the action area they relate to. This is subject to review and agreement with Committee Chairs.

2.9 An update will be provided on the Financial & Commercial actions only to the Private Audit Committee meetings going forward.

2.10 Bi-annual updates will be provided on progress against the whole action plan to the Board in its private meeting.

2.11 The contract for the review of the income base and to identify opportunity for increasing the income was signed recently and it is anticipated the work will commence in the next few weeks and is expected to take between 7 to 8 months to complete.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATIONS

The Audit Committee is asked to:

4.1 **NOTE** the updated Action Plan and **AGREE** to the extension of deadlines for the strategic actions. **(Appendix 1 – circulated to members as includes detail of weaknesses in Trust processes which could be exploited)**

4.2 **NOTE** the governance arrangements for revieing progress against the actions in the plan and providing assurance around delivery to Independent Members through Audit Committee, Quality Safety & Performance Committee and Strategic Development Committee

4.3 **NOTE** the establishment of a Private Patient Project Board with the Executive Director of Nursing, AHP's & Medical Scientists as SRO to oversee implementation of the Improvement Pan, first meeting arranged in July '22.

4.4 **NOTE** the contract agreement for external specialist support to undertake a review of the private patient income base and identify opportunity for increasing income over the next 7 – 8 months

4.5 **NOTE** the proposed procurement of further external support to support the shaping of the service strategic direction and delivery of certain of the specialist areas of service improvement identified in the management response and action plan

AUDIT COMMITTEE

Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	01/07/2022	ENDORSED FOR COMMITTEE APPROVAL

ACRONYMS	
EMB	Executive Management Board

1. SITUATION/BACKGROUND

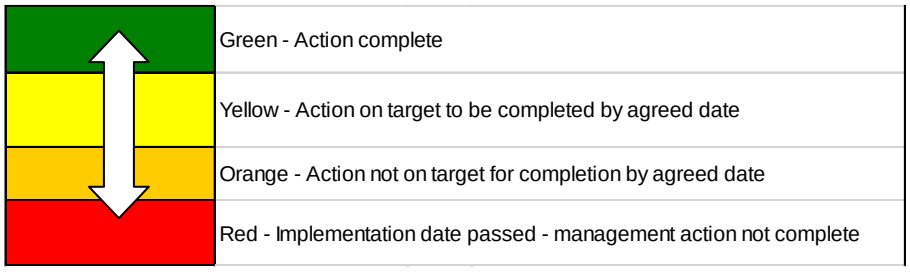
1.1 Internal and External Audit reports form part of the Trust Assurance Framework being an element of the 3rd line of defence to management and mitigation of risks.

1.2 The annual Internal Audit plan and External Audit Structured Assessment plan are discussed and agreed at Executive Management Board (EMB), however currently not all the individual Internal Audit reports are discussed and agreed through EMB. This could lead to a lack of collective understanding and ownership of the risk or system control weakness the audit recommendations are designed to remove or mitigate and whether the management response actions will achieve this.

1.3 There have been engagement difficulties during 2021-22 audit field work in terms of staff timeliness in response, no responses and not providing sufficient evidence as well as management responses to reports not being received in a timely way.

1.4 The Audit Committee currently receives the Internal & External Audit Report Action Tracker for assurance that the Trust Executive Directors and Officers are implementing the actions by the timescales agreed with Audit, however the Audit Report Action Tracker currently does not get discussed at EMB to ensure individual and collective oversight of progress against delivery of audit actions and whether the risks or system control weaknesses have been managed.

1.5 The Audit Committee currently receives the full Audit Action Tracker once a year i.e. all actions, those that are overdue and passed the originally agreed implementation date (Red), those not yet due, either on track to deliver by agreed date (yellow) or not on track to deliver by date (orange) and completed actions (Green). All other Audit Committees receive only the overdue (Red) and those that have been implemented by the agreed date and are recommended for closure (Green).



2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 All Internal and External audit reports should be discussed and agreed through EMB to ensure collective understanding of the risk or system control weakness the audit recommendations are designed to remove or mitigate and whether the management response actions will achieve this.

2.2 Internal Audit identified that there have been engagement difficulties during 2021-22 audit field work in terms of staff timeliness in response, in some cases no responses, not providing sufficient evidence, as well as management responses to report recommendations not being received in a timely way. Internal Audit have identified a number of mechanisms they are putting in place for 2022-23 and what Internal Audit requires from the Trust. These are set out in **Appendix A**.

2.3 Currently the Trust does not have a written procedure for the management of Internal and External Audit agreed actions in response to audit recommendations

2.4 The paper presents to the Audit Committee for discussion and review a draft procedure (**Appendix B**) for the management of Internal and External audit recommendations, management responses and actions.

2.5 The paper presents to the Audit Committee proposed new overview and summary reporting of the Audit Action Tracker (**Appendix C**), of audit activity within the current and previous years. Some of these overviews have been included in the revised audit action tracker cover paper, including a summary of changes to the number of overdue (red) actions from the previous meeting

2.6 **Procedure for the Management of Internal and External Audit Recommendations**

The draft procedure, attached at **Appendix B**, sets out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit review recommendations (signed off by the lead Executive Director);

- requirement that management responses and action plans will lead to mitigation or removal of the risk or system control weakness the audit recommendations are designed to achieve;

- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;

- the role of the Audit Committee in:
    - receiving final Internal and External reports, alongside management responses and action plans;
    - being assured of the adequacy of the management responses and actions to resolve the risk or control weakness identified by internal and external audit and the arrangements for monitoring respective actions going forward;
    - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
    - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
    - overseeing the closure of actions.

- the current frequency of monitoring audit actions by the Audit Committee is that the full action tracker is only reviewed once a year, and the other three Committee meetings receive only the overdue actions and those that have been implemented by the agreed date and are recommended for closure. The procedure includes a proposal that the full tracker is reviewed twice a year, however it may be considered more appropriate that the full tracker is considered at each Audit Committee (four times a year) given the concerns around meeting our action timescales.

- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations. This requires appropriate resource to support a robust monitoring process.

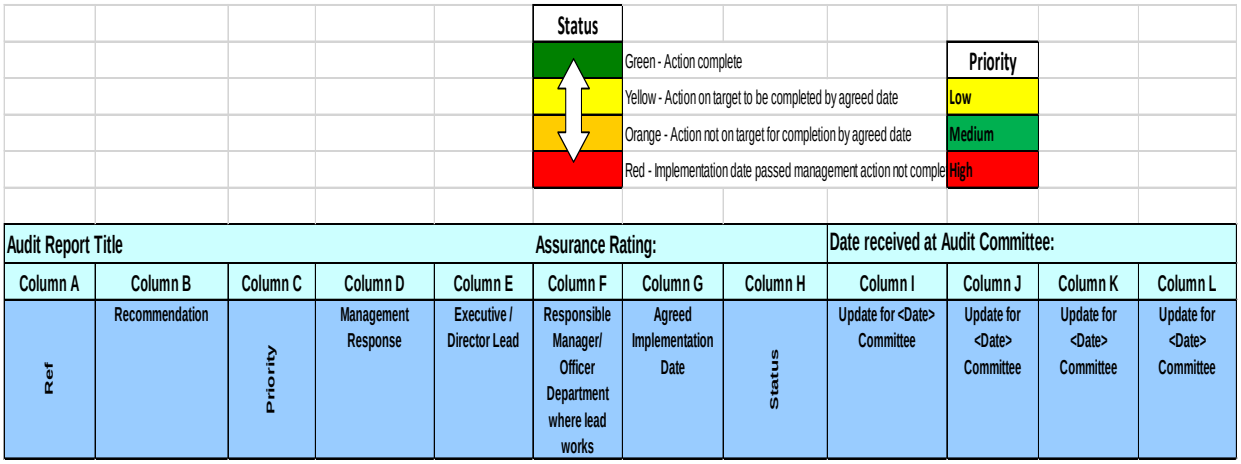
It is intended that the procedure supports a structured approach to the management of internal and external audit recommendations, with clearly defined actions that will enable the Trust to have a comprehensive oversight of its internal and external audit activity.

The draft procedure does not extend to the management of improvement actions arising from Regulatory Inspections or Independent Reviews (such as those undertaken by the Health Inspectorate Wales and Community Health Council). The nature of which are dealt with under a separate process and overseen by the Trust's Quality, Safety and Performance Committee.

2.7 Audit Master Action Tracker

The action tracker and its design has been reviewed and a number of changes have already been made in response to the Internal Audit report follow-up review recommendations relating to the action tracker design and process. Possible further changes and additional information to be included in the Tracker to improve oversight and assurance are suggested below

The content of the current Master Action Tracker is set out below:



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

Priority
Low
Medium
High

Audit Report Title					Assurance Rating:			Date received at Audit Committee:			
Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	Column K	Column L
Ref	Recommendation	Priority	Management Response	Executive / Director Lead	Responsible Manager/ Officer Department where lead works	Agreed Implementation Date	Status	Update for <Date> Committee	Update for <Date> Committee	Update for <Date> Committee	Update for <Date> Committee

Column A	Audit Report Reference
Column B	Detail of the recommendation raised by the audit team
Column C	Prioritisation of the recommendation by the audit team (high, medium, low, not rated)
Column D	The final management response to the recommendation/action
Column E	Executive / Director Lead responsible for ensuring recommendation/actions are implemented
Column F	Manager / Officer Lead responsible for implementing recommendation/action
Column G	Agreed deadline for implementation of actions as per the final audit report and any revised deadlines following approved requests for extension
Column H	Status of the action (not yet due, overdue, complete, closed)
Columns I to L	Progress in implementing actions; explanation for overdue actions, including an outline of any barriers/interdependencies and how the identified risk is being mitigated pending implementation; request for extension to agreed implementation date; request to close action with summary of action taken and confirmation risk has been removed / mitigated

It is proposed the addition of audit action tracker summary tables are included in the cover paper, to support the committee in fulfilling its role in respect of audit action tracking (as set out above and within the draft procedure attached at **Appendix B**). The new oversight and summary tables and the full Master Action Tracker, used as the basis of reporting at **Appendix C**, will enable the committee to have comprehensive oversight of Audit Action completion status.

The following changes and reasoning have already been made to the Tracker in response to the Internal Audit Report follow-up review:

Previous	**Revised**	**Reason**
No Executive / Director Lead included against each Audit Action	Executive / Director Lead included	To ensure there is clarity as to who has overall responsibility for ensuring actions are delivered by the agreed deadlines
Only last two updates retained in Master Tracker, all updates prior to this are deleted (although are maintained through previous iterations of the Tracker)	All updates retained in one version of Master Tracker	To ensure easy to follow audit trail is maintained of progress against action delivery
Completed / Closed actions deleted from the tracker	Completed / Closed actions are copied to a Completed / Closed action tab in the tracker	To ensure there is an audit trail of the closed actions
Lead for action described as Responsible Manager / Department	Lead for action described as Responsible Manager / Officer and Department where lead works	Changed to include Officer as lead for action implementation may not be a Manager. To clarify actions can't be assigned to a department. Department refers to where lead works. Possibly move Department to separate column at some point
Often no explanation or justification for request to close action	Requirement for summary of key actions taken to close and confirmation that risk has been removed / mitigated as a request to close the action	To provide assurance and evidence that the actions have been completed and the risk removed / mitigated

Possible further changes and additional information to be included in the Master Action Tracker to improve oversight and assurance:

Change / Additional Information	Reason
Add a further 'Status' of 'Blue – Action Closed' to identify the actions that have approved for closure by audit committee	Currently the status 'Green – Action complete' is used to identify to the Audit Committee which actions officers are seeking audit committee agreement to close. In order to avoid confusion between those actions audit committee have agreed to close and those awaiting audit committee agreement the closed actions are removed from the tracker and saved to a separate 'tab'. However, this means that all the recommendations and actions included in the final audit are not retained in one place, which does not aid reconciliation and audit trail. The addition of the 'Blue – Action Closed' would mean all action relating to an audit remained in tracker.
Create a unique Trust Ref for each Audit Report	To provide a consistent and unique referencing system to facilitate identification of each Audit Report. This would be linked to establishment of a central master list of all audit reports
Create two Excel spreadsheets, one for all Internal Audit Reports and one for all External Audit Reports to replace the multiple tab Excel workbook, in which a separate tab is created for each audit report	Easier to manipulate, sort, filter data to provide summary & oversight reports. Easier to include tracker in reports to Audit Committee / EMB as doesn't require consolidation of information form separate tabs Possibly create one spreadsheet only and add column for Audit Type – Internal or External Would require additional columns to be added for: • Report Title • Overall Assurance Rating • Date Received at Audit Committee As these are currently part of the heading for each tab in current tracker
Include multiple columns for agreed deadlines	1st Column: agreed deadline for implementation as per the final audit report 2nd Column: First revised deadline agreed by Audit Committee (ref to minutes) 3rd Column: Second revised deadline agreed by Audit Committee (ref to minutes) Updates where deadlines have passed often do not include clear requests or justifications for an extension to the deadline or indicate the updated target date. . To aid audit trail of changes to action deadlines
Include columns for: • no. months past original deadline agreed in final audit report	To aid understanding of the extent of the delays in completing agreed action and the ongoing risk that remains

Change / Additional Information	Reason
• no. months past First revised deadline • no. months past Second revised deadline Would require another column for date reporting to audit committee to calculate no. months action is overdue	
Either add separate column to identify action 'Closed' or add 5th option to status column to identify action 'Closed'	To make it easier to identify closed actions and facilitate creation of summary and oversight reports
Include date action added to the tracker (following presentation of the final audit report to the Audit Committee)	To provide metrics around timeliness of Tracker update following final audit report

Work has been undertaken to review the Master Action Tracker to ensure it accurately reflects the outstanding recommendations and management actions from historical audit reports, as well as ensuring that all 2021-22 final audits are included. The Master Action Tracker as at 6th July 2022 is included in the normal action tracker report on the agenda.

2.8 As set out within the draft procedure at **Appendix B**, it is proposed that the Audit Committee will focus its attention at two of the four meetings p.a. on reviewing each of the recommendations that are overdue - past the original agreed timeframe for completion and those that have been completed during the last reporting period which require audit committee agreement to close. A summary of the number of audit recommendation actions that are not yet due for implementation will be provided. At the other two meetings a review of all audit recommendation actions will be undertaken.

2.9 Further aspects of the Audit Action tracker and how actions are completed and closed are reflected in the tracker, new actions linked to others that are still open and actions linked to other previously closed or re-opened, have been raised with Internal Audit, and their suggested approach has been considered. This is set out in **Appendix D**.

2.10 One of the potential scenarios set out in **Appendix D** which requires greater oversight of completion is where the Trust re-opens previously closed actions. The Audit Action Tracker process reflects this.

2.11 The above scenario raises the importance of understanding the link between the actions and the related risk to ensure actions are not closed until the Executive / Director Lead is assured the related risk has been addressed. This may lead to an action being open for slightly longer on the tracker, but with the benefit of the assurance that the action has been effective in mitigating the risk or issue identified. If the action is not effective in mitigating

the risk, the Executive / Director Lead / or responsible individual should communicate this in the tracker update and identify further action required and a new target deadline. The original-but-updated action should remain open in the tracker until the risk is mitigated.

2.12 The Board Secretary (Director of Governance) / Executive Director of Finance will ensure that all completed actions are retained for any potential future reference, to ensure there is an up-to-date record of previously completed internal or external audit recommendations.

Internal and External Audit Action Tracker, July 2022

As mentioned above, work has been undertaken to ensure the Master Tracker is accurate and reflects all audit reports finalised and updates to actions provided by leads.
The Master tracker is included as a separate report for review**.**

Internal Audit
The position reported to the Audit Committee on 3rd May 2022, in respect of overdue internal audit actions (Red) was:

Year	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2015/16		1			**1**
2019/20		2			**2**
2020/21	1	1	1	9	**12**
2021/22		16	8		**24**
Total	**1**	**20**	**8**	**9**	**39**

Executive Lead	2015/16	2019/20	2020/21	2021/22	Total
Executive Director of Finance			2		**2**
Director of Strategic Transformation, Planning & Digital	1	1	9	2	**13**
Director of Governance & Chief of Staff		1	1	3	**5**

Executive Lead	2015/16	2019/20	2020/21	2021/22	Total
Director of Nursing, AHPs & Health Science				1	**1**
Director of OD and Workforce					**0**
Chief Operating Officer				17	**17**
Executive Director of Finance and Chief Operating Officer				1	**1**
Total	**1**	**2**	**12**	**24**	**39**

Current position in respect of overdue audit actions at 8th July 2022 is:

Year	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2015/16					
2019/20		1			**1**
2020/21	1			1	**2**
2021/22		8	7		**15**
Total	**1**	**9**	**7**	**1**	**18**

Executive Lead	2015/16	2019/20	2020/21	2021/22	Total
Executive Director of Finance				2	**2**
Director of Strategic Transformation, Planning & Digital			1	1	**2**
Director of Governance & Chief of Staff		1	1	2	**4**
Director of Nursing, AHPs & Health Science					**0**
Director of OD and Workforce				1	**1**
Chief Operating Officer				2	**2**

Executive Lead	2015/16	2019/20	2020/21	2021/22	Total
Executive Director of Finance and Chief Operating Officer				2	**2**
Chief Operating Officer and Director of Governance & Chief of Staff				5	**5**
Total	**0**	**1**	**2**	**15**	**18**

The detail provided at **Appendix C**, provides the Audit Committee with an example of the proposed overview report of progress in implementing the totality of audit actions arising from internal audit reviews; showing the number of actions implemented, overdue and not yet due at an individual audit review level. It is proposed that this oversight is provided to the Audit Committee with each audit tracking report to enable the Committee to focus its attention on those actions overdue for implementation as well as being able to take assurance that action plans are being completed.

The detail provided will include all Internal Audit Reviews reported in 2021/22 to the Audit Committee. The Internal Audit Reviews to be reported to the Audit Committee in July 2022 have been added into the Master Tracker

A number of summaries are proposed and included in **Appendix C** for illustrative purposes to support the Audit Committee's review of internal audit action tracking:

- Internal Audit Actions that are Overdue (passed the original agreed implementation date)
- Internal Audit and External Audit Actions that are Not Yet Due for Implementation
- Master Internal and External Audit Action Tracker (inclusive of overdue and not yet due actions)

External Audit

The position reported to the Audit Committee on 3rd May 2022, in respect of overdue External audit action was:

Year	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2015/16					**0**
2019/20	1	1			**2**

Year	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2020/21					0
2021/22					0
Total	1	1	0	0	2

Executive Lead	2015/16	2019/20	2020/21	2021/22	Total
Executive Director of Finance		1			1
Director of Governance & Chief of Staff		1			1
Total	0	2	0	0	2

Current position in respect of overdue audit actions at 8th July 2022 is:

Year	Priority Rating of Recommendation				Total
	High	Medium	Low	Not Rated	
2015/16					0
2019/20		1			1
2020/21					0
2021/22					0
Total	0	1	0	0	1

Executive Lead	2015/16	2019/20	2020/21	2021/22	Total
Executive Director of Finance					0
Director of Governance & Chief of Staff		1			1
Total	0	1	0	0	1

2.13 The Trust's Tracker is maintained by the Business Support Officer for Finance (BSFO) with oversight from the Executive Director of Finance as the Executive Lead for the Audit Committee.

2.14 In the 2021/22 Internal Audit Follow up audit: Previous Recommendations (VEL-2122-16) identified several areas for improvement in the Audit Action Tracker design and process the detail of which is contained in **Appendix E**:

- Clarity of Executive oversight for management responses and action updates
- Authority to request updates to management responses and action updates
- Enhancing information for Audit Committee reporting:
- Maintenance of clear update history
    - Ability to effectively monitor progress / trends:
    - Loss of information
- Comparing the January 2022 Tracker status to the findings of previous audit work identified:
    - Tracker status differs to their findings; and
    - Recommendation not on Track.

- Audit traced recommendations sampled as part of the 2021/22 Follow up: Previous Recommendations audit to the Tracker progress updates, noting:
    - Lack of clarity in updates and closure justification
    - Actions going missing from Tracker
    - Incorrect update
    - Differing treatment of identical responses
    - Common themes not being addressed

2.15 Internal Audit conclusion was that these findings demonstrate a need to strengthen Executive oversight and accountability in the Audit Action Tracker process. It recommended:

- The Trust should develop a documented process for the governance of its Audit Action Tracker
- The Audit Committee should approve the Audit Action Tracker Governance process
- The approved process should be communicated to all relevant staff, for example, through inclusion of a link when Internal Audit (or other reports) are sent out
- The Trust should undertake a thorough review of the current Tracker
- That all action updates (not just the previous two) should be kept in the Audit Tracker to create a more robust audit trail and allow for effective trend monitoring
- The Tracker spreadsheet includes closed recommendations / actions rather than deleting them
- 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 (recommendation 2018 R4b)

2.16 The impact of these recommendations not being implemented is a potential risk of:

- failure to implement agreed audit recommendations in a timely manner;
- increased financial, clinical, statutory and reputational risk for the Trust; and
- inaccurate reporting of the Tracker within the Trust.

2.17 It is proposed that:

- the Audit Committee can if necessary assign recommendations and associated management response and actions to other Committees to provide scrutiny and oversight.

- the audit action Tracker be reviewed regularly by the Executive Management Board.

- that audit recommendations and associated management response and actions be reviewed regularly by the relevant management meeting and team:

    - Divisional performance reviews;
    - Corporate Directorate team meetings;
    - Operational Management Group; and
    - Divisional SLT / SMT
    - Directorate / Department team meetings

2.18 A summary of the actions in the audit tracker will be provided to give an overview of progress towards implementation. This will provide:

- For the latest year of audit actions the number of actions by priority category that are:
    - Implementation date passed management action not complete (RED)
    - Action not on target for completion by agreed date (AMBER)
    - Action on target to be completed by agreed date (YELLOW)
    - Action complete (GREEN)

- For all actions where implementation date has passed and management action is not complete the number of actions by priority category for each financial year

- A comparison and changes of the number of recommendations and analysis

- The above analysis will be provided by Executive Director Lead for each action

2.19 Next Steps

- The Audit Committee members to provide feedback on:

- changes already made to the Tracker;
- possible further changes / additional information proposed;
- other areas for improvement;
- any errors or omissions in the Tracker;
- the draft Procedure for the Management of Internal and External Audit Actions

- The DoF to consider possible alternatives to management of the Audit Action Tracker via an Excel Spreadsheet / workbook. Possible options include:

  - Use of a Microsoft Teams Group to share the Master Action Tracker which is then updated by the Executive, Manager or Officer Lead
  - Use of MS365 Planning tool to manage Master Action Tracker update requests from leads
  - Use of existing Trust digital systems to manage the Master Action Tracker e.g. new clinical audit system

- The DoF to undertake ongoing detailed review of the Tracker to ensure there are no errors or omissions

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There will be quality & safety implications relating to specific audit report recommendations and associated actions
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	There are no equality issues associated with this report at this stage, but equality impact assessment may be a feature of the work being undertaken as part of the actions
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Ensure regulatory and legal compliance
FINANCIAL IMPLICATIONS /	Yes (Include further detail below)

IMPACT	There may be financial consequences of individual actions however there is no direct financial impact associated with this report at this stage.

4. RECOMMENDATION

The Audit Committee is asked to:

4.1 **NOTE** the mechanisms to improve engagement that Internal Audit have identified which they are putting in place for 2022-23 and what is required from Trust staff. These are set out in **Appendix A.**

4.2 **DISCUSS & REVIEW** the draft procedure at **Appendix B** for the Management of Internal and External Audit Actions and if agreed **APPROVE**;

4.3 **DISCUSS & REVIEW** the changes already made to the action tracker (**Table page 6**), summary and oversight reports proposed (**Appendix C**), possible further changes and additional information for inclusion in the Audit Action Tracker (**Table pages 7 & 8**), and if agreed **APPROVE**;

4.4 **DISCUSS & REVIEW** the proposal that the full action tracker is reviewed by the Audit Committee twice a year instead of the current once a year, or whether it is considered more appropriate that the full tracker is reviewed at each Audit Committee (four times a year). If agreed **APPROVE** the change to frequency of review of the full action tracker;

4.5 **NOTE** Internal Audit suggested approach to questions raised by the Trust on how best to reflect: actions that are completed and closed in the tracker, new actions linked to others that are still open and actions linked to others previously closed or re-opened. This is set out in **Appendix D**;

4.6 **NOTE** the areas for improvement in the Audit Action Tracker design and process identified in the Internal Audit Follow up audit, the detail of which is contained in **Appendix E**;

4.7 **NOTE** the DoF action to undertake a review of possible alternative solutions to the management of the Audit Action Tracker.

Appendix A

Engagement matters arising during 2021/22 Internal Audit fieldwork

Matter arising	Impact
Poor engagement during audit fieldwork, where auditees did not: • respond to queries or information requests in a timely manger or, in some cases, did not provide responses at all • communicate regarding delays or challenges they were encountering in providing requested information • provide sufficient evidence, eg, not providing what asked for or not fully answering queries	Ineffective / inefficient use of resource for both the Trust and Internal Audit: • takes longer / is more involved to finalise reports, even if KPI deadline is met • matters being reported as findings in draft reports which subsequently turn out to not be issues, just that IA wasn't provided with appropriate evidence during the audit. • more toing and froing and time spent to update the report and audit file • more time spent to provide appropriate supporting evidence and respond to queries • audits take longer to complete - insufficient responses to audit evidence requests / queries means IA has to come back multiple times on one matter to get a satisfactory answer, or something ends up in the report that didn't need to be there (see above point too) Staff wellbeing implications – all the above can negatively impact on the relationship between auditor and auditee, which may have a knock-on effect on wellbeing Added value implications – auditors spending more time to complete the audit, so don't have the time / space to identify potential added value items for inclusion in the report Reduced time for reporting – fieldwork delays often lead to tighter turn-around times for reporting and push Audit Committee deadlines. This can mean papers deadlines are missed, or reports don't make the agreed Audit Committee
Management responses to reports not provided in a timely manner	Reports missing Audit Committee papers deadlines and, in some cases, the agreed Audit Committee meeting Poor KPI performance

Internal Audit actions to support improved engagement

Engagement mechanisms Internal Audit (IA) already has in place (since September 2021 or earlier):

- Monthly meetings with Director of Finance, includes progress updates and escalation where necessary
- Reporting – management responses:
  - Clear articulation of reporting KPIs and deadlines when report sent out, including request for initial comments within 10 working days
  - Auditor has reminders in diary to flag the deadlines, reminders are sent out to the Executive Lead(s) and key contact(s)
- Audit logistics
  - Start dates agreed during planning meetings for each audit
  - Planned dates for fieldwork completion and debriefing/reporting agreed during planning meetings for each audit
  - Briefs are finalised at least 1 week prior to the start date
  - Initial deliverables list is sent out at least 1 week prior to start date
  - Where practical, kick-off meetings held by the auditor in advance of the start date to discuss systems in place and to clarify the deliverables list
  - Auditors generally meet at least weekly with the key contact during the fieldwork, as well as ad hoc communications / calls in between as needed. *Note: it has been difficult to get time in diaries to ensure regular communication (see comment below about empowering / giving permission)*

Mechanisms Internal Audit is putting in place now (beginning 2022/23):

- Regular meetings with individual executives throughout the year to support better engagement, early communication of upcoming audits in their portfolios, horizon scanning and the annual planning process
- Monthly KPI reporting to the Director of Finance and Director of Corporate Governance (through monthly meetings) to ensure timely action if KPIs start slipping
- Enhanced use of Teams during audit fieldwork:
  - Auditor to set up a Teams group chat for each audit to be used for all audit correspondence and file sharing, allowing for:
    - joined up monitoring on requests for / receipt of deliverables
    - more timely provision of responses as any team member can see the requests and respond if appropriate
    - a 'one-stop' repository for the provision of audit evidence (also reducing the risk associated with email misdirection)
    - oversight and accountability from Trust and Internal Audit senior management
  - To include:
    - Auditor(s)
    - Auditees able to provide information
    - For admin support: relevant Business Support Officer(s) (see 'what we need' below)
    - For information and accountability: Deputy Head of Internal Audit and an agreed senior Trust lead for the audit (e.g., an Executive or Assistant Director, Divisional Management Team, Head of Service, etc, as appropriate for the specific review)

Internal Audit actions to support improved engagement

- Working on site – auditors will begin to spend time on site during the audit depending on the requirements of the fieldwork. For example, a desk-top review could be supported by occasional face-to-face meetings, or a morning/afternoon spent on site. To be agreed during the planning for each audit dependent upon fieldwork needs, available space on site and any pandemic restrictions in place.

What Internal Audit needs from the Trust:

- Business Support Officer (BSO) engagement – Internal Audit already engages with the BSOs to organise meetings with Executive Leads (planning and debrief), but the BSOs could provide further support throughout audit assignments as follows:
  - Support coordination of responses to evidence requests during fieldwork
  - Support coordination of management responses to:
    - Ensure KPI and Audit Committee deadlines are met
    - Ensure timely joined up responses where multiple Executive Leads are involved
- Visible expression of support on the importance of Internal Audit from Executive Directors to their teams – this helps to empower auditees and gives them "permission" to give higher priority to responses to audit queries.
- Early communication to auditees from Executive Directors on the timing and outline scope (from 22/23 plan) of upcoming audits (before briefs are agreed). Executive Directors also to communicate final brief and agreed timing to all auditees.
- Greater communication with the audit team throughout audit fieldwork, particularly where Trust teams may be struggling to provide evidence in a timely manner. Early communication of such issues will allow IA to work around them where possible. This will be supported by some of the mechanisms above, but it remains down to the auditees to speak up and let IA know.
- Feedback – during 2021/22, IA only had 1 post-audit questionnaire returned out of the 14 sent out. IA greatly values feedback, so would appreciate improved responses from the Trust. IA is happy to discuss alternative mechanisms, for example, use of MS Forms rather than the word document.

Other IA suggestions to support improved engagement:

- Documented process covering IA reporting (including management responses) and audit action tracking. When reports are sent out, IA could share a flowchart summarising the process or link to SharePoint / Intranet so Executive Leads / Auditees are aware of the process.
- Occasional IA attendance at Executive Management Board meetings, for example, quarterly to provide progress update on the plan and horizon scanning for upcoming audits.
- Potential use of the Operational Management Group to raise the profile of the IA plan, although we would expect the Executive Directors to be filtering this information down to their Assistant Directors and other senior management.
- 'Taking stock' / Mid-Audit Review meeting with Executive Lead or nominated Assistant Director and Audit Key Contact – helps to ensure ongoing engagement at a senior level, timely update on findings throughout the audit and may also provide a catalyst for the provision of timely audit evidence.
- Board development session on the value of Internal Audit, could also be extended to or replicated at OMG level.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix B

PROCEDURE FOR THE MANAGEMENT OF INTERNAL AND EXTERNAL AUDIT REOMMENDATIONS AND MANAGEMENT ACTIONS

June 2022

AUDIT RECOMMENDATIONS

The Trust should develop a documented process for the governance of its Audit Action Tracker, considering the findings of this report and covering:

i. roles and responsibilities of:
   - the Board and Audit Committee;
   - Internal and External Audit (and other reporting bodies where appropriate);
   - Executive Leads and responsible individuals identified in reports, including the requirement for oversight, accountability and scrutiny by the Executive Leads; and
   - those charged with maintaining the Tracker.

ii. the process for providing management responses to audit recommendations, including expectations on the quality of the responses;

iii. mechanisms to ensure all recommendations are included within the Tracker, including recommendations raised in follow up reports;

iv. the process for managing updates to recommendations on the Tracker;

v. expectations on the quality of updates and justifications for extensions to deadlines or recommendation closure;

vi. clarity on the expectations of Internal and External Audit (and other reporting bodies, for example Healthcare Inspectorate Wales) on what is required to close a recommendation;

vii. regular review of the Tracker to identify themes, e.g., lack of progress in implementing recommendations or common issues occurring which may benefit from a Trust-wide solution or an alternative approach to ensure effective resolution; and

viii. Audit Committee reporting requirements – this should consider the appropriate level of information required by the Audit Committee to provide an overview of implementation status and to hold the Trust to account for timely implementation of recommendations.

Purpose

The purpose of this Procedure is to set out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit Reviews (signed off by the lead Executive Director);
- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;
- the role of the Audit Committee in:
    - receiving final Internal and External reports, alongside management responses and action plans;
    - being assured of the adequacy of the management response to issues identified by internal and external audit and the arrangements for monitoring respective actions going forward;
    - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
    - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
    - overseeing the closure of action plans;

- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations.

This procedure does not extend to the management of improvement actions arising from Regulatory Inspections or Independent Reviews (such as those undertaken by the Health Inspectorate Wales and Community Health Council). The nature of which are dealt with under a separate process and overseen by the Trust's Quality, Safety and Performance Committee.

The Role of the Board in respect of Internal and External Audit

As set out within Standing Orders, the Board is expected to set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and

objectives. The Board shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers. In doing so, the Trust shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee.

The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards.

The Board will also seek assurance from the work carried out by external audit on the adequacy of the Trust's assurance framework. However, that external assurance activity shall

not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

The Role of the Audit Committee

The Codes of Conduct and Accountability for NHS Trusts and the Code of Conduct for NHS Managers Directions 2006 [WHC (2006) 090] establishes the requirement for every NHS Board to establish an Audit Committee, and this has been incorporated into Standing Orders for Trust.

The Audit Committee supports the Trust Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an effective system of assurance.

The Audit Committee's primary role is to ensure the system of assurance is valid and suitable for the Board's requirements. The Audit Committee will

review whether:

- The system of assurance is appropriate for the organisation;
- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

In fulfilling its role, the Audit Committee will rely on the organisation's internal arrangements and take into account audit work.

The role of Internal Audit

Internal Audit is a key source of independent internal assurance to the Trust Board and Accountable Officer (Chief Executive Officer). The Public Sector Internal Audit Standards (PSAIS_1_April_2017.pdf (publishing.service.gov.uk)) describe the role of internal audit as enhancing and protecting organisational value by providing risk-based and objective assurance, advice and insight.

As such, its role embraces two key areas:

1. The provision of an independent and objective opinion (the Head of Internal Audit Opinion) to the Accountable Officer, the Trust Board, and the Audit Committee based on an objective assessment of the framework of governance, risk management and control; and

2. The provision of an independent and objective advisory service, with the aim of supporting management to improve governance, risk management and control and contributing to the overall opinion of the Head of Internal Audit.

The Public Sector Internal Audit Standards provide an essential reference source for the Audit Committee in understanding what it can expect from internal audit and also when assessing the service provided.

To support the system of assurance, Internal Audit will develop a risk based annual internal audit plan which details all the audit reviews to be undertaken in the coming financial year.

The Role of External Audit

The Auditor General for Wales (the Auditor General) is the external auditor of NHS Wales. The statutory duties of the Auditor General in respect of individual NHS bodies fall under two broad headings – to review and report on:

- The audited body's financial statements, and on its Annual Governance Statement; and
- Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The external audit role is exercised in accordance with statutory provisions and the work of external auditors is subject to the 'Code of Audit Practice of the Auditor General for Wales' (Code of Audit Practice | Audit Wales) and 'the Statement of the responsibilities of the Auditor General for Wales and of the bodies that he or she audits'.

The Auditor General's representatives (the External Audit Team) will develop an annual audit plan designed to deliver a safe opinion on the accounts and to enable the Auditor General to draw conclusions on whether the NHS body has made proper arrangements for securing economy, efficient and effectiveness in its use of resources.

The audit plan will also cover issues such as regularity, propriety and value for money.

In developing the annual audit plan the Auditor General's representatives will take into account the audit needs of the organisation, using a risk-based approach.

Internal and External Audit Reports and Management Responses/Action Plan

For each review in both the internal and external audit plans, an audit report will be issued which includes an assurance opinion on how effective the internal controls are in the scope of that review.

Draft reports are issued to management to support discussion and a review for factual accuracy. Management responses and responding action plans are then developed, particularly in response to any recommendations that may have been made. Officers should use the draft report clearance process to highlight for the attention of auditors any concerns they have about the wording, practicality or relevance of audit recommendations.

When developing the management response and action plan, management must ensure consideration is given to the capacity and costs required to deliver the actions and any associated risks, ensuring value for money. Where actions require capital investment, consideration also must be given to managing the risk in the interim as capital funding to enable progress may not be available within the timescales committed to in the management

response. In these circumstances, other action should be taken to manage the risk which must also be detailed in the action plan and, where appropriate, be added to operational risk registers.

There may also be occasions where recommendations fall outside the gift of the division/directorate/service/team audited to implement and therefore other functions within the Health Board, for example corporate teams such as Digital, W&OD or Estates, will be required to develop appropriate actions for management responses, and be responsible for the delivery of these. Management responses must:-

- respond directly to the finding and its recommendation(s);
- provide specific actions that the Trust commits to take to correct the finding;
- exclude information that is not pertinent to the finding or its corrective action plan;
- identify a specific individual for the implementation of an action;
- provide a specific and realistic timetable for implementation;
- be SMART (Specific, Measurable, Achievable, Realistic, with a clear timeframe);
- be approved by the relevant Executive Director prior to finalising with internal or external audit; and
- be provided to internal audit by the agreed deadlines contained in our Internal Audit SLA:
    - responses within 15 working days of receipt of draft audit report
    - final responses following issue of final audit report within 5 working days

It is also important to assess at an early stage, whether or not the recommendations can be actioned by the Trust alone or whether implementation is outside of the Trust's direct control because of the involvement and dependency on third parties. Such situations should be made clear at the outset (to both auditors and the Committee) and should be formally recorded in updates to the tracking database.

Once the management response and action plan has been approved by the relevant Director and has been accepted by the respective audit team as addressing the risks or control weaknesses and the timescales are acceptable, the report is issued as final.

The Board Secretary (Director of Corporate Governance) and Executive Director of Finance will via the BSO Finance maintain an Audit Action Tracker of all Internal and External Audit Reports, with each report once Final added to the tracker inclusive of management responses/action plans. The BSO Finance will check that all recommendations and management actions have been included within the Tracker, including recommendations and actions raised in follow up reports. The Board Secretary (Director of Corporate Governance) or Executive Director of Finance and Executive Lead will review the Audit Action Tracker to confirm that all actions from the Audit Report have been added to the tracker.

A copy of each report is then presented to the Executive Management Board (EMB) and Audit Committee at its next available meeting. The Audit Committee will be required to know the level of assurance that has been given, the recommendations for improvement that have been made to management, and management's response and actions. In this way the EMB and Audit Committee will receive prompt notification of internal audit findings and assurances.

A flowchart setting out the process for the management of audit reports when issued is set out at **Appendix 1a**.

Monitoring Implementation of Internal and External Audit Recommendations

An important responsibility of the EMB and Audit Committee is to monitor the implementation of agreed audit recommendations through management actions. The EMB and Audit Committee should ensure the organisation adopts a robust process for monitoring the implementation of agreed actions and that regular progress reports are provided to the EMB and Audit Committee identifying any that have not been implemented within agreed timescales and what the corrective action will be and by when.

The process for monitoring and reporting progress against the implementation of internal and external audit recommendations within the Trust will be led by the Board Secretary (Director of Corporate Governance) and Executive Director of Finance.

The key principles associated with the monitoring of internal and external audit recommendations include:

- Audit Recommendations, management responses & actions will be added to the Audit Action Tracker, once the final Audit Report has been received by the EMB and Audit Committee;
- Executive Directors will be responsible for respective audit recommendations management responses & actions and ensure oversight of progress within respective teams;
- The EMB and Audit Committee will monitor progress against the implementation of all audit recommendations, regardless of Internal Audit priority rating (high, medium, low and not rated), as set out in Appendix B;
- Progress against the implementation of all audit recommendations should be monitored through appropriate meetings:
    - Divisional performance reviews;
    - Corporate Directorate team meetings;
    - Operational Management Group; and
    - Divisional SLT / SMT
    - Directorate / Department team meetings
- Executive Directors, with their teams, will be asked to update on progress against the implementation of audit recommendations as the completion date arises and an update will be reported to the next meeting of the Audit Committee;
- Executive Directors will be responsible for approving the closure of audit recommendations, which will be subject to reporting to the Audit Committee;
- The Audit Committee will focus its attention at each meeting on:
    - actions that are overdue - Implementation date passed management action not complete (RED)
    - actions that have been completed during the last reporting period which require review and agreement to close; and
    - the number of audit actions that are not yet due for completion:

- actions on target to be completed by agreed date (YELLOW)
- actions not on target for completion by agreed date (AMBER)

- the Audit Committee will undertake an in-depth review of all actions in the Audit Action Tracker twice-yearly and review in detail only overdue and completed actions for approval to close and note a summary of actions not yet completed in the other two meetings each year;
- the Audit Committee can if necessary assign recommendations and associated management response and actions to other Committees to provide scrutiny and oversight, as well as the tracker being reviewed regularly by the Executive Management Team via EMB;
- the Executive Team via EMB RUN will undertake an in-depth review of all actions in the Audit Action Tracker four times a year prior to each Audit Committee meeting;
- the Executive Team at each EMB RUN will review:
    - each action that is overdue (RED) and discuss and agree what corrective action is required to complete each action and what the revised completion date for each action
    - the quality of action updates and where not considered of sufficient standard agree a timescale for the Executive Lead for the action to provide via their team a revised update
    - justifications for extensions to deadlines to ensure they are appropriate and agree revised deadline to be requested from audit committee
    - actions recommended for closure and ensure that there is a summary of actions completed and that the risk(s) identified in the audit has been mitigated or removed
    - new actions linked to action that has previously been closed on the tracker OR previous action is re-raised in a new report, to ensure there is additional scrutiny and oversight that the new action is implemented effectively and addresses the related risk.
- The Audit Committee will be asked to approve the revision of any previously agreed completion dates within action plans, on the advice of internal or external audit;
- Internal and External Audit Teams will assess the position against previous audit recommendations as part of any relevant follow-up audit work.

Where the Audit Committee or Head of Internal Audit/External Auditor are concerned about the lack of implementation of audit recommendations in a particular area, the Audit Committee has the authority to invite the respective Director to attend and provide an update. This will be with a view to ensuring risks and identified weaknesses in internal control are mitigated, recognising that the actions will have been approved by the Director and their management team.

Where it is possible to do so, as part of the updates to the Audit Committee, and particularly as part of a proposed closure of recommendations, reports will confirm that the risk(s) the actions have been designed to remove or mitigate have been addressed and provide an

indication of the impact that implementing the recommendation will have had on the Trust in terms of:

- quality & safety improvement;
- better outcomes;
- the provision of more efficient and effective patient care or blood supply chain;
- improved governance;
- increased security;
- better use of resources etc.

A flowchart setting out the process for the Monitoring Implementation of Internal and External Audit Recommendations is set out at **Appendix 1b**.

Appendix 1a

Management of Internal and External Audit Reports and Management Responses

Internal and External Audit Reports and Management Responses/Action Plan

1. • Draft Internal / Extenral audit report issued to the Trust via the relevant Officer Lead(s) and Executive Director lead(s) identified in the the Audit Report and copied to the Board Secretary (Director of Corporate Governance) and Executive Director of Finance

2. • Officer Lead to consider draft findings for accuracy and populate the management response ensuring the principles covered within the procedure and adhered to

3. • Draft Management Responses to be reviewed and approved by the lead Executive Director

4. • Management responses sent back to relevant audit team at latest by agreed response timescale
• Internal Audit: The KPI for report turnaround between issuing the draft report and receipt of initial management responses is a maximum of 15 working days. There is allowance of a further 5 working days from issue of final report for management responses

5. • Auditors issue final report (including management responses) to the respective Officer Lead(s) and Executive Director lead(s) and copied to the Board Secretary (Director of Corporate Governance) and Executive Director of Finance

6. • Board Secretary (Director of Corporate Governance) or Executive Director of Finance ensures Final Report:
  • is logged on central register
  • is presented to EMB RUN and the next Audit Committee
  • is presented to to relevant other committees e..g Quality, Safety & Performance, Strategic Development Committee, TCS Scrutiny Committee

7. • Once Final Audit Report has been considered by the Audit Committee, the audit recommendations and manageemnt responses and actions will be transferred to the central Audit Action Tracker for monitoring & reporting

Appendix 1b

Monitoring Implementation of Internal and External Audit Recommendations

1. •Executive Directors will be responsible for audit actions they are identified lead and ensure oversight of progress in implementation within their teams

2. •Audit Committee will monitor progress against the implementation of all audit recommendations, regardless of Internal Audit priority rating (high, medium, low and not rated), as set out in Appendix B;

3. •Progress against the implementation of all audit recommendations should be monitored through appropriate meetings:Divisional performance reviews; Corporate Directorate team meetings; Operational Management Group; Divisional SLT / SMTDirectorate / Department team meetings

4. •Audit Committee will focus its attention at each meeting on:
   - •actions overdue - Implementation date passed management action not complete (RED)
   - •actions completed during the last reporting period which require review and agreement to close; and
   - •the number of audit actions that are not yet due for completion - on target (Yellow) & not on target (Orange)

5. •Audit Committee will undertake an in-depth review of all actions in the Audit Action Tracker twice-yearly

6. •Executive Team via EMB RUN will undertake an in-depth review of all actions in the Audit Action Tracker four times a year prior to each Audit Committee

7. •Executive Directors will be responsible for approving the closure of audit actions, which will be subject to review of the justification for closure & agreement by the Audit Committee

8. •Audit Committee will be asked to approve the revision of any previously agreed completion dates within action plans, on the advice of internal or external audit

Appendix 2

Prioritisation of Internal/External Audit Recommendations

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.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix C

Audit Action Tracker Proposed Summaries & Oversight Tables

Summary of Audit Reports and actions outstanding by audit financial year

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

Summary of change in total outstanding actions current Audit Committee from previous Audit Committee

Outstanding Actions Previous Audit Committee	
New Final Audit Report Actions added	
Completed Actions agreed by Audit Committee as CLOSED	
Other adjustments	
Outstanding Actions Current Audit Committee	

Summary of Actions by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete	Closed Actions
High						
Medium						
Low						
N/A (Advisory Audit)						
Total						
%						

Summary of Actions by Executive / Director Lead

Executive / Director Lead	Total	Implementation date passed management action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete	Closed Action
Executive Director of Finance						
Director of Strategic Transformation, Planning & Digital						
Director of Governance & Chief of Staff						
Director of Nursing, AHPs & Health Science						
Director of OD and Workforce						
Chief Operating Officer						
TCS n VCC Project Director						
Total						

Summary of Implementation date passed management action not complete by audit financial year

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

Summary of Implementation Date Extended by

Priority	Total	More than 24 Months	18 - 24 Months	12 - 18 Months	6 - 12 Months
High	0				
Medium	0				
Low	0				

N/A (Advisory Audit)	0				
Total	**0**	**0**	**0**	**0**	**0**
%	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Pre 2021/22 Audit Actions

- 2015/16
- 2019/20
- 2020/21

VUNHST Ref	Audit Title	Assurance Rating: Substantial Reasonable Limited No	Total Number of Audit Actions Arising from Review	Audit Actions Arising from Review				Audit Actions Implemented to date				Audit Actions Overdue (against original agreed timescale)				Audit Actions Not Yet Due				All Audit Actions Imple-mented
				H	M	L	Not Rated	H	M	L	Not Rated	H	M	L	Not Rated	H	M	L	Not Rated	
2015/16: EM2015.1	ESTATES MAINTENANCE - Dec 2015																			
2019/20: RM2019.5	RISK MANAGEMENT - May 2019	Reasonable																		
2019/20-2019/20-R3	Capital Systems: Financial Safeguarding	Reasonable																		
2020/21	Governance Arrangements during COVID-19 Pandemic	Advisory																		
2020/21	Velindre Cancer Centre - Divisional Review	Reasonable																		
2020/21	IM&T Control and Risk Assessment	Advisory																		
2020/21	New Velindre Cancer Centre Development Governance and Financial Management	Substantial																		
2020/21	Core Financial Systems	Reasonable																		
TOTAL			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2021/22 Audit Actions by Audit Report

VUNHST Ref	Audit Title	Assurance Rating: Substantial Reasonable Limited No	Total Number of Audit Actions Arising from	Audit Actions Arising from Review				Audit Actions Implemented to date				Audit Actions Overdue (against original agreed timescale)				Audit Actions Not Yet Due				All Audit Actions Implemented	Status
				H	M	L	Not Rated	H	M	L	Not Rated	H	M	L	Not Rated	H	M	L	Not Rated		
2021/22	Infection Prevention & Control	Reasonable	0																		Final report
2021/22	CaNISC Replacement	Reasonable	0																		Final report
2021/22	Divisional review – Incident Management	Reasonable	0																		Final report
2021/22	Divisional review – Risk Management	Reasonable	0																		Final report
2021/22	Use of Technology – Fit for the Future	Advisory	0																		Final report
2021/22	Board Committee Effectiveness	Reasonable	0																		Final report
2021/22	Trust Assurance Framework	Reasonable	0																		Final report
2021/22	Financial Systems	Reasonable	0																		Final report
2021/22	Charitable Funds	Reasonable	0																		Final report
2021/22	Scrutiny of Expenditure above £100,000	Reasonable	0																		Final report
2021/22	Disclosure Barring Service Checks	Reasonable	0																		Final report
2021/22	Follow-up	Reasonable	0																		Draft report
2021/22	Wellbeing of Future Generations Act	Advisory	0																		Fieldwork
2021/22	Ways of Working	Advisory	0																		Cancelled
2021/22	Quality & Safety Framework		0																		Deferred
2021/22	Private & Overseas Patients		0																		Deferred
			0																		
	Capital & Estates		0																		
2021/22	Estates Assurance – Waste Management	Reasonable	0																		Final report
			0																		
	New Velindre Cancer Centre Integrated Audit and Assurance Plan:		0																		
2021/22	Contract Management	Reasonable	0																		Final report
2021/22	Mutual Investment Model (MIM) Governance	Substantial	0																		Final report
2021/22	MIM Procurement		0																		Fieldwork
2021/22	Financial Reporting		0																		Fieldwork
2021/22	Design and Change Management		0																		Fieldwork
2021/22	Enabling Works		0																		Fieldwork
TOTAL			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

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Velindre University NHS Trust

Appendix D

IA proposals for Scenarios for recording actions in tracker

Scenario	Include in tracker	Status in tracker	Comments / Further action
1 Action identified as complete in the management response	Yes	Closed	For completeness and Audit Committee oversight All complete recommendations should remain on the tracker, although we would accept completed recommendations closed in previous years being transferred to a separate document to stop the live tracker from becoming unwieldy. For example, the current live tracker would contain all open recommendations and any recommendations closed during 2022/23. Recommendations closed in 2021/22 and before would be in the separate closed recommendations document.
2 New action linked to other still open recommendation(s)	Yes	Open	This could be the case with a recommendation in a follow-up report / section but could also be the case in a standard report. Actions required: • Executive Lead and Responsible Individual to assess whether the new and existing recommendations should be combined. • Audit Tracker update section should be explicit as to any decisions taken on both the new and existing recommendations. • If recommendations are ultimately combined, one could be closed (provided the justification is explicit – see the above bullet) and the related action moved into the one that remains open, rather than having to continuously cross-reference between the two until closed.
3 New action linked to action that has previously been closed on the tracker OR	Yes	Open	This is likely to be in a follow up report, where the Responsible Individual has deemed the action to have been previously completed but our current testing has identified otherwise OR

Scenario	Include in tracker	Status in tracker	Comments / Further action
previous action is re-raised in a new report.			where we have found the action taken has not addressed the original risk. Actions required: Executive Lead and Responsible Individual to ensure the new / re-raised actions are implemented effectively and that the related risk has been addressed.

Appendix E

2021/22 Internal Audit Follow up audit: Audit Action Tracking Previous Recommendations (VEL2122-16)

- **Clarity of Executive oversight for management responses and action updates**

    - The Executive Leads for Internal Audit reports have not been sighted on the requests for updates, or the updates provided, to the Tracker, therefore are unable to effectively hold responsible individuals to account to provide clear, appropriate responses or ensure timely implementation of actions.

- **Authority to request updates to management responses and action updates**
    - The individual who is responsible for requesting updates (the BSOF) does not have sufficient authority to request updates to the Tracker, which has led to difficulty in obtaining timely and adequate updates for reporting to the Audit Committee and, in some instances, has led to no responses being reported against some recommendations.

- **Enhancing information for Audit Committee reporting:**
    - **Recommendations included in reports**: The Audit Committee only receives the full Tracker annually. At other meetings it only receives updates on overdue (red) and closed (green) recommendations. There is a risk the Audit Committee is not able to effectively hold the Trust to account on timely implementation of recommendations not yet completed or past the target date.

    - **Tracker cover report:** The Tracker cover report only details the key to the status of recommendations on the Tracker. It does not provide sufficient information to give an overview of the status of recommendations on the Tracker, e.g., it does not give an indication of the number of recommendations on the tracker or an analysis of those recommendations and changes since the previous update.

- **Maintenance of clear update history**
    - **Ability to effectively monitor progress / trends**: The Tracker only contains the current and previous update, all updates prior to this are deleted (although are maintained through previous iterations of the Tracker). It is difficult to trace continued progress against recommendations through to completion and trends in lack of progress may not be identified. All previous updates should be retained on the Tracker spreadsheets.

    - **Loss of information:** The approach to deleting recommendations once they have been completed and reported to the Audit Committee means the audit trail for completed recommendations is difficult to trace. Additionally, important information

may be lost from the spreadsheet for recommendations with multiple management responses where part of the response is closed but part remains open.

- Comparing the January 2022 Tracker status for the 18 recommendations followed up during 2021/22 work to the findings of previous audit work:
    - **Tracker status differs to their findings:** 7 recommendations had been closed on the Tracker, but audit work found them to be partially implemented (2 recommendations), superseded (2 recommendations) or not implemented (2 recommendations); and
    - **Recommendation not on Tracker:** for 1 recommendation, which audit classed as not implemented based on their work, audit could not locate it on the Tracker spreadsheet or Tracker reports to the Audit Committee.

- Audit traced 5 recommendations sampled as part of the 2021/22 Follow up: Previous Recommendations audit to the Tracker progress updates, noting:
    - **Lack of clarity in updates and closure justification:** Updates where deadlines have passed often do not include clear requests or justifications for an extension to the deadline or indicate the updated target date. Similarly, explanations for closing recommendations often do not clearly state the action taken or justification for action closure.
    - **Actions going missing from Tracker**: For 2 recommendations, actions sometimes went missing from the Tracker spreadsheets and Audit Committee reports without explanation, despite deadlines having passed and the recommendation not being closed. Sometimes (but not always), these actions reappeared in subsequent Tracker spreadsheets / reports.

    - **Incorrect update:** For 1 recommendation, the updates provided in the Tracker spreadsheet and Audit Committee reports referred to another recommendation and did not address the recommendation they had been provided against**.**

    - **Differing treatment of identical responses:** For 1 recommendation, one part of the four-part management response was identical to a management response on another recommendation but was treated differently on the Tracker (similar updates were provided, but one action was closed on the July update whilst the other remained open until the October 2021 update).

    - **Common themes not being addressed:** Through audits review of the Tracker spreadsheets / reports and the findings of 2021/22 Internal Audit reports, they note there appears to be a commonly recurring theme regarding Datix training in our audit findings, both in current and previous years.

Internal Audit conclusion was that these findings demonstrate a need to strengthen Executive oversight and accountability in the Audit Action Tracker process. It recommended:

- The Trust should develop a documented process for the governance of its Audit Action Tracker
- The Audit Committee should approve the Audit Action Tracker Governance process
- The approved process should be communicated to all relevant staff, for example, through inclusion of a link when Internal Audit (or other reports) are sent out
- The Trust should undertake a thorough review of the current Tracker
- That all action updates (not just the previous two) should be kept in the Audit Tracker to create a more robust audit trail and allow for effective trend monitoring
- The Tracker spreadsheet includes closed recommendations / actions rather than deleting them
- 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 (recommendation 2018 R4b)

The impact of these recommendations not being implemented is a potential risk of:

- failure to implement agreed audit recommendations in a timely manner;
- increased financial, clinical, statutory and reputational risk for the Trust; and
- inaccurate reporting of the Tracker within the Trust.

AUDIT COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	19.07.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	This is a public document

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

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
EMB Run	01.07.2022	Endorsed by EMB

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

1. SITUATION AND BACKGROUND

The purpose of this report is to:

- Summarise the final phase in implementing the Risk Framework.
- Consideration of the Trust Risk Management Policy for Trust Board approval
- Share the May extract of risk registers to allow the Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Key Points for the Committee:

1. There has been good progress on completing the final phase of the risk framework implementation, as outlined in section 3.

2. Recommend the Trust Risk Management Policy for Trust Board endorsement. Attached, Appendix 1. This Policy has been through Divisional consultation and has been endorsed by the Executive Management Board.

3. Although the extract of the May risk register for 20 and 16 level risks is included, to note that for the purpose of Audit Committee, this is in the context of the operating effectiveness overview of the framework, rather and specific oversight of the risks included.

3 RISK FRAMEWORK

An overview of the development of the risk framework forms part of the Level 2 and 3 training modules:

Risk and Assurance Programme of Work under scope of Organisational Design Programme
Now-ish
Risk Policy
New Policy
Embedded Policy
Clear roles and responsibilities
Defined clearly
Strong risk management culture for all staff
Risk governance
Defined and operating Board, Exec and SLT/SMT
Embedded through all governance
Risk Procedures/ SOPs
New Trust Level Procedure – linking to Divisional/ subject matter SOPs
Delightful experience for staff
Risk Registers
Datix 14 risk management tool, transparent reporting
Management, management, management
Trust Assurance Framework
Strategic risk, 1/2/3 LOD Assurance Mapping, Control effectiveness assessment
Triangulated quality, performance risk and assurance framework
Training
Level 1-3 Training
Strong risk management culture for all staff

Progress during the period:

Policy & Procedure

The new Risk Management Policy has been completed and been out for consultation. The policy has been endorsed by the Executive Management Board and will be received by the Audit Committee for endorsement for Trust Board approval in July.

In addition, a new Corporate Risk Management Procedure has been finalised and will be distributed in line with approved Policy in August.

Training

Management Level 2 Training module is being rolled out. Over 100 staff trained to date over 7 sessions. Remainder are being scheduled. Most to complete by mid-August however there will be an opportunity for final wash up sessions in early September, to reflect the holiday period for staff.

Management Level 1 training has been finalised and will be rolled out on ESR from late August, following the completion of the bulk of the level 2 training. This sequencing is important to ensure that managers are clear on the processes and their roles prior to all their teams being trained.

Leadership Level 3 is near complete, with Trust Board, Executive Management Board and Velindre Cancer Centre Senior Leadership Team having received their training. Transforming Cancer Services Leadership Team session is confirmed for August and Welsh Blood Service Senior Management Team slot is being confirmed for the same period.

DATIX 14

Welsh Blood Service on track for transition of all new risk activity from end July.

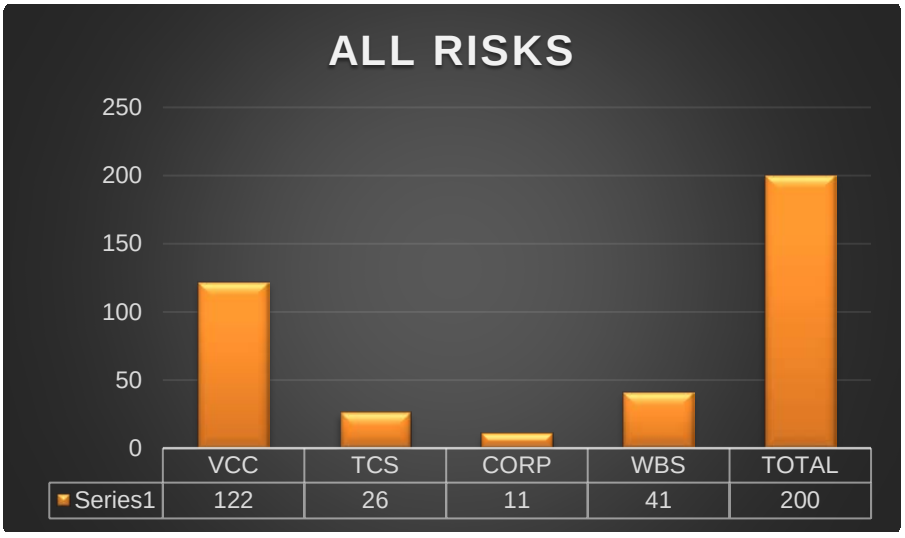
4. THE TRUST RISK REGISTER

For the Committee to note that following oversight at Executive Management Board there were two risks areas that were requested to be assessed and reflected in the next reporting period as appropriate: firstly regarding service SACT capacity risks; and secondly ensuring the workforce and finance triangulated identified risks are appropriately reflected in DATIX.

Secondly, in terms of the formatting of this report, the focus over the previous period has been the completion of the risk framework implementation. It is recognised that this cover paper is not currently in most effective format as the clarity on SMART action plans is not being demonstrated in the way in which the data is being pulled from DATIX. This will be rectified for the next reporting period.

Risks by level

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



2.1.3 Analysis of risks

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

Risks level 25

There remain no level 25 risks up to 31st May 2022.

Risks level 20

ID	Division	Review date	Title	Risk (in brief)	Rating (current)	Rating (Target)	RR - Current Controls
2400	Transforming Cancer Services	01/08/2022	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	6	No changes made to current risk ratings as no review & confirmation undertaken by Risk Owner whilst Project remains On Hold. 1) Project Manager role currently going through recruitment process – September 2) Outcomes of Programme Stocktake (July) will inform governance structure of TCS & VF Programmes - September
2529	Velindre Cancer Centre	01/08/2022	There is a risk that the e-film service operated in xray within VCC may fail as a result of unsupported hardware and software.	The device is used when importing images from Oncology and from outside of NHS Wales. In addition, it's also used to push images back to the Oncology service. It is the only way staff can import images off Radiology CT /MRI/ scanners that fall outside of Fuji PACS. There is no resilience, backup, business continuity or disaster recovery plans in place should the device and/or e-film software fail. Merge, the company who produce e-film software are no longer supporting ANY version of the software from 30 June 2022, therefore a new solution will need to be sought.Any migration to a supported solution will need to be done in advance of the aforementioned date, which needs to be considered.	20	1	Operationally, no controls are in place to prevent the risk from happening.

Risks level 16

ID	Division	Opened	Review date	Risk (in brief)	Rating (current)	Rating (Target)	RR - Current Controls
2200	Velindre Cancer Centre	30/08/2022	01/08/2022	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.	16	6	13/6/2022 Update - Ongoing monitoring of capacity, demand breaches and waiting times targets. Development of breach escalation process to ensure, where needed patients are prioritised effectively. - Extended working hours are in place on the treatment machines and in many other areas of service. - Agency Radiographers are in place to support additional hours. Assessment of potential Agency staff experience at point of hire to ensure that Agency staff are able to rotate around more than one work area / linac type / OMS type within department. - Changes made to RT Booking processes, and staff flexibility used to maximise use of resources. - Understand and prioritise activities that promote wellbeing in the team. Diverse training sessions held to enhance mindfulness, wellbeing, and resilience. - Review of dose & fractionation, plan complexity and recruitment at clinical trials is being reviewed by SST's and Clinical Director. - Revisit maximising capacity document. - Reassess potential to outsource patients.
2211	Velindre Cancer Centre		01/08/2022	Digital Health & Care Record (DH&CR - Canisc Replacement) programme. DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	12	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

2326	Velindre Cancer Centre		01/08/2022	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live.A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	9	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.
2402	Transforming Cancer Services		01/08/2022	Project 5 – Outreach - There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	9	No changes made to current risk ratings as no review & confirmation undertaken from Risk Owner whilst Project remains On Hold.
2454	Corporate Services		01/08/2022	There is a risk that the Digital Services team are unable to support agreed Divisional and/or Trust strategic and operational objectives as a result of limited capacity within the team, which may lead to a delay in the delivery of new / updated digital services.	16	8	Head of Digital Delivery and Head of Digital Programmes developing resource and financial strategy, to present to DoF and EMB in Q1 2022/23. Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.

3 IMPACT ASSESSMENT

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

4 RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the on-going developments of the Trust's risk framework.
- **ENDORSE** for the Risk Management Policy for Trust Board approval

Velindre University NHS Trust
Risk Management Policy

v. 1.0

Contents

1. Purpose of this Policy

This Policy provides an overarching and strategic level document for the framework of managing risk in Velindre University NHS Trust.

The primary objective of the Policy is to support staff across the Trust to identify and manage the risks that may prevent the achievement of the Trust's objectives. This includes assessing risks to patient and donor safety, compliance across our legal and regulatory frameworks and risks attached to our key dependencies, core processes, stakeholder expectations and in so doing, the achievement of Trust Strategy. It is also important to emphasise that the Trust's commitment to quality and safety is the 'golden thread' throughout the organisation and recognise the key role that a strong risk management culture has in that. As with everything the Trust does, this is achieved by putting our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving.

The Policy aims to deliver a pragmatic and effective multidisciplinary approach to risk management which is underpinned by a clear accountability structure through the organisation. It recognises the need for robust systems and processes to support the continuous and ever-changing nature of risk. The Policy requires individuals throughout the Trust to embed risk management in their day to day activities and support better decision making through a deeper understanding and insight into risks and their potential impact.

2. Scope

VUNHST's Risk Management Policy represents compulsory minimum standards. Activities and functions in and out of scope are outlined below:

In scope

All members of staff

This Policy represents compulsory minimum standards in risk management. It applies organisation wide to all members of staff, those seconded to work in the organisation, and contractors engaged by us in every aspect of their work including all programmes and projects.

All activities, services and new initiatives (projects) across VUNHST's managed Departments and Divisions, including the Velindre University NHS Trust Charity

All activities of the Trust are in scope of the Policy. This includes assessing risks to patient and donor safety, compliance across our legal and regulatory frameworks and risks attached to our key dependencies, core processes, stakeholder expectations and in so doing, the achievement of Trust Strategy. The 10 year Trust Strategy was approved by the Trust Board in January 2022:

Our Purpose: To improve lives

Our Vision: Excellent care, Inspirational Learning, Healthier People

Our Strategic goals – by 2032 we will be recognised as:

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.

Hosted Units

Velindre University NHS Trust is 'Host' to a number of external organisations:

The Directors sign an annual Governance Compliance Statement to support the Trust Chief Executive in signing the Trust's Annual Governance Statement.

Each hosted organisation has its own risk register. Risks are only be escalated to the Trust risk register where matters directly affecting the Trust's statutory hosting role are apparent. Matters relating to service delivery and performance are a matter for the hosted organisation to receive, manage, and escalate as necessary to the relevant sponsor body.

This Risk Management Policy is applicable to hosted organisations. Supporting procedures and guidance for hosted organisations which align to this Policy are referenced in section 4.

All domains/categories and levels of risk

A risk is "*an uncertain event or set of events that, should it occur will have an effect on the achievement of objectives*". The Trust faces numerous levels of risk in delivering on objectives; these can relate to strategic challenges, our tactics/programmes, clinical and operational matters, compliance with laws, statutory duties and reporting obligations.

The Trust categorises risks across eleven Domains: quality; safety; compliance; research and development; reputation; performance and service sustainability; financial sustainability; workforce; environment; information governance; and partnerships. All types of risk are in scope.

Out of direct scope

Issue management, Incident Reporting and Investigations

Issues are managed and reported on separately through various means, including concerns, performance, quality, incident and change management reporting.

For clarity a risk as an event that has not happened yet whereas an issue as something that already has happened.

Although these matters are out of the direct scope of this Policy, there are some key considerations regarding the importance of linking between these matters. For instance, risk assessment is an integral part of the overall incident management process and as a result of the risk assessment, there may be risks identified which then would fall into the scope of this Policy. For details of the incident reporting and investigation process,

please refer to the Trust's Incident Reporting and Investigation Policy (including Serious Incidents) and any supplementary guidance in this area.

3. Why do we manage risk?

It is also important to consider the importance of risk management in the context of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Having a strong foundation of risk management across the organisation is crucial to improving the quality of health care services. These three core "whys" form an important part of the Trust's training of staff in risk and underpin the strong risk culture the Trust is continuing to develop.

1. **Duty of Quality – "First do no Harm"**
   - All staff in the Trust make risk-based decisions everyday.
   - Donor, patient and staff safety must come first.
   - The Trust has statutory duties for legal compliance, financial stewardship, environment and information governance.

2. **Evidence based decisions**
   - Allows a structured approach to support decisions at all levels.
   - Allows proportionate decisions to be made.

3. **System, process and product design and validation**
   - System and process controls should be used appropriately to prevent risks through mitigation or early detection.
   - Process validation should provide assurance that risks have been mitigated.

4. What this Policy does

The Policy is a key component in the Trust's risk management framework. As such it:

- promotes consistency and transparency by articulating an overarching framework for managing risk and establishing a common risk language across Trust;
- explains how the three lines of defence operates;
- explains how risk management is aligned to the governance structures across the organisation;
- defines risk management roles and responsibilities for individuals and teams within VUNHST;
- ensures that risk management processes support and align with the overarching strategy for the Trust, in which the golden thread is our commitment to quality and safety, ensuring that we put our patients and donors at the centre of everything we do;
- recognises that timely and accurate monitoring, review, communication and reporting of risk are critical to providing:
  - early warning mechanisms for the effective management of risk occurrences
  - assurance to our patients and donors
  - assurance through governance structures to the Trust Board and to our partners/stakeholders such as Regulators and Inspection bodies
  - a sound platform for organisational resilience
- supports decision-making through risk based information;
- and supports the continued development a culture where proactive risk management is integrated into all Trust business.

5. Components of the Risk Management Framework

Risk management framework requirements	Description
A **risk management Policy** in place, approved by the Trust Board and communicated to all staff	This Policy provides an overarching and strategic level document for the framework of managing risk in the organisation. It is formally reviewed every two years, or upon significant change. Any changes require endorsement from the Audit Committee and approval from Trust Board. *This Policy.*
Clear **roles, responsibilities and accountabilities for risk management** established	We have clear risk management roles, responsibilities and accountabilities across the organisation, both at individual role level and through governance arrangements. *Outlined in this Policy and guidance to support in Trust Risk Management Procedure.*
Established **Risk governance** arrangements	Our organisational structure helps us manage risk effectively. A 'three lines of defence' model ensures clear accountability and expectation for risk management. This gives departments / divisions and hosted units autonomy for identifying, managing and reporting risk, as the first line of defence; with our central functions, for instance, governance, digital, workforce, quality & safety etc providing oversight, forming the second line of defence; and internal audit, Audit Wales, Regulators and other Inspectors providing independent assurance, as the third line of defence. The following is also in place: • Governance structures and terms of references; • internal risk reporting requirements, specifically the reporting and escalation of key risk information through the governance structure on a monthly basis; • procedures for responding to urgent incidents and external events; • external reporting, disclosures and certification. *Outlined in this Policy and guidance to support in Trust Risk Management Procedure.*

High level **risk appetite** statements and risk tolerance limits should be in place for principal risk categories/types.	The Trust has a clear approach to risk taking and innovation, outlined within the Risk Appetite Strategy: • **Risk appetite statements** align with the organisation's strategic objectives, and this is structured according to risk domains; • **Embedding risk appetite through the organisation**, including in decision making, delegation frameworks and risk reporting levels through governance levels. *See Risk Appetite Strategy.*
A Trust level **risk management procedure** available to guide staff in identifying, assessing, treating, reporting and communicating risks	A Trust level risk management procedures is in place for use by all teams to outline the Trust level principles and processes in identifying, analysing, managing, monitoring and reporting on risks impacting on objectives. This includes guidance on using the risk quantification matrix, which assesses the impact if a risk is not well managed and the likelihood of the risk occurring. It also includes details of how reporting operates through the governance structures of the organisation. *See Trust Risk Management Procedure.*
Specific Divisional or Subject Matter procedures and guidance	Where appropriate, and aligned to the Trust level risk management procedure referenced above, there are Standard Operating Procedures and guidance documents to support different parts or subjects within the Trust. Examples include: Welsh Blood Service Standard Operating Procedure for Risk Management; Health & Safety guidance for specific risk assessment requirements; Transforming Cancer Services programme guidance to support project teams; and Hosted Organisations procedural documents. A central register of these aligned procedures and forms will be maintained as an appendix to the Trust level risk management procedure, which will include document owners, review timeframes and version control. *See Trust Risk Management Procedure.*
Risk registers recorded on Datix and managed through governance arrangements.	Our departments and divisions are each accountable for managing their risks and maintain a **record of these risks on Datix**. Major programmes and/or projects will also have risk registers where necessary again recorded on Datix. Hosted organisations arrangements for recording of risks are set out in their procedural level documents. *See Trust Risk Management Procedure for details.*

Trust Assurance Framework (TAF): Regular evaluation of the nature and extent of strategic risks that the Trust is exposed to, the adequacy of key controls, sources of assurance and commentary against any gaps in control or assurance are provided	The Trust has also developed a Trust Assurance Framework, in order to identify the key strategic risks and track the insight gained from first, second and third Line of Defence assurance against these risks. The Framework also monitors and transparently records the progress in managing the design and operating effectiveness of the control framework for these strategic risks. The Trust Assurance Framework is considered by relevant Committees and also by Trust Board. *See Trust Assurance Framework.*
Opportunities for **training** and shared learning on risk management provided	A variety of risk training materials tailored to the various audiences within the Trust. *See risk management training material, as outlined in Trust Risk Management Procedure.*

6. Risk governance

Risk governance and the internal control system

Velindre University NHS Trust recognise that risk governance is a fundamental part of its organisational governance and broader internal control system. Risk governance refers to the architecture within which risk management operates in our organisation and is fundamental to the day-to-day running of the Trust.

Good risk governance should therefore:

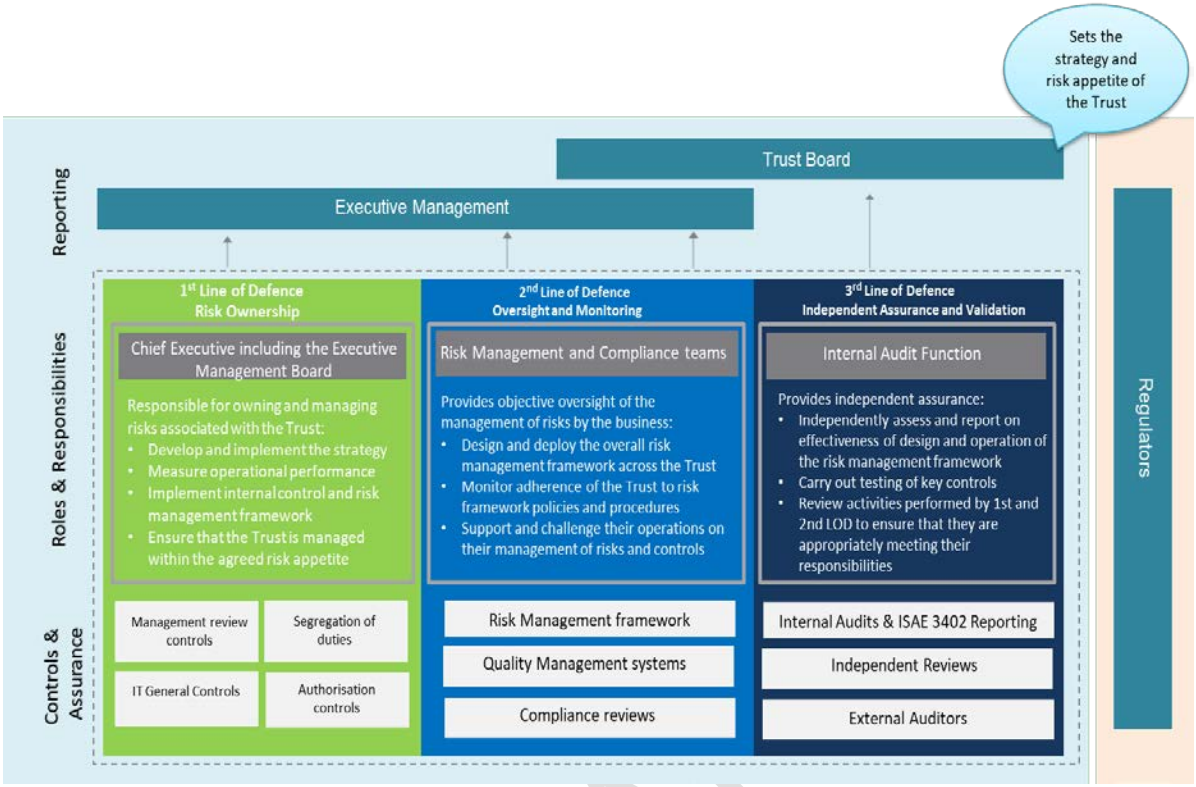
- put in place a structure of risk responsibility throughout the organisation so that everybody is aware of their own risk responsibilities and accountabilities and those of others with whom they work
- establish clear and effective lines of communication up and down the organisation and a culture in which good and bad news travel freely
- result in risk being accepted and managed within known and agreed risk appetites.

Three lines of defence risk governance model

The Trust operates the three lines of defence model, which is a leading practice in risk governance, to help ensure segregation between direct accountability for risk decisions, oversight and assurance.

Figure 2 below illustrates the three lines of defence summarising reporting responsibilities and roles within the Trust.

Figure 2: VUNHST's three lines of defence model



The first line of defence

The first line of defence relates to functions that own and manage risk. Staff and managers working in departments and divisions have direct ownership, responsibility and accountability for identifying, managing and controlling risks to their objectives. Assurance is provided through the monitoring and reporting of risk and control activities through senior leadership and management team meetings. This is ongoing.

The second line of defence

The second line of defence relates to functions that oversee or specialise in risk management and compliance. They guide, support and challenge the first line by bringing expertise and subject matter knowledge to help ensure risks and controls are effectively managed and assured. The corporate governance team and other internal oversight teams such as divisional risk teams, digital, performance and business planning, finance and workforce and organisational development, among others, form the second line of defence and are responsible for co-ordinating, facilitating and overseeing the Trust's effectiveness and integrity.

The third line of defence

The third line of defence relates to functions that provide independent assurance. It provides assurance to senior management and the Board over both the first- and second-lines' efforts. It is independent of the design, implementation, control and operation of control activities and they are not permitted to perform management or operational functions. This is a crucial part of the model and helps protect objectivity and independence.

Internal audit and external scrutiny through Audit Wales provide independent assurance and challenge concerning the integrity and effectiveness of risk management and internal control. The independent audit team will, through a risk-based approach, provide assurance to the Boards and senior managers. This will include assurance on the effectiveness of the first and second lines of defence. Audit Wales will review and report on internal controls over financial reporting. Assurance is provided through monitoring and reporting of strategic/corporate risk and control activities through the Audit Committee. In addition the third line of defence includes assurance from regulators and inspectors.

7. Key accountabilities, roles and responsibilities

Risk management is a core responsibility, and staff at all levels are responsible for being risk aware and for implementing the framework. Key risk management roles, responsibilities and accountabilities are summarised as follows:

Governance Roles

Board

The Board has overall responsibility for risk management and will ensure our risk management approach is appropriate by considering whether the Trust Risk Register and Trust Assurance Framework identify principal areas of risk against objectives and that adequate risk mitigation strategies have been designed and implemented to manage all identified principal risks. The Trust Board is also responsible for reviewing the framework's effectiveness as assured by the Audit Committee. It sets the 'tone at the top' for risk management culture by setting risk appetite and explicitly considering risk when developing or updating the strategy, or when considering performance and/or major programmes of change.

Audit Committee

The Audit Committee reviews the adequacy and effectiveness of the risk and assurance frameworks across the Trust. Through a programme of work, it will review internal and external audit plans and monitor the effectiveness of risk reporting.

Internal Audit will provide assurance to the Audit Committee on the effectiveness of the Trust's Risk Management Framework and its application across the business. It will also use the outputs from the risk management framework to drive its assurance plan going forward throughout the year.

Quality, Safety & Performance Committee

The Quality, Safety & Performance Committee reviews the Trust Risk Register at each Committee. It provides: assurance to the Trust Board that the risk register appropriately reflects the most significant risks facing the organisation, through a Quality and Safety lens; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

Strategic Development Committee

The Strategic Development Committee reviews the Trust Assurance Framework at each Committee. See Trust Assurance Framework Strategy and Process for further details.

Other Board Committees

Other Board Committees provide assurance to the Trust Board, that the specific sections of the Trust Risk Register: appropriately reflects the most significant risks facing the organisation, in accordance to their scope; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

Executive Management Board

The Executive Management Board is responsible for overseeing the implementation of the Trust's risk management framework, including defining, supporting, debating and challenging key risk and risk management activity across the Trust.

It reviews the Trust Risk Register each month and ensures that: the risk register appropriately reflects the most significant risks facing the organisation; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

Divisional Senior Leadership and Management Teams and Programme Boards

Divisional Senior Leadership and Management Teams and major Programme and Project Boards are responsible for managing the risks which fall within their respective areas in accordance to this Policy, the Trust Risk Management Procedure and Divisional/ Local Standard Operating Procedures.

Individual Roles

Executive Management Board Directors

Directors will support and promote risk management. They must ensure that risk management is integrated into all activities, and should demonstrate leadership and commitment by ensuring:

- their portfolios (department/division) implement this Policy;
- risk is considered when setting their objectives/drafting their business plan and discussed alongside their performance and in any local management meetings;
- all risks, controls and risk management issues under their control are adequately co-ordinated, managed, monitored, reviewed and reported/escalated in accordance with the requirements of this framework;
- necessary resources are allocated to managing risk/that they identify individuals who have the accountability and authority to manage risk under their control (i.e. risk owners).

Executive Lead for Risk Management Framework

The Director of Corporate Governance will act as the Executive Lead for the risk framework of the Trust. The Executive Lead will own the risk management framework and associated Trust level risk management procedures and is accountable for the strategic development of organisational risk management. Including arrangements for:

- Maintaining and updating appropriate risk management Policies and Procedures;
- Ensuring the Trust has a comprehensive and dynamic Risk Register by working with executive and divisional management teams to ensure that they understand their accountability and responsibilities for managing risks in their areas;
- Ensuring that risk is reported though, and challenged appropriately, through the governance structures of the Trust.

Risk Owner

A risk owner is the person who will be accountable if the risk occurs. Risk owners need to ensure: that the risks in their ownership are defined appropriately; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

All Managers and Staff

All managers are responsible for the local implementation of this Policy and associated Procedures and Divisional/Local Standard Operating Procedure documents.

All managers have a 'first line' responsibility for identifying, assessing and managing risk within their own area of responsibility, for implementing agreed actions to manage risk and for reporting activities or circumstance that may give risk to new or changed risk.

All staff should:

- Follow the Trust's risk management arrangements;
- Take action to protect themselves and others from risks;
- Identify and report risks in Datix;
- Attend appropriate training.

AUDIT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	1.7.22	Discussed and reviewed
Strategic Development Committee	9.7.22	Discussed and reviewed

1. SITUATION

1.1 As discussed in the previous Committee, the paper will be more clearly focused on the respective roles of the various parts of the governance structure.

1.2 Audit Committee has two key roles. Firstly as providing assurance to the Trust Board regarding the overall development and effectiveness of the Trust Assurance Framework. Secondly in terms of any of the principal risks that specifically fall within the Committee's scope, which is currently Risk 10 – Governance.

2. KEY POINTS FOR THE COMMITTEE

2.1 Section 3.1. describes the ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework within the Trust, with specific focus on the next three month period up to end of September 2022.

2.2 Update the Committee on the actions agreed in Executive Management Board on this paper which will further feed into the development programme of work. This is outlined in section 3.2.

2.3 In 3.3 the Governance strategic risk is summarised.

2.4 3.4 provides an overview of development of the Principal Risks and the appendix contains the complete latest view of the framework.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 **Key developments, previously noted to the Committee, and planned up to end September 2022 for October Committee reporting:**

3.1.1 **Link to Risk Register, Performance Framework and Quality Framework**

An important step in the development of the Trust Assurance Framework will be to develop the link between the Trust Risk Management Framework, Performance Management Framework and Quality & Safety Management Framework. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards.

The first step is to link the Trust Risk Management Framework and Trust Assurance Framework – and this work will be completed over the summer for October Strategic Development Committee reporting.

Following the development of the Trust Performance Management and Quality Management Frameworks, key metrics relating to the strategic risks will also be linked during Q3.

3.1.2 Reverse Stress Testing

Reverse stress testing is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability.

This work will be underway and reported to Committee in October. This work will progress in parallel with the review of the overall risk profile, as approaching the macro level risk questions in this way will be a useful tool and input into the annual review.

3.1.3 Link to Strategy Development

In reviewing the profile, in addition to the reserve stress testing exercise described above, there are two further key suggested inputs:

- Using research and insight on global organisational and health care trends to challenge and support our thinking on macro strategic risks.
- Frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then culminate into the October Committee reporting.

3.1.4 **Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.**

Following discussion and engagement with risk colleagues in other Health Boards across Wales and the identification and assessment of increased automation of the Trust Assurance Framework colleagues in the Datix team are liaising with the Hywel Dda Datix team regarding the development of principal risks within Datix Version 14.

Initial scoping work has taken place and a gap analysis and mapping exercise will take place in August in order to further progress this work.

3.2 **Further developments discussed and agreed in previous reporting period:**

In the July Executive Management Board discussion, the following actions were discussed and agreed:

3.2.1 **Actions on specific strategic risks**

As noted in section 3.4, Executive Management Board agreed that the scoring of the strategic workforce planning risk 03 needed to be reviewed, as consensus was the assessment was likely to result in an increased score.

Secondly that the organisational culture risk 04 needed to be linked more specifically to the development of the organisational design work.

3.2.2 **Mapping Trust Assurance Framework to governance cycle**

In line with Board development discussions with Internal Audit and Audit Wales during this period, there should be a clearer link between the Trust Assurance Framework. This will be progressed during the next reporting period. Work will include:

- Ensuring that cycles of business provide appropriate consideration of each of the TAF controls and sources of assurance.
- Mapping the relevant actions into governance cycles.

- Ensure each committee scrutinise progress to address gaps in controls and Assurances within it's scope.

3.2.3 **Link to Audit tracker**

Executive Management Board also agreed to map the Audit tracker to the third line of defence mapping in the Trust Assurance Framework in order to provide assurance that all current insight, including the impact of open actions on the effectiveness of the control framework, are taken into account.

3.3 **Principal Governance Risk – TAF 10**

3.3.1 Specifically within the scope of the Audit Committee is the Governance risk. Summary over the reporting period:

- ***Residual Risk Score*** – has remained the same at **12**.
- ***Overall Level of Control Effectiveness*** - has been assessed as 'Effective'. This remains unchanged since the last review.
- ***Sources of Assurance:*** the existing key controls in place remain unchanged since the last review.
- ***Action plan:*** the action plan remain unchanged since the last review. In future reporting cycles, the governance and assurance programmes of work under the organisational design programme will be reflected in the action plan.

Further detail is outlined in ***Appendix 1.***

3.4 **Trust Assurance Framework Dashboard**

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

3.4.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since May 2022 in respect of the following Principal Risks.

3.4.3 To note that in July the Strategic Development Committee, the summary of each strategic risk was discussed and reviewed, in line with the scope of that Committee to ensure that the Principal Risks are being managed in an effective way in order to enable the realisation of the Trust's strategic objectives.

			NO REVIEW TAKEN PLACE			
			REVIEWED NO CHANGES			
			REVIEWED AND UPDATED			
			MAR	APR	MAY	JUN
01	Demand and Capacity	**COB**				
02	Partnership Working / Stakeholder Engagement	**CJ**				
03	Workforce Planning	**SFM**				
04	Organisational Culture	**SFM**				
05	Organisational Change / 'strategic execution risk'	**CJ**				
06	Quality & Safety	**NW**				
07	Digital Transformation – failure to embrace new technology	**CJ**				
08	Trust Financial Investment Risk	**MB**				
09	Future Direction of Travel	**CJ**				
10	Governance	**LF**				

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 Committee is asked to:

a. **DISCUSS AND REVIEW** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in sections 3.1 and 3.2.

b. **DISCUSS AND REVIEW** the Principal Risk 10 – Governance

TAF DASHBOARD

DEMAND AND CAPACITY

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Blood stock planning and management function WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against national and international standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience and inform and predict any surge demand.	PA	Senior Management Team, COO review and EMB Review, QSP committee and Board.	PA	Welsh Government Quality, Planning and Delivery Review.	PA

TAF DASHBOARD

DEMAND AND CAPACITY

C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangement	Director WBS	X			E	Department Head review with escalation to Director	PA	Performance Report Senior Management Team and EMB Review, QSP committee and Board	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCC (VCS)	X	X		PE	SE Wales Group	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would need digital systems to be in place which are out of WBS control. Projects are progressing externally.	
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inapproprite use if blood, which impacts demand.	
Lack of visibility of granular level planning data and Health Board activity plans to clear backlog at VCC.	
Lack of a formal oversight of capacity and demand management at a divisional level to recognise the complexity of interdependencies of various functions and services at VCC.	Executive Team oversight of the more detailed capacity and demand plans

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

TAF DASHBOARD

DEMAND AND CAPACITY

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Project is underway in Cardiff and Vale, supported by WBS. Funding options are being sought	Dec-23
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Gap anaylysis is underway across Health Boards. The IBI lens will be used on this project	Dec-22
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Email sent via COO to each HB requesting further meetings to discuss data	Aug-22
A formal demand and capcity review meeting has been established at VCC	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently expericencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.		
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Aug-22			
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**		

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

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

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
1.1	System structures – core cancer services commissioning arrangements		X			PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
1.2	Strategic partnerships which support effective delivery of working/ work programmes			X		PE	Supply and demand reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Regulatory scope re MHRA tbc	PA
3.1	Local Partnership Forum		X	X		PE	Feedback from LPF	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				

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 and second lines of defence assurance are in place to a certain extent

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
Action Plan		**Owner**	**Progress Update**	**Due Date**
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete
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		Complete
1.3	Development of CCLG leadership and goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Complete

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS

SOURCES OF ASSURANCE

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

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA				
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	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	PA				
C9	Agile Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA				

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

WORKFORCE PLANNING

1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and the outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The Trust has appointed a staff psychologist to support mental health and wellbeing. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Trust has approved a set of Hybrid working principles. There are now task and finish groups working under the Hybrid working project to develop the operational systems and toolkits that will allow the Trust to fully relaise the benefits of hybrid working arrangements.	Dec-22

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA
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	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA

TAF DASHBOARD

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group	PA				
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	PA				
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	PA				
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	PA				
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board	PA				
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA				

TAF DASHBOARD

ORGANISATIONAL CULTURE

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

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 defence 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	Development of Organisationa Design approach for the Trust to encapsulate both process and cultural elements that need to be inplace to allow the organisation to achieve its strategic goals	Sarah Morley	Stakeholder engagement has taken place on the rationale for this work and an overview of some of the elements of work that may sit within it with the Executive Team, Divisional Senior Leadership Teams and the Board. Work has taken place to identify a Quality management System for the Trust. The scope of the programme and governance arrangements will be developed by August 2022, during which the timelines associated with the main elemtns will be determined.	Aug-22
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	It has been decided that the Trust Values Project will fulfill a wider brief under the Organisational Design Approach. Interviews are being put in place with Board members as first round of engagement activity.	Dec-22

TAF DASHBOARD 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	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Aug-22			

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

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x				Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.2	Integrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x				Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x		Executive Management Board review/ patient and donor feedback	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x			Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x				Executive Management Board review / staff feedback	IA	Strategy Committee/QSP/Internal Audt Review / CHC	IA	Audit Wales	IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x					IA	Internal Audt Review	PA	Audit Wales/HIW	PA

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enabkers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures (on track for September 2022)	Sep-22
Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022)	Sep-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate 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	Jun-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Aug-22	Goal 1		
EXECUTIVE LEAD	Nicola Willams			

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS

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

SOURCES OF ASSURANCE

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

TAF DASHBOARD

QUALITY AND SAFETY

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

TAF DASHBOARD

QUALITY AND SAFETY

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

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.									
LAST REVIEW	Jun-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe									
NEXT REVIEW	Aug-22										
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	3	4	**12**	

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA	Wales Audit Office	PA
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA	Wales Audit Office	PE

TAF DASHBOARD

DIGITAL TRANSFORMATION

C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PE
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PE
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital officer			X	PE	Review via Divisional SMT / SLT	PA	Review via EMB / Trust Board	PA	Wales Audit Office	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

TAF DASHBOARD

DIGITAL TRANSFORMATION

1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (on track for July 2022) (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (new CDO commences on 1st July - will pick up on appointment)	Oct-22

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.									
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Aug-22	**Goal 2**									
EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	4	4	**16**	3	4	**12**	

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

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

TAF DASHBOARD

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			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify 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.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Aug-22	**Goal 2**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			PE	Executive Management Board review	PA	Strategic Development Committee	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review	IA	Strategic Development Committeen and performance management framework	IA	Audit Wales Reviews	PA

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE	Executive Management Board review/ patient and donor feedback	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management	IA	Audit Wales/External Research organisations & Welsh	PA
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management Framework	IA	Audit Wales/External Research organisations & Welsh Government	PA
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review	IA		IA	Audit Wales/External Research organisations & Welsh Government	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppor	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions)
1.5	development of clinical and scientific strategy	Jacinta Abraham		tbc
1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions)

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.			
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience			
NEXT REVIEW	Aug-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	PA	Internal Audit of Board Committee Effectiveness	PA

TAF DASHBOARD

GOVERNANCE

								Trust Board		Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial 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 PA	IA	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA

TAF DASHBOARD

GOVERNANCE

C6	Quality of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role. IA	IA	Trust Board assessment via formal annual and additional effectiveness review exercises. IA	IA	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
None	Third line of defence 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.	Complete
Ongoing input from the Independent Members via the repurposed Integrated Governance Group		Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete

AUDIT COMMITTEE

AUDIT ACTION PLAN

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	01/07/2022	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

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

1.2 This report focuses on:

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

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

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

1.4 Audit Report actions that are not yet due for completion, those assessed as on track for delivery by the agreed date **(Yellow Status)** and those that are assessed as currently not on track for delivery by the agreed date **(Orange Status)** are not included in the Tracker, but a summary of the number of actions with this status are presented in this report.

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Context

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

2.1.2 Currently the Audit Committee only reviews all audit report actions once a year, which it undertook at its meeting held on 14 October 2021. This included **all** actions as at the 30 September 2021.

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

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

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

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

2.2 Internal Audit Actions Analysis

2.2.1 6 audit reports were added to the Audit Action Tracker following the May 2022 Audit Committee and consisted of 27 recommendations of which 17 were medium priority and 10 low priority. In response to these recommendations management identified 58 actions in total, of which 34 were medium priority and 24 low priority. The 6 reports added were:

- nVCC MIM Governance
- nVCC Contract Management
- Financial Systems 2021-22
- Scrutiny of Expenditure >£100k
- DBS Checks
- Charitable Funds

Review	Status	Rating	Summary of Recommendations			Total	Audit Committee
			High	Medium	Low		
Infection Prevention & Control	Final report	Reasonable		4		4	Oct-21
CaNISC Replacement	Final report	Reasonable		2	1	3	Oct-21
Divisional review – Incident Management	Final report	Reasonable		4	1	5	Oct-21
Divisional review – Risk Management	Final report	Reasonable		2	2	4	Oct-21
Use of Technology – Fit for the Future	Final report	Advisory				0	Jan-22
Board Committee Effectiveness	Final report	Reasonable		2	4	6	Jan-22
Trust Assurance Framework	Final report	Reasonable	1	2		3	Jan-22
Financial Systems	Final report	Reasonable		5	2	7	May-22
Charitable Funds	Final report	Reasonable		4	6	10	May-22
Scrutiny of Expenditure above £100,000	Final report	Reasonable		2		2	May-22
Disclosure Barring Service Checks	Final report	Reasonable		2	2	4	May-22
Follow-up	Draft report	Reasonable	1	2		3	Jul-22
Wellbeing of Future Generations Act	Fieldwork	Advisory				0	Jul-22
Ways of Working	Cancelled	N/A				0	
Quality & Safety Framework	Deferred	N/A				0	
Private & Overseas Patients	Deferred	N/A				0	
Capital & Estates							
Estates Assurance – Waste Management	Final report	Reasonable		4		4	Oct-21
New Velindre Cancer Centre Integrated Audit and Assurance Plan:							
Contract Management	Final report	Reasonable		3		3	May-22
Mutual Investment Model (MIM) Governance	Final report	Substantial		1		1	May-22
MIM Procurement	Fieldwork						Jul-22
Financial Reporting	Fieldwork						Jul-22
Design and Change Management	Fieldwork						Jul-22
Enabling Works	Fieldwork						Jul-22
Total			**2**	**39**	**18**	**59**	
Final Report			**1**	**37**	**18**	**56**	
Draft Report			**1**	**2**	**0**	**3**	

2.2.2 Considerable effort has been made by Management / Officer leads to complete actions since the May Audit Committee which has resulted in 78 Internal Audit actions being completed and recommended for closure.

2.2.3 The table below provides a summary of the movement in total internal audit actions from May '22 to 14th July Audit Committee:

Outstanding Actions May '22 Audit Committee (All actions excluding CLOSED – Blue)	84
Add: New Final Audit Report Actions added	58
Less: Completed Actions agreed by Audit Committee as CLOSED	(15)
Add: 3 Green that had been deleted since January 2022 meeting and never got closed.	3
Outstanding Actions 19th July Audit Committee (All action excluding CLOSED – Blue)	130

2.2.4 The tables below provide a summary of the audit action status position as at 14th July 2022 and that reported at the May '22 Audit Committee to provide an indication of the changes.

May '22 Audit Committee – Internal Audit

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

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports	1	3	7	7	**18**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE	1	3	20	60	**84**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete May 2022
High	3	1			2
Medium	42	19	7	4	12
Low	25	9	8	2	6
N/A (Advisory Audit)	14	10			4
Total	**84**	**39**	**15**	**6**	**24**
%	**100%**	**46%**	**18%**	**7%**	**29%**

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete May 2022
Executive Director of Finance	5	2			3
Director of Strategic Transformation, Planning & Digital	22	13			9
Director of Governance & Chief of Staff	24	5	15		4
Director of Nursing, AHPs & Health Science	6	1		4	1
Director of OD and Workforce	0				
Chief Operating Officer	25	17		1	7
TCS nVCC Project Director	1			1	
Chief Operating Officer and Director of Governance & Chief of Staff	1	1			
Total	**84**	**39**	**15**	**6**	**24**

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

Priority	2015/16	2019/20	2020/21	2021/22	Total
High			1		1
Medium	1	2		16	19
Low			1	8	9
N/A (Advisory Audit)			10		10
Total	**1**	2	12	24	39

2.2.5 In the action tracker presented to the May '22 Audit Committee there were 84 actions in total from 18 Final Audit Reports.

2.2.6 There were 39 actions (46%) for which the implementation date had passed and management action was not complete (Red). There were requests to extend the implementation dates for some of these, which were agreed, but the majority did not have a formal request to extend the deadline. The Audit Committee agreed a deadline extension to the July Audit Committee where no specific request had been made.

2.2.7 There were 15 actions (18%) not on target for completion by the agreed date (Orange) and 6 actions (7%) on target for completion by the agreed date (Yellow).

2.2.8 24 Actions (29%) were identified as compete (Green). The Audit Committee agreed to formally close these actions.

July '22 Audit Committee – Internal Audit

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

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

Action Status by Prioritisation Timescale

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

Action Status by Executive / Director Lead

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

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

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

2.2.9 There are 78 actions (60%) since the May '22 Audit Committee that have been completed. There are recommendations to the Audit Committee to close these actions.

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

2.2.11 It is important to recognize that high levels of sickness above normal (pre Covid-19 levels) continues to impact on service delivery and completion of audit actions.

2.2.12 Further work will be undertaken to explore how feasible it is to provide details on the number of months action dates have been extended by.

2.3 External Audit Actions Analysis

2.3.1 Management / Officer leads have completed 1 further action since the May Audit Committee which is recommended for closure.

2.3.2 The tables below provide a summary of the audit action status position as at 14th July 2022 and that reported at the May '22 Audit Committee to provide an indication of the changes.

May '22 Audit Committee – External Audit

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

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports		1			**1**

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

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete
High	1	1			
Medium	1	1			
Low	1				1
N/A (Advisory Audit)	0				
Total	**3**	**2**	**0**	**0**	**1**
%	**100%**	**67%**	**0%**	**0%**	**33%**

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete May 2022
Executive Director of Finance	1	1			
Director of Strategic Transformation, Planning & Digital	1				1
Director of Governance & Chief of Staff	1	1			
Total	**3**	**2**	**0**	**0**	**1**

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

Priority	2015/16	2019/20	2020/21	2021/22
High		1		
Medium		1		
Low				
N/A (Advisory Audit)				
Total	0	2	0	0

2.3.3 In the action tracker presented to the May '22 Audit Committee there were 3 actions in total from the 2019/20 Structured Assessment Final Audit Report.

2.3.4 There were 2 actions (67%) for which the implementation date had passed and management action was not complete (Red). The Audit Committee agreed a deadline extension to the July Audit Committee.

2.3.5 1 action (33%) was identified as compete (Green). The Audit Committee agreed to formally close this action.

2.3.6 The tables below provide a summary of the position as at **8th July 2022**

July '22 Audit Committee – External Audit

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

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

Action Status by Prioritisation Timescale

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

Action Status by Executive / Director Lead

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

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

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

3. IMPACT ASSESSMENT

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

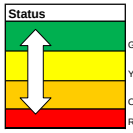
4. **RECOMMENDATION**

4.1 The Committee are asked to **NOTE** the contents of the report and the assurance it provides regarding the activities undertaken to address audit recommendations.

4.2 There are 78 Internal Audit report actions (60%) and 1 External Audit report action since the May '22 Audit Committee that have been completed **(Green Status)**. The Committee is asked to **APPROVE** closure of these actions. If agreed these actions will be formally Closed (**Blue Status)**

4.3 There are 18 Internal Audit report actions (14%) and 1 External Audit report action that have passed their agreed implementation date (**Red Status)** which the Executive / Director lead is seeking extensions to the completion date. The Committee is asked to **APPROVE** the extension dates identified and where there has been no date identified agree extension to the next Audit Committee meeting in Oct '22.

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

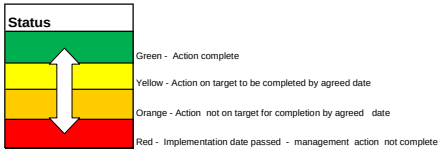
Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Velindre UNHSTrust

INTERNAL AUDIT - ESTATES MAINTENANCE - Dec 2015 AC					Assurance Rating:			Date received at Audit Committee:			
Column1	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
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.	Carl James, Director of Strategic Transformation, Planning & Digital	Stephen Lloyd Now undertaken by Jason Hoskins, Assistant Director	~~31st August 2016 AC agreed extension of date to April 2017~~ ~~31st May 2018~~ ~~September 18~~ ~~31st March 2019~~ ~~30 September2019~~ ~~September 2020~~ ~~December 2020~~ ~~March 2021~~ **Extension requested to 31 May 2021. Update 08 Jul 2021: Extention to 30/11/2021.**	Complete	Ongoing. Significant process made in this area including completion of engagement process with the wider organisation on support strategies	Further engagement is planned for the new year in support of adopting this strategy. Strategy documentation due to be finalised and presented to EMB and Board during Q4 2021/22. Implementation expected Q1 2022/23	Consultation has taken place surrounding the strategies, and comments from earlier EMB have been included in the latest itterations.. The Estates strategy will formally be presented to EMB and Board for sign off in Q1	Complete: Estates Strategy has been signed off by Trust Board May 2022
	Total Number of Actions		1								

Audit Action Plan



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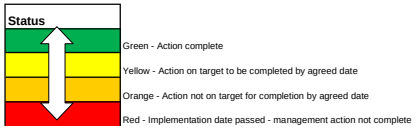
INTERNAL AUDIT -RISK MANAGEMENT					Assurance Rating: Reasonable			Date received at Audit Committee: 01/05/2019			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
RM2019.5	Management needs to ensure that formal Risk Management training is provided for relevant staff that have responsibility for identifying new risks, carrying out risk assessments and updating the DATIX system. Management should review the arrangements in place for the provision of Risk Management advice.	Medium	A Training Needs Assessment (TNA) will be completed to identify training requirements for relevant staff who have responsibility for identifying new risks, carrying out risk assessments and updating the DATIX system. A review of the arrangements in place for the provision of Risk Management advice will be undertaken as part of a wider Executive/Director portfolio review.	Lauren Fear,Director of Corporate Governance & Chief of Staff	~~Lisa Heydon~~ This action now falls with Lauren Fear, Director of Corporate Governance & Chief of Staff	Extention to 30 June 2022 requested.	Overdue	• Datix form finalised • Training to be completed by end Nov 2021 • Approach to migration of risks from version 12 of Datix module to version 14 of the module to be agreed and implemented in full for VCC and Corporate - WBS in plan to follow by end November • Updated to risk Policy package, including user guides etc, to be refreshed through Trust Board November 2021	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development Junesession.	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.
			Total Number of Actions	1							

Audit Action Plan



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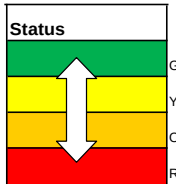
Final External Audit Report - WAO - Structured Assessment 2019 /20					Reasonable Assurance			Date received at Audit Committee:			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
2019-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& Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	Extention to 30 June 2022 requested. Update May 2022: Extension Requested to 19 July 2022	Overdue	a and b complete, regarding finalising framework and completing a first version of the BAF- and c, regarding training for Board, execs and staff.	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.
	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.	High		Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	No progress (overdue) No progress has been made on this recommendation. Update May 2022: Extension Requested to 19 July 2022	Complete			As part of its 2021/22 follow-up on prior year recommendations review, Internal Audit is considering the appropriateness of action updates provided on the recommendation tracker and will provide recommendations on the Audit Tracker process, including sharing learning from other NHS Wales organisations. This work was nearing completion at the time of writing and will be reported to the 19 July 2022 Audit Committee.	1) E-mails are sent from the DoF seeking updates from responsible officers to actions. These e-mails set out the requirement to privde as summary of the actions taken to respond to the audit recommendation and request to close the action 2) Paper setting out proposed changes to Audit Action Tracking proces and draft procedure for teh process are presented to the Audit Committee in July '22
			Total Number of Actions	2							

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Priority
Low
Medium
High

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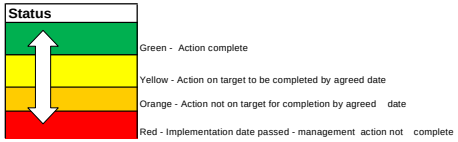
Final Internal Audit 2019/2020 - Capital Systems: Financial Safeguarding					Assurance Rating: Assurance			Date received at Audit Committee: Jan 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
2019/20-R3	When selecting contractors to include in a quotation/tender exercise, new contractors should be periodically invited, to re-test the market and ensure best value for money is being achieved	Medium	An approved list of Contractors will be prepared that will be updated on a 3 year basis, with options to extend for a further 2 years.	Carl James, Director of Strategic Transformation, Planning& Digital	Jason Hoskins, Assistant Director of Estates, Environment and Capital Development	~~01/09/2020~~ ~~DECEMBER 2020~~ ~~MARCH 2021~~ Extension requested to 30 JUNE 2021. **Update 08 July 2021: Completion Date April 2022.** Update May 2022: Extension Requested to 19 July 2022	Complete	this exercise is ongoing with a number of meetings being undertaken between procurement and estates identifying the needs of the framework	The process is still underdevelopment with a view that the sytems will be in place by the April deadline	Estates supported by procurement colleagues have engaged an alternative route to market through a professional services frame work which has seen the introduction of new suppliers supporting the delivery of the capital programme. The current market position is extremely challenging but the adopted approach has been hugely successful with recently tendered works having favourible returns including new suppliers. Procurement colleagues are seeking a longer term solution which is being explored. Extension Requested to 19 July 2022	Complete. The work in partnership with Gleeds has provided the a range of additional firms which has been used to update the approved contractors list to ensure VFM is tested. t is worth note that all tenders are presented to the open market to encourage competition as part of the procurement strategy. Further work will be undertake to develop this with a series of supplier days over the coming months to establish relationships with local SME's, to ensure the supplioer base is expanded further.
			Total Number of Actions	1							

Audit Action Plan



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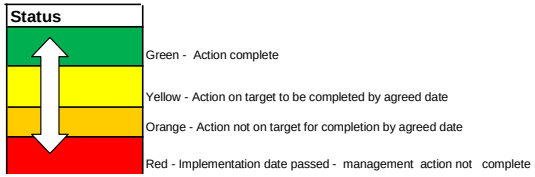
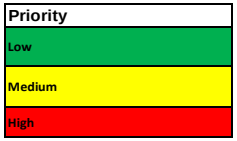
INTERNAL AUDIT - Governance Arrangements during COVID-19 Pandemic:				Advisory Audit				Date received at Audit Committee:			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
11	**Information Governance** * The need to maintain privacy in the household when using video conference/telephone call or other applicable work from other household members. * Ensuring that laptops are locked when not in use/away from the desk. This is even more important in a public environment if agile working is to be promoted, for example, coffee shops. Consideration could be given to reducing the screen lock functionality within Windows. * How physical copies of information are held and how they should be securely stored away from other household members/visitors. * The risk that staff using their own devices at home are potentially more susceptible to malware/phishing attacks, as they may have insufficient security on their phones/home computers etc. This is likely to be more relevant with people able to access the OneDrive/Office 365 with just an internet connectionfrom any device.	N/A		Matthew Bunce , Executive Director of Finance	Ian Bevan, Head of Information Governance	30/06/2021. **Update: 08 July 2021: Extention to 30/09/2021.** **Update October 2021 meeting: Extension agreed 31 December 2021 Estimated Completion 31 January 2022.** **Extention requested to May 2022.** **Extension requested to July 2022**	Complete	New Information Governance Manager start date is not yet confirmed, but will hopefully start in the next two months and take forward this action as they start.	The Head of IG came in to post on 29 Nov 21. A review of all IG policies is underway with the aim of bringing them up to date, aligning them with UK GDPR (Post-Brexit) and include remote working considerations. The estimated completion date is 31 Jan 22. The first Policy to be reviewed is the Data Protection Policy, the draft of which now incorporates significant changes in an expanded Section 6 (Training, Awareness and PracticalConsiderations). The revised Policy includes all of the recommended points from the Internal Audit report (Column B) as well as other additlonal practical remote working considerations which will be cross referred across all IG policies. Training will be delivered in the new year to "bolt on" to the existing ESR package to support Policy and to re-inforce remote working considerations on a risk-based approach basis (i.e. - areas within the Trust which present the highest risk/balanced against compliance data).	The policies are being worked on with the aim of getting them to EMB during May 22.	IG policies and cover paper which gives overview of changes to Policies submitted to EMB Run for approval on 1st July 2022. Policies submitted are: • Data Protection and Confidentiality Policy • Records Management Policy • Confidentiality Breach Reporting Policy • Freedom of Information Act Policy All policies have been through a socialisation process within the Corporate area, WBS and VCC.
			Total Number of Actions	1							

Audit Action Plan





Velindre UNHS Trust

Final Internal Audit Report 2020/2021 - Velindre Cancer Centre Divisional Review			Assurance Rating: Reasonable					Date received at Audit Committee:			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
		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 & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	Extention to 30 June 2022 requested. Update May 2022: Extension Requested to 19 July 2022	Overdue	Datix form finalised • Training to be completed by end Nov 2021 • Approach to migration of risks from version 12 of Datix module to version 14 of the module to be agreed and implemented in full for VCC and Corporate - WBS in plan to followby end November • Updated to risk Policypackage, including user guides etc, to be refreshed through Trust Board November 2021	Recommend Training completed by end March 2022 in line with current service pressures.	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.
		Total Number of Actions	1								

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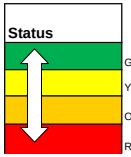
Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

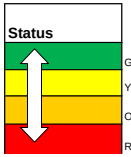
Red - Implementation date passed - management action not complete

Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Advisory Report					Advisory Audit			Date received at Audit Committee: 22 March 2021			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
4	Departmentally managed systems should comply with good practice for the management of ICT. Digital services should produce good practice guidance documentation for the Trust overall, with all departments required to comply for areas such as: • BYOD; and • Change control.	N/A	Revised governance arrangements (including the establishment of a Digital Programme Board) will set out the approach for how all departments are required to implement and manage ICT. Where relevant, appropriate documentation will be developed by the Digital Services team to ensure staff are aware of their responsibilities and that clear roles and responsibilities between the Digital Services team and other departments are clearly set out.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	New Trust governance procedures in the process of being established, yet to be formalised - anticipate new arrangements will be stood up in Q3 2021/22. Work to compile good practice guides yet to commence, but planned to be completed before year end.	Awaiting confirmation of revised Trust governance procedures.	Awaiting confirmation of revised Trust governance procedures. Extension Requested to 19 July 2022	Completed: appropriate documented procedures in place for management of ICT within Digital Service, managed in line with ITIL Service Management arrangements. Recommendation not related to overall goverance arrangments / new ways of working change programme not connected to this recommendation
5	Work on the digital strategy should be completed. This work should include an evaluation of the current position of the Trust in relation to both the external environment and current ways of working in order to provide a baseline position from which to work.	N/A	A refreshed Digital Strategy to be approved by the Trust Board following a process of engagement and consultation with stakeholders.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 3 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022.	Digital Strategy scheduled to be presented for Trust Board approval in May 2022. Extension Requested to 19 July 2022	Action completed - Digital Strategy approved at May 2022 Trust Board.
6	The development of the digital strategy should consider the wider digital strategy implications and the supporting digital infrastructure. Consideration should also be given to establishing a strategy governance and management group such as a Digital Programme Board to oversee, coordinate and prioritise digital strategy issues.	N/A	A new pan Trust Digital Board will be established for the Trust to oversee and coordinate the digital strategy.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 3 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	New Trust governance procedures in the process of being established, yet to be formalised - anticipate new arrangements will be stood up in Q3 2021/22.	Awaiting confirmation of revised Trust governance procedures.	Development of proposal to establish Digital Strategy Group to deliver digital strategy developed: to be discussed with Executive Management Board in May 2022 Internal discussions commenced with a view to establish an interim group who can perform this role. Extension Requested to 19 July 2022	Complete: Digital Strategy approved in May 2022. Wider Trust governance arrangements under ongoing discussion. Consideration of need to establish Trust-wide Digital Board discussed with CEO as part of new organisational design (will be taken forward within Q5 / organisational design work)
7	The current position of the Trust should be assessed in relation to the target digital position and the required changes across the business, information, data, applications and technology domains identified, together with the benefits of each change and the implication of a lack of change.	N/A	An assessment of the target Digital position to commence with the approval of the Trust Annual Plan 2021/2022, and then subsequently reviewed with the launch of the new Digital Strategy and reflected in the Digital work plan and completion of the Integrated Medium Term Plan / Annual Plan for 2022/2023.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	In progress - to be completed by end of Q3 2021/22.	Digital Strategy scheduled to be published in March 2022.	Digital Strategy scheduled to be presented for Trust Board approval in May 2022. Extension Requested to 19 July 2022	Completed - Digital Strategy approved at May 2022 Trust Board.

THIS IS AN ADVISORY AUDIT

Audit Action Plan



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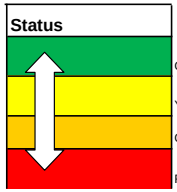
Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Advisory Report					Advisory Audit			Date received at Audit Committee: 22 March 2021			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
17	business critical activities, based on a BIA, and which identifies key stakeholders. This should describe potential disruptive scenarios, the mitigations in place and the residual impact over time. The level of continuity provided should be described in terms of RTO / RPO and discussed with user departments. Options should be provided for departments to move to a greater continuity position if required and the level of provision should then be agreed with departments an executives.	N/A	In progress Business Impact Assessment for Infrastructure complete Digital Services business continuity plans to be developed and fully tested	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2020/2021 Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Complete	Digital Services BIA completed - March 2021. Development of Digital Services MI Comms & Response procedure being drafted via Trust BC Group. BC arrangements across VCC under review - Digital Services are supporting discussions, as required. BC arrangements for WBS defined.	As per October 2021 update.	Digital Service BIA completed, due to be refreshed in 2022/23. Cyber Security and IT Business Continuity Incident Response Plans re-drafted, to align with national response plans. To be reviewed (for approval) in May 2022 QSPP Committee. Extension Requested to 19 July 2022	Action completed - incident response plans approved via QSP Committee in May 2022.
18	A formal Project Management SOP should be developed which sets out the requirements for managing projects, including how and when agile methodologies may be used.	N/A	Standard Operating Procedures for Project and Programme Management will need to be aligned with wider Trust Programme Offices. Work has commenced on the standardisation of roles and templates. SOP will be developed as part of this work programme.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022	Complete	In progress - work aligned to the creation of a Transformation Office and alignment with the Programme Management Offices within each service / directorate. Awaiting confirmation of funding for the Trust wide function	As per October 2021 update.	As per October 2021 update.	Completed: Digital SOP developed as interim, whilst Trust-wide approach considered. Process being established for accepting new projects outside of annual plan. New Service Request Form drafted and new internal digital governance structure agreed for the management and prioritisation of these requests, whilst ensuring to link with WBC SMT and VCC Velindre Futures.
			Total Number of Actions	6							

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

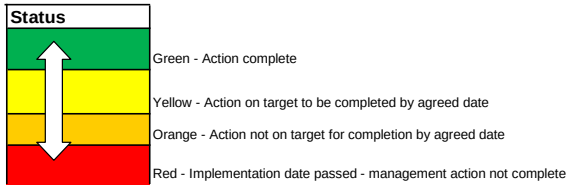
Orange - Action not on target for completion by agreed date

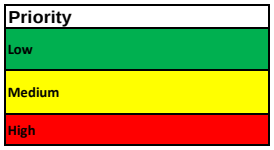
Red - Implementation date passed - management action not complete

Velindre UNHS Trust

INTERNAL AUDIT - Core Financial Systems					Assurance Rating: Reasonable			Date received at Audit Committee: 21 January 2021			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update October 2021 Audit Committee	Update January 2022 Audit Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
5	The Financial Department should introduce a rolling programme of budgetary management information training in place for new budget holders	Low	The recommendation is accepted. The Finance Department will introduce training for new budget holders as suggested	~~Mark Osland, Executive Director of Finance~~ Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/05/2021. **Update 08 July 2021: Extension agreed to 31/12/2021.** **Update October 2021: Extension agreed to 31 March 2022.** **Update May 2022: Extension Supported to Sep 2022**	Complete	Training materials and subsequent roll out plan remain in development. Budget Holders (new and existing) are met with on a regular basis and direct training issues addressed, bespoke awareness session provided to aspiring leaders/managers. **Extension required to March 2022**, in view of optimising potential face to face/Teams facilitation and a core comprehensive programme of core competencies (assesment and training) for budget holders.	No update provided, intention remained to have a developed budget holder training programme and initiate rollout.	Extension requested to Sept 2022, comprised of Q1 focus on development of training materials (part completed) and Q2 rollout (additionally, dedicated sessions for non budget holders planned May and Oct). Delays resultant from focus to support services at peaks of high pressure due to pandemic. Additionally, a rollout of training at peak times of elevated staff absences within services was not deemed appropriate.	Extension Supported at May 2022 Audit Committee. New Budget Holders have received direct Financial support and training once in post. Financial Awareness session provided to INSPIRE cohorts of developing managers in May 2022. Refresher programme for existing budget holders provided as Business as Usual.
			Total Number of Actions	1							

Audit Action Plan

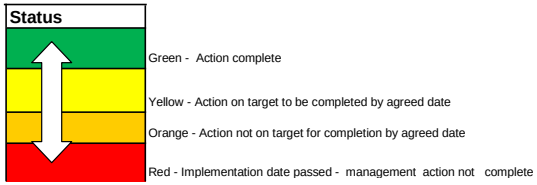




Velindre UNHS Trust

Infection Prevention and Control Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	**Recommendation**	**Priority**	**Management Response**	**Executive/Director Lead**	**Responsible Manager/Officer Lead Department where lead works**	**Agreed Implementation Date**	**Status**	**Update for January 2022 Committee**	**Update May 2022 Audit Committee**	**Update July 2022 Audit Committee**
	Policies and Procedures (Operation). 1.1 The Corporate IPC Team should ensure that there is a programme of on-going review for IPC policies and SOPs, ideally on a three-year cyclical basis in line with good practice guidance.	Medium	1.1 The policy reviews were delayed due to re-prioritisation of IPC Team to ensure the Trust staff, patients & donors remained safe throughout the pandemic. As we have moved into wave 2 recovery there has been capacity for the team to commence the reviews. Two have been completed and the third commenced. All current out of date corporate IPC policies and procedures will be formally reviewed and changes approved.	Nicola Williams, Director of Nursing, AHPs & Health Science	Muhammed Yaseen, Head of Infection Prevention & Control	March 2022 Update May 2022: Extension Requested to 19 July 2022	Complete	The appropriate policies are being revised and the drafts will be circulated for comment at the Trust Infection Prevention and Control Management Group (IPCMG) meeting on 22nd January 2022.	Two of the three outdated policies were updated and approved by QSP on 24th March. The third MRSA policy is will be submitted to EMB on 24th April 2022. Extension Requested to 19 July 2022	Revised IPC policy review and monitoring mechanism in place since April 2022
			Total Number of Actions	1						

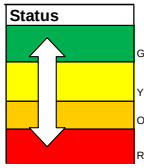
Audit Action Plan



Velindre UNHS Trust

Digital Health & Care Record for Cancer (Canisc Replacement) 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	Business Continuity Departmental Plan (Design). a. The Trust should ensure each affected department is aware of the changes and has considered the risk assessment in relation to changes in procedures and processes.	Low	a. Following the established process for approving ways of working, all changes to operational process will be approved at a workstream and project board level prior to transition from Canisc to WPAS &WCP.	Cath O'Brien, Chief Operating Officer	Paul Wilkins, Interim Director of VCC	29/05/2022	Complete	The majority of the new ways of working and process maps have been signed off by the by the operational leads and ratified by the Project Board. The remaining processes are dependent on the delivery of software from Digital Health & Care Wales.	**Closed** Impact assessments are in progress and full plans for their completion are in place. The go live implementation plan will include consideration of the impact of change. These cannot be fully completed as subject to interative change through the life cycle of testing and user acceptance in line with standard procedure for implementation of software.	n/a - Complete May 2022
	b. Once formally approved changes to procedures and processes are documented and a revised business continuity plan should be prepared and distributed.	Low	b. The business continuity plans will be approved via the Senior Leadership Team	Cath O'Brien, Chief Operating Officer	Paul Wilkins, Interim Director of VCC	29/05/2022	Complete	The operational leads and Senior Leadership Team will approve the business continuity plans in line with any changes to ways of working.	5/7 disaster recovery plans have been approved within Directorates. The remaining 2 are being refreshed currently. Again, this will be an interative ongoingprocess.	**Complete.** Operational business continuity plans are in place which are being reviewed in light of 'go live' planning. These operational plans have been implemented on many occasions during previous issues with CANISC reliability. A 'go live' plan and associated risk assessment is under development working closely with the Digital Programme team and are being managed as part of the ongoing programme.
			Total Number of Actions	2						

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Priority
Low
Medium
High

Velindre UNHS Trust

Waste Management - Reasonable Assurance 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	Policy & Procedures (Design). 1.1.a The new Trust-wide waste policy should ensure all key elements of WHTM 07-01 guidance are incorporated.	Medium	1.1.a Accepted - the WHTM will be incorporated in the revised Waste Management Policy.	Carl James, Director of Strategic Transformation, Planning & Digital	Rhiannon Freshney, Environmental Development Officer	December 2021	Complete	COMPLETE - Included in the DRAFT Waste Management Policy, which is currently with te Estates Management Group for review.	COMPLETE - The Waste Management Policy is currently under EQIA review	n/a - Complete May 2021
	1.1.b Associated Division policy / procedural documents should be updated to ensure alignment with the overarching policy or removed from publication if no longer applicable.	Medium	1.1.b Accepted. Corporate policy documents will be updated in accordance with the Waste Management Policy. VCC and WBS procedural documents will be updated in accordance with the revised Waste Management Policy and procedures.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	December 2021 Update May 2022: Extension Requested to 19 July 2022	Complete	Current Divisional Waste Management procedure has been updated and follows our Trust Policy, with the addition of audit waste Audit schedule. The WBS procedure will be updated to incorporate any changes in line with the Trust policy.	COMPLETE - VCC procedure aligned with Trust Policy Clinical waste Training and the WBS Clincal Waste disposal SOP is currently being reviewed by the WBS H&S and Environmental Compliance Manager along with relevant managers. Extension Requested to 19 July 2022	COMPLETE - VCC procedure aligned with Trust Policy COMPLETE - WBS. SOP reviewed and site practice aligned with Trust Policy .
	Governance Structure (Operation). 2.1.a The new sustainability governance structure, including a suitable forum for central oversight of waste management, should be agreed and implemented as soon as possible.	Medium	2.1.a Accepted. The proposal for the Sustainability Management Board will taken to the Executive Management Board for consideration.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins Assistant Director of Estates, Environment & Capital Development	January 2022 Update May 2022: Extension Requested to 19 July 2022	Complete	Draft terms of refeance in support of the Sustainability management Board have been drafted and will be submitted to EMB in January. If approved the Board will be established shortly after with consideration to how this forum supports the cycle of business.	Introduction of the proposed governance structure (Sustainability Board) has been put on hold. The adoption of the Board will be introduced along with the sustainability strategy in June. Extension Requested to 19 July 2022	Completed: Waste information is reported to The Cynefin Group in WBS and Operational Management Group in VCC. Central oversight is provided at the ISO14001 Management Group (along with any concerns/initiatives related to waste etc.). It is centrally reviewed against the Annual Net Zero Reporting tool to Welsh Government. Further opportunities may exist to enhance arrangements if the a Trust Sustainability Board is introduced as part of the refreshed organisational working arrangements.
	2.1.b Velindre Cancer Centre should further consider the implementation of an operational Estates forum at which waste management matters can be reported and scrutinised / discussed.	Medium	2.1.b Accepted. VCC will review the options regarding operational estates management.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC	January 2022	Complete	Awaiting the new Operational Estates Management group to be set up	COMPLETE - Operations Management Group has been established and future audits, action plans and concerns will be raised in this forma prior to escalation to Trust Meetings	n/a - Complete May 2021

Audit Action Plan

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

Priority
Low
Medium
High

Velindre UNHS Trust

Waste Management - Reasonable Assurance 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	Training (Operation). 3.1.a The targeted action plan for environmental awareness training should be taken forward, as soon as possible noting ongoing Covid restrictions.	Medium	3.1a Accepted. An action plan for environmental awareness training will be developed.	Carl James, Director of Strategic Transformation, Planning & Digital	Rhiannon Freshney, Environmental Development Officer	March 2022	Complete	Following issues identifying training records for Environmental Awareness being rectified, a comprehensive breakdown of staff non compliant staff has been produced. Work has now begun to create an action plan to improve compliance.	COMPLETE - targetted plan created and monthly compliance updates received from Education team.	n/a - Complete May 2021
	3.1.b Training needs assessments, and resulting training programmes, should be developed for Division staff handling clinical waste.	Medium	3.1b Accepted. A training needs analysis will be undertaken regarding clinical waste handling at Divisional level. Training programmes will be developed for clinical waste handling at Divisional level.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	March 2022 Update May 2022: Extension Requested to 19 July 2022 **Extention requested to 17 October 2022**	Overdue	VCC Operational Services have recenty re recenand Development tearecruited a new Training Supervisor, part of their role is to liease with the Education the Development TNA for waste handling will be incorportaed in their role. WBS will review the clinical waste training and ensure relevant staff are trained.	VCC - Currently working with Training Supervisor on Induction Handbook for Employees to include Waste Handling, and Segregation WBS - Clinical waste Training and the WBS Clincal Waste disposal SOP is currently being reviewed by the WBS H&S and Environmental Compliance Manager along with relevant managers. This will be fed into the Cynefin Group. Extension Requested to 19 July 2022	Complete: TNA completed VCC – Provision of training: the TNA identified the porters and domestic staff required clinical waste handling training. This is being delivered with compliance currently at 90% and on-track for 100% by the end of July 2022. Further clinical waste training is being piloted by Operational Services in August and following feedback will be rolled out across the division from September. 2022 WBS – Provision of training: the TNA identified porters required additional clinical waste training. This is being delivered and expected to achieve 100% compliance by end of July 2022. Laboratory staff are also receiving CPD, managed through Q Pulse, with 100% compliance expected by September 2022. Extension requested to October 17th review compliance against September 2022 100% training compliance.
			Total Number of Actions	6						

Audit Action Plan

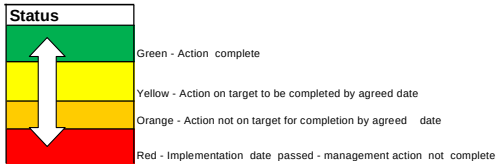
Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - Action not complete

Priority
Low
Medium
High

Velindre UNHSTrust

Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	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 & Chief of Staff	Lauren Fear Director of Corporate Governance, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extention to 30June 2022 requested.	Overdue	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.
		Low	− The Quality & Safety Team is in the process of developing a divisional Standard Operating Procedure to align with the Trust Risk Management Framework. Once completed, this will be shared with Directorate leads for review and comment before review and sign off by the VCC Senior Leadership Team. The updated SOP will then be widely circulated to all relevant staff.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Tracey Langford VCC Quality & Safety Officer	October 2021 Update May 2022: Extention to 30June 2022 requested. **Extension requested to August 2022.**	Overdue	The SOP will be produced once the Revised Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales.	Aligned Trust and VCC agreed and reflected in May Executive Management Board Risk paper	The SOP will be produced once the Revised Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales. **Extension requested to August 2022.**
	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 & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	October 2021 Update May 2022: Extention to 30June 2022 requested.	Overdue	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subject to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over remainder of July. Level 1 training will then follow in August.
		Medium	2.1 b.• VCC: − The training on the new risk management programme, including training materials, is currently in development and due to be finalised by 5th October 2021. − Training will be made available to all directorates and training compliance will be captured and monitored by Directorate leads and regularly reviewed by at the VCC Quality & Safety Management Group as an assurance measure. − The Senior Leadership Team will monitor training compliance by exception.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen VCC Quality & Safety Manager	October 2021 Update May 2022: Extention to 30June 2022 requested. **Extension requested to August 2022.**	Overdue	The SOP will be produced once the Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales.,	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	VCC are waiting for Trust to confirm the training materials/guides. **Extension requested to August 2022.**
	Consistency of approach to risk mangement (Design). 3.1 a. The Trust should implement a mechanism to ensure risk management practice is consistent between the divisions and good practice can be shared. 3.1 b. The Trust should ensure that WBS follows the risk scoring system set out in the Risk Management Framework when reporting to the Board and its Committees.	Low	3.1 Trust response: a & b Recommendation agreed.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extention to 30June 2022 requested.	Overdue	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subject to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over remainder of July. Level 1 training will then follow in August.

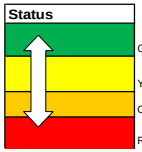
Audit Action Plan



Velindre UNHS Trust

Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
		Low	WBS: a. The WBS Risk Management Team is engaged with the Corporate Governance team to agree an approach to risk management practice that meets the specific regulatory needs of WBS and can be applied consistently across the Trust.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance& Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extention to 30June 2022 requested.	Complete	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	**Complete.** The Policy is with EMB for approval and training is due to be delivered by 10 July 2022.
		Low	VCC: a. Further discussions needed with Trust Risk Management leads and in turn, Senior Leadership teams of VCC and WBS to agree consistent approach to risk management and sharing of good practice	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance	Lauren Fear, Director of Corporate Governance& Chiefof Staff / Paul Wilkins, Interim Director of VCC / Alan Prosser, Director of WBS	October 2021 Update May 2022: Extention to 30June 2022 requested. **Requesting extention to September 2022.**	Overdue	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	A Workshop with representative from both divisions and corporate services is planned for late July 2022. **Requesting extention to September 2022.**
	Scrutiny of Directorate Risk Registers (Operation). 4.1 a. The Divisional Management Teams should ensure directorate risk registers are monitored and scrutinised frequentlyat directorate meetings and that meeting minutes evidence this process. 4.1 b. Whilst we appreciate the challenges of the Covid-19 pandemic, the Trust should ensure that it always appropriately evidences governance processes at all levels of the organisation. This requirement should be communicated to the divisions and directorates.	Medium	4.1a WBS response: a. WBS will introduce a review of open risks consistently across all departmental OSG meetings. b. N/A – VCC action only.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	December 2021 Update May 2022: Extention to 30June 2022 requested.	Overdue	Recommended by March 2022. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	Whilst open risks are shared in OSG meetings, following the training on the new policy further consideration will be given to how these open risks are reveiewed in a consistent manor and this will be taken forward in line with 3.1a. This will be implemented following delivery of training week commencing 13 July2022.
		Medium	4.1 a & b. Risk registers will be added as a standing agenda item on all directorate meetings. Minutes will capture discussions had regarding risk.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	All Directorate leads	Oct-21	Complete	VCC - Risk registers are being reviewed by each Directorate. This has now been completed and directorates have now been set up. This action is complete.	n/a - Complete January 2022	n/a - Complete January 2022
		Medium	4.1 a & b. Governance processes for risk management to be standardised across the divisions and directorates providing assurance to the Quality & Safety Management Group. Modify and set up within Datix to enable dashboards to be produced by directorates	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen, VCC Quality & Safety Manager Sarah Owen, VCC Quality & Safety Manager	October 2021 **Recommended March 2022** **February 2022**	Complete	VCC governance processes are in place. The risk registers are discussed at departmental level, where they are scruitnised. Any for escalation will be received and discussed at the VCC Quality & Safety Management Group. For Corporate and WBS - Recommended by March 2022 Timeline also reflects current service pressures The Q&S Team have been set up on datix to have the ability to push dashboards out to departments. This action is now closed.	n/a - Complete January 2022	n/a - Complete January 2022
			Total Number of Actions	10						

Audit Action Plan



Velindre UNHSTrust

Divisional Review - Incident Management Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	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.	Cath O'Brien, Chief Operating Officer	Jennie Palmer Trust Quality & Safety Manager Quality leads at VCC & WBS - Sarah Owen (VCC) and Peter Richardson (WBS)	November 2021 **28 February 2022**	Complete	Policy to be completed by February 2022 for approval at EMB. Divisions unable to complete process flow charts and documents until policy approved. Scheduled for completion of the Incident Management policy has been changed to the 28th February 2022. Working to achieve this deadline.	Trust Incident Policy was approved at the last Trust QSP Committee. Action can beclosed.	n/a - Complete May 2022
	1.1 b. Divisional management should • ensure local incident management SOPs are updated to reflect the updated Policy; and • ensure all relevant staff are aware of the updated SOPs	Low	1.1 b. Divisional response: WBS: − Related incident SOPs to be reviewed in line with new policy requirements. Revised SOPs to be issued. − Awareness/training to be provided to WBS staff in relation to new SOPs and recorded as training events in Q-Pulse in line with established processes.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS Peter Richardson, Head of Quality & Regulation WBS	April 2022 May 2022 **Extention requested to24th July 2022.**	Overdue	To be completed once the Trust Incident Mangement policy has been reviewed and associated SOP's issued	Extension to May 2022 requested	Further review of incident management of SOP's required following MHRA Audit. This will be completed by the 10th July 2022. Training will be completed by the 24th July 2022. **Extention requested to 24th July 2022.**
		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.	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager	November 2021	Complete	Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** SOP approved at SLT 30 June 2022.
		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.	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Quality and Safety Office to facilitate	November 2021	Complete	Divisional Quality & Safety Officer will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** SOP approved at SLT 30 June 2022.
	2.1 c. We understand the Datix O4W system will have the functionality to report on timeliness of recording in Datix. This should be incorporated into divisional reporting on incidents – see matter arising 4 also.	Medium	WBS: 2.1 c. Timeliness of incident reporting will be introduced into Operational Service Group, Regulatory Assurance and Governance Group, and Senior Management Team meetings. once reporting dashboards are available from Datix O4W (Expected Q3 2021/22)	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	January 2022	Complete	On track to be implemented January 2022		**Complete.** Timeliness of recording DATIX has been implemented and has been incorporated into SMT reports since January 2022.
		Medium	VCC: 2.1 c. The Divisional incident management SOP will reflect the required reporting and escalation	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality & Safty Manager (VCC), supported by the Tracey Langford, Quality & Safety Officer (VCC)	November 2021	Complete	Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed and will ensure the required reporting and escalation processes are included.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** SOP approved at SLT 30 June 2022.
		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.	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager	November 2021	Complete	Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** SOP approved at SLT 30 June 2022.

Audit Action Plan

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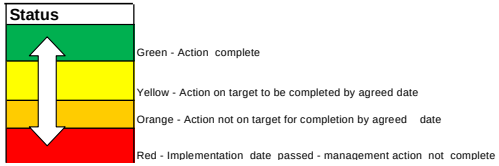

Divisional Review - Incident Management Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	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.	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Quality and Safety Officer Amanda Jenkins, Workforce Business Partner / Lisa Miller, Head of Operational Services and Delivery	September 2021 October 2021	Complete	Training records are being maintained by Quality & Safety Officer. **Complete.** 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.	**Complete January 2022** Complete Complete Managers reminded of responsibilities to maintain their staff records. The use of QPULSE or alternative document respositorywill be explored during 2022/2023 but requires a full Trust wide review.	n/a Complete January 2022.
	3.1 c. Divisional management should ensure that the quality of incident investigations and compliance with the Policy are incorporated into their audit plans on a cyclical basis; and • consider whether a joint audit of investigations should be undertaken to support further identification of inconsistencies, good practice and/or training needs for incident management across the Trust.	Medium	3.1 c. WBS Quality team to engage with their VCC counterparts to agree a plan for reciprocal joint audits focussing on the quality of incident investigations	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	March 2022	Complete	This action has been awaiting appointment of new Quality Manager at VCC. Initial introductions made and will be followed up during Janury 2022.		**Complete.** Across Divisional Audits will take place in Quarter 3.
		Medium	3.1. c. VCC: Formalise work to include Divisional incident activity to be visible on the Clinical Audit Plan.	Cath O'Brien, Chief Operating Officer	Sara Walters, VCC Clinical Audit Manager / Sarah Owen, VCC Quality and Safety Manager	December 2021	Complete	A meeting has been arranged with Quality & Safety Team and Cllinical Audit Team for 07.01.2022 to instigate discussions.	A quality forum has been set up to include Quallity & Safety, Service Improvement and Clinical Audit. A successful pilot forum has been held for the Ambulatory and Assessment Units. This will be rolled out to the First Floor Ward. An evaluaton to next steps and resoruce requirements will be presnted to a future Quality and Safety Management Group.	n/a - Complete May 2022
	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)	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021	Complete	Template will be introduced following approval at the January 2022 Regulatory Assurance and GovernanceGroupmeeting		The template was introduced. **Proposal to close.** To note further enhancements are being made to the document following MHRA feedback**.**
		Medium	4.1 a VCC response:a. Incident Reporting and Investigating Policy will outline the required approach to incident reporting and scrutiny. This will be reflected in the Divisional Incident Management SOP	Cath O'Brien, Chief Operating Officer	Jennie Palmer, Trust Quality and Safety Manager and Sarah Owen, VCC Quality and Safety Manager	30 June 2022	Complete	Divisional Quality & Safety Manager will develop the incident management SOP when Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** SOP approved at SLT 30 June 2022.

Audit Action Plan

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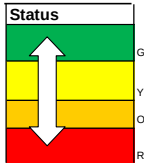


Green - Action complete

Yellow - Action on target to be completed by agreed date

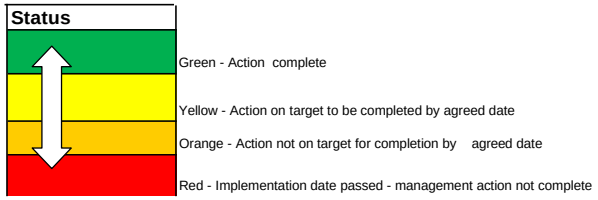
Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Priority
Low
Medium
High

Divisional Review - Incident Management Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
	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, levelof open incidents, recording of investigations and learning in Datix, etc;• trend monitoring on the above KPIs and other metrics, for example, incidents bytype, 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.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021	Complete	Delayed to February 2022, awaiting BI reporting tool for DatixOfW.		**Complete.** This work has been completed to support the Trust PMF and includes a BI visalisation tool.
		Medium	VCC: 4.1 b. Divisional Incident Management SOP will document the set KPI's for the Division and supporting learning narrative. These will be monitored at Directorate meetings by DATIX leads. Any areas of concern escalated to Quality and Safety Management Group	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager and Tracey Lanford, VCC Datix leads	30 June 2022	Complete	Divisional Quality & Safety Manager will document the set of KPIs within the incident management SOP when the Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** Trust Incident Policy received in VCC on Friday 8th April 2022. SOP approved at SLT 30 June 2022.
	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	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Datix leads	31-Oct-21	Complete	Datix incidents are being discussed at departmental level and the Directorate Lead will escalate as and when required.	**Complete January 2022 Audit Committee meeting.**	n/a Complete January 2022.
		Medium	5.1 a VCC response:a. The Divisional incident management SOP will reflect the need for all staff to record incident investigations in DATIX and the closure process	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager	20 June 2022	Complete	Divisional Quality & Safety Manager will document the need for all staff to record incident investigation within the incident management SOP when the Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** Trust Incident Policy received in VCC on Friday 8th April 2022. SOP approved at SLT 30 June 2022.
	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 reporting functionality being in place for DatixO4W.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	January 2022	Complete	Delayed to February 2022, awaiting BI reporting tool for DatixOfW.		**Complete.** This work has been completed to support the Trust PMF and includes a BI visalisation tool.
		Medium	VCC: 5.1 b. Divisional Incident Management SOP will document the set KPI's for the Division and supporting learning narrative. These will be monitored at Directorate meetings by DATIX leads. Any areas of concern escalated to Quality and Safety Management Group	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager and Tracey Langford, VCC Datix leads	30 June 2022	Complete	Divisional Quality & Safety Manager will document the set of KPIs within the incident management SOP when the Trust Incident Policy has been reviewed.	Trust Incident Policy received in VCC on Friday 8th April 2022, SOP will be drafted for SLT sign off by end of June 2022.	**Complete.** All Dashboard in place and being reviewed.
	5.1.c. ensure consistency of approach across the Trust to lessons learned, including the use of the AAR database. Should this approach be used, it should be logged in Datix rather than maintainedas aseparatedatabase.	Medium	VCC 5.1 c. Incident Reporting and Investigating Policy will reflect the learning requirements from an incident investigation This will be included in department meetings and will inform VCC Quality and Safety Management Group. We will continue to work with O4W module once available. implement the learning	Cath O'Brien, Chief Operating Officer	Trust Quality and Safety Manager Sarah Owen, VCC Quality and Safety Manager	March 2022 April 2022	Complete	The Quality & Safety Teamhave scheduled monthly meetings with departments to discuss incidents, themes and lessons learned, linking in with Service Improvement and Education & Development. A highlight report will be submitted to each VCC Quality & Safety Management Group meeting. **Complete.**	n/a Complete January 2022	n/a Complete January 2022
	Total Number of Actions		19							

Audit Action Plan

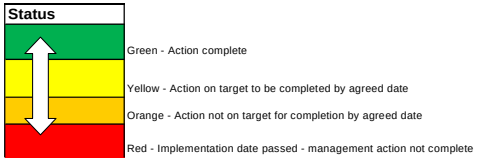


Priority
Low
Medium
High

Velindre UNHS Trust

Trust Assurance Framework 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022	
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for May 2022 Committee	Update for July 2022 Committee
Matter arising 2	**Matter arising 2: Operational risk reporting (TRR) (Operation)** 2.1 The Trust should: a. ensure the review and refinement of the risks on the TRR is completed as planned by the end of March 2021; and	Medium	2.1 a. To complete, taking into account current service pressures, still aim for March, given medium priority	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022	Complete	Complete	n/a - Complete May 2022
			Total Number of Actions	1					

Audit Action Plan



Priority
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Medium
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Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matter arising 1	**Matter arising 1: Late payment of invoices (Operation)** 1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary;	Medium	1.1 a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Matthew Bunce, Executive Director of Finance	N/A	Complete	Complete	Complete on May 2022 Committee Audit Report
Matter arising 2	Matter arising 2: Exception reporting (Operation) 2.1 The Finance team should: a. undertake a formal, documented monthly review of the exception reports, even if no specific matters are identified through the informal weekly reviews;	Medium	2.1 a. The recommendation is accepted. The Divisions will undertake a more formal review which will be signed off by a senior finance business partner. The review will be put in place by the target date.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Complete	**Complete** - The Divisional Finance Teams operate a monthly review of reports, the formal sign off has been established from Q1 2022.
Matter arising	2.1 The Finance team should: b. take action to address the aged items on the exception reports; and	Medium	2.1 b. The recommendation is accepted. Discussion will take place amongst the Senior Finance Team to agree action to be taken on aged invoices to address the immediate issue and long-term approach which will form part of the review process under item 2.1.a	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Complete	**Complete -** SFT has requested a T&F Group to review causation of aged items and establish an action plan for improvement. T&F Group met in May and June 2022, with feedback to be discussed at July Financial Management Meeting
Matter arising 2	2.1 The Finance team should: c. formally monitor progress in clearing aged items at an appropriate forum to ensure action is effectively implemented	Medium	c. The recommendation is accepted. This will be added to the standard agenda of the Financial management meeting under PSPP.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Complete	**Complete -** PSPP is a standard agenda item, on the Financial Management Meeting, supported by the T&F Group for improvements
Matter arising 3	Matter arising 3: Authorisation of proforma invoices (Operation) 3.1 The Trust should: a. remind its authorised signatories only to approve proforma invoices for payment under appropriate circumstances; and	Low	3.1 a. The recommendation is accepted. A reminder will be issued to all staff.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	28/02/2022	Complete	A Financial Guidance note in this respect has been developed and was shared with all Trust staff via the Trust newsletter issued on 22/06/2022. It is therefore requested that these actions are **COMPLETED**. To support this work, in addition, Finance Business Partners will highlight this to budget holders via emails / meetings as appropriate.
Matter arising 3	3.1 b. consider producing documented guidance on authorisation of proforma invoices.	Low	b. The recommendation is accepted. Consideration will be given to producing documented guidance on authorisation of proforma invoices.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Complete	
Matter arising 3	3.2 The Finance team should investigate the specific circumstances of the exception noted in our testing (details have Low been provided) to understand: a. whether a duplicate payment has been made;	Low	3.2 a. The recommendation is accepted. The item has been investigated and no duplicate payment made.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Complete	Complete on May 2022 Committee Audit Report
Matter arising 3	3.2 b. whether the goods were received; and	Low	b. The recommendation is accepted. The item has been investigated and goods received.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Complete	Complete on May 2022 Committee Audit Report

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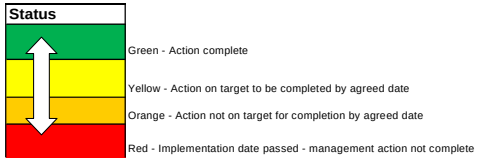

Priority
Low
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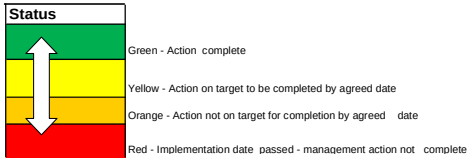
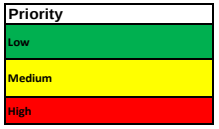
Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matter arising 3	3.2 c. why the proforma was authorised for payment, liaising with NWSSP Accounts Payable if necessary.	Low	c. The recommendation is accepted. NWSSP has advised that this specific supplier operates a cash account requiring payment against estimate before items are released. Practice is not local to the Trust and NWSSP would be required to undertake any further actions in particular ensuring the process for this supplier (and any other suppliers operating cash accounts requiring payment against estimate) is incorporated into any existing documented guidance in place or developed for proforma invoices.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Complete	Complete on May 2022 Committee Audit Report
Matter arising 4	Matter arising 4: Compliance with Fixed Assets FCP (Operating effectiveness) 4.1 The Finance team should remind the divisions of the requirement to complete, approve and submit asset disposal forms prior to asset disposal, not least to ensure value for money is obtained from assets' residual values.	Medium	4.1 The recommendation is accepted. Reminders will be provided at the Capital Planning Group and Divisional Business Planning Group meetings.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Complete	**Complete -** This was discussed at the Capital planning group. Capital team are also now emailing out to the Divisional capital leads as part of month end closedown querying if there are any disposals within month.
Matter arising 4	4.2 a. The Trust should update its Fixed Assets FCP to: − reflect actual practice regarding maintenance of the FAR, capital ledgers and AUC and the related reconciliations to the general ledger; and − incorporate the asset verification coverage target of 80%.	Medium	4.2 a. The recommendation is accepted and the FCP will be updated.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Complete	**Complete -** FCP has been updated per recommendation and is currently going through due process for final approval by audit committee.
Matter arising 4	4.2 b. The Audit Committee should approve the updated FCP.	Medium	4.2 b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee. .	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	31/05/2022	Overdue	The FCP is currently going through the due process for final approval by audit committee.
Previous Matter arising	Previous Matter arising 1: Pursuance of Private Patient (PP) debts (Operating effectiveness) 1.1 a. We concur with the actions taken by the Trust to address the aged Private Patient debt balance. The Trust should maintain its focus on this area through formal continuous monitoring, including reporting to Audit Committee until an acceptable position is reached.	Medium	1.1 a. The recommendation is accepted. A detailed aged debt position has been documented, with monitoring arrangements in place including the status of each debt line and the outcome of actions taken to-date. A standard report will be developed for continuous monitoring by the VCC SMT and EMB and reported to the Audit Committee detailing the position and progress made until the Audit Committee agree they have assurance that private patient debt management isacceptable.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	31/05/2022	Overdue	20.06.22 A report template has been submitted and approved by the Audit Committee to support on-going monitoring arrangements of the Private Patient Debt position. The report is submitted to the VCC SLT via the Operational Delivery Directorate Highlight Report.
Previous Matter arising 1	1.1 b. To support reporting on Private Patient aged debt, the Trust should consider identifying formal key performance indicators with clear targets, for example: • split of debt between self-payers and insured; • percentage of aged amounts vs total debt; • percentage of debt recovered vs total debt (with a similar sub-metric for aged debts); • maximum accepted level for Private Patient aged debts (by percentage and / or value) and monitoring performance against this at an appropriate forum to ensure accountability.	Medium	b. The recommendation is accepted. Key performance indicators are being collated from a patient and financial perspective and the measures identified within this recommendation will be considered and presented to VCC SMT and then EMB for formal approval / sign off.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	30/04/2022	Overdue	20.06.22 The Audit Committee are asked to agree an extension of the delivery date to the 31st August 2022. A report template has been developed which details the debt position against private patient classifications, the movement between each month and the position against key performance indicators. The report will be presented to the VCC SLT on the 30th June 2022, and the Private Patients Management Group on 6th July 2022.

Audit Action Plan

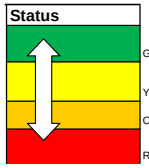




Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Previous Matter arising 2	2.1 b. We concur with the Finance team's intention to increase the frequency of its Long Term Agreement reconciliation. We recommend that the Finance team should undertake this review at monthly to support and ensure aged unallocated and unidentified receipts balances are reduced to a minimum level, ensuring the review is documented, and evidenced.	Medium	b. The recommendation is accepted. Monthly reconciliations of LTA money due and received are now standard practice.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Complete	Complete on May 2022 Committee Audit Report Action Taken: Monthly reconciliations of LTA money due and received are now standard practice
Previous Matter arising 2	c. The Trust should ensure the SOP for Private Patients unallocated and unidentified receipts is approved at an appropriate forum (e.g., by the Audit Committee).	Medium	c. The recommendation is accepted. A Departmental SOP has been drafted for the management of unallocated and unidentified receipts, with significant work undertaken to date resulting in a reduction in the reported aged debt position. The SOP will be submitted for approval to the Audit Committee.	Cath O'Brien, Chief Operating Officer	Ann-Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Service	30/04/2022	Overdue	15.06.22 SOP drafted in readiness for submission to the Private Patient Operational Management Group, scheduled for 06.07.22.
Previous Matter arising 3	Previous matter arising 3: Management of Aged Debts (Operating effectiveness) 3.1 We concur with the Trust's continued focus on general and charity aged debts. We further recommend: a. Charity debts: the Trust should formally review its processes for charity invoicing and debt collection, both internally between finance and the divisions and through discussions with relevant charities (particularly Macmillan and Marie Curie) to identify inefficiencies within the process;	Low	3.1 a. The recommendation is accepted. Increased frequency of liaison and enhanced formal processes will be put in place both internally and with partners	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/03/2022	Complete	This action is **COMPLETE**. In parrallel with systems audit, historic aged debt balances were cleansed, with periodic reconciliations established with cash receipted, volume of aged debt significantly reduced. Regular meetings with Divisional Leads to ensure Charity submissions are completed on time and bi-annual meeting with Charity.
Previous Matter arising 3	3.1. b. General debts: the Trust should consider identifying and monitoring formal key performance indicators with clear targets for general debts, similar to those set out in recommendation 1.1(b) of prior year recommendation 1.	Low	b. The recommendation is accepted. Consideration will be given to identifying and monitoring formal key performance indicators with clear targets for general debts.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022 Complete but request to keep action open until **October 2022 meeting** to allow review	Overdue	Consideration has been given to identifying and monitoring formal KPIs with clear targets for general debts. It has been agreed that from July 2022 onwards the Senior Finance team will receive a monthly update detailing outstanding balances, in month collection and performance metrics to inform ongoing actions needed to reduce and / or maintain the aged debts at an appropriate level. The action as written has therefore been completed, but to ensure the work taken supports effective debt management, it is suggested that the action is kept open until t**he October 2022 Committee meeting** to allow review and update of the metrics as appropriate.
			Total Number of Actions	18				

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

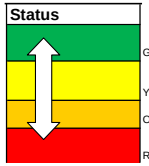
Red - Implementation date passed - management action not complete

Velindre UNHS Trust

Scrutiny of Expenditure >£100k 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matther arising 1	Matter arising 1: Proposals Documentation (Design and Operation) 1.1 a. The Trust should enhance the user guidance for the proposal forms, including, but not limited to the following: • determine the minimum number of options that should be included in a proposal (including "do nothing option"); • additional guidanceon: - risk identification and analysis; - benefits identification and measurements; • the requirement to provide supporting justification for the procurement route, particularly if a less preferred option (e.g., Single Tender Action) is proposed; • clarify the approval route for proposals submitted by corporate (as opposed to divisional) teams;	Medium	1.1a The guidance will be enhanced further to: - specify the minimum number of options required inclusive of the 'do-nothing' option - provide additional guidance / expectations on risk identification and analysis - include the requirement to provide supporting justification of the procurement route - clarify the corporate approval routes.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022 Complete	Complete	**Complete.** The guidance has been enhanced further to request the inclusion of a do nothing option and provide additional guidance / expectations on risk identification and analysis - include the requirement to provide supporting justification of the procurement route - clarify the corporate approval routes. It should be noted that this will be enacted for all new proposals received and will not be expected to be captured for those proposals already submitted for approval through the various governance stagegates.
Matther arising 1	1.1 b. The Trust should share the learning identified throughout this audit with those responsible for completing and scrutinising proposals via the established mechanisms for regular and ongoing engagement with service leads in place	Medium	1.1b Management has already shared the high-level findings with the key service leads to support continued development and enhancement of the process. This will be disseminated further through the established local mechanisms once the final report is confirmed.	Matthew Bunce, Executive Director of Finance		Complete	Complete	**Complete.** Ref. Management Response included with submission of Final Report, column D for further details.
Matther arising 1	1.2 Furthermore, we suggest that all proposal documentation should include details of future monitoring to be completed at a divisional level.	Low	1.2 The guidance will be enhanced to require details of any planned future monitoring arrangements proportionate to the scheme proposal.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Complete	**Complete.** The guidance has been enhanced to request where applicable / proportionate to the scheme any planned divisional monitoring arrangements are included. It has been highlighted by the divisions that for a large number of schemes this will not be appropriate / proportionate given the nature of some captial schemes.
Matther arising 1	1.3 The Trust should consider maintaining a register of proposals for expenditure above £100,000 to monitor the type of proposals being made (e.g., proactive / reactive proposals, what areas they relate to etc…). This will enable the Trust to identify any trends / recurring issues and take appropriate proactive action to address them.	Low	1.3 Management will consider the development of register of proposals to support future monitoring of expenditure.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Complete	**Complete.** A register has been developed to track all Trust Board Approval Submissions from July 2022 onwards.

Audit Action Plan

Velindre UNHS Trust



Priority
Low
Medium
High

Scrutiny of Expenditure >£100k 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matther arising 2	Matter arising 2: Pre-Board Scrutiny Evidence (Design) 2.1 We recommend that: a. the proposal guidance should reinforce the need to fully complete all sections of the proposal prior to submission to EMB and Trust Board;	Medium	2.1 a. The guidance will be enhanced further to reinforce the need to fully complete all sections of the proposal prior to the submission to EMB and Trust Board. This is supported by feedback and engagement with service leads that has already taken place on a regular basis since the new scrutiny process was established to support its continued development.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Complete	**Complete.** Engagement with key service leads has been undertaken to emphasise the requirements to ensure that all sections of the proposal prior to the submission to EMB and Trust Board are fully detailed as required. This process has been augmented and supported by feedback and engagement with service leads that has already taken place on a regular basis since the new scrutiny process was established to support its continued development.
Matther arising 2	2.1 b. the scrutiny role and responsibilities of the forums should be clearly defined in the proposal guidance, including that the scrutiny process should assess the quality of information against the guidance requirements;	Medium	2.1 b. The guidance will be enhanced further to outline the scrutiny role and responsibilities of the assessing forums i.e. they are required to review all aspects of the form for completeness, accuracy and quality of information provided.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Complete	**Complete.** The guidance has been enhanced further to outline the scrutiny role and responsibilities of the assessing forums i.e. they are required to review all aspects of the form for completeness, accuracy and quality of information provided.
Matther arising 2	2.1 c. meeting minutes (or equivalent) should clearly demonstrate that scrutiny and discussions were undertaken over each proposal;	Medium	2.1 c. Separate guidance / information will be provided to the relevant meeting secretariat within the divisions to specify the exact requirements and expectations for documenting any discussion and scrutiny applied of the scheme proposals. This is already in place for corporate services.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Complete	**Complete.** Guidance / information has been discussed with the relevant meeting secretariat within the divisions to specify the exact requirements and expectations for documenting any discussion and scrutiny applied of the scheme proposals. This was already in place for corporate services prior to audit.
			Total Number of Actions	7				

Audit Action Plan

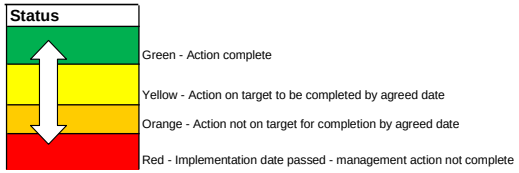
Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - management action not complete

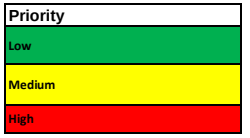
Priority
Low
Medium
High

Velindre UNHS Trust

DBS Check 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	**Recommendation**	**Priority**	**Management Response**	**Executive/Director Lead**	**Responsible Manager/Officer Lead Department where lead works**	**Agreed Implementation Date**	**Status**	**Update for July 2022 Committee**
Matther arising 1		Medium	1.1 ii. A second written standard operating procedure will be written to add DBS quality check within Job Evaluation process. This will ensure Job Descriptions have correctly identified the DBS requirement of the role during the quality assurance checking stage before job descriptions are signed off for recruitment. Action: Write a standard operating procedure to add the DBS quality check to the Job Evaluation process.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager (Job Evaluation Lead)	Jun-22	Complete	**Complete.** A standard operating procedure has been written to add the DBS quality check to the Job Evaluation process.
Matther arising 2		Medium	2.1 a. (ii) The Trust's Attraction, Recruitment and Retention Group will consider the development of the Trust's Recruitment Policy. This is a wider project that needs to encompass the ongoing work on Talent Management, Organisational Values, Workforce Planning, Education Commissioning and Student Streamlining and have involvement from key stakeholders in the process. Action: Develop a Trust Recruitment Policy	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Apr-23	Complete	**Complete.** Task and Finish group established and terms of reference agreed
Matther arising 2	2.1 b. ensure the policy / procedure is communicated to all relevant staff and is made available on the intranet; and	Medium	2.1 b. The Trust's intranet is currently under development and the previous cascade system will end in June 2022. It is expected the next intranet will be available to staff from July 2022 and the Workforce and OD page will include all policies and procedures. Action: Communicate DBS policy to staff via staff communications and intranet.	Sarah Morley, Director of OD and Workforce	Victoria Davies Project Manager – Workforce Planning	Jul 22 **Extension Requested September 2022**	Overdue	Request to Extend to September given policy will be completed in September. Engagement on policy ongoing - Policy to be completed by September. Clear procedure in place in interim
Matther arising 2	2.1 c. put in place a mechanism to monitor compliance with the Trust's new policy.	Medium	2.1 c. Alongside the development of a new policy, toolkits, guidance and standard operating procedures will be developed, hence the need for engagement from all stakeholders in the process. Action: Standard operating procedure for the monitoring of compliance with the DBS Policy.	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Jul 22 **Extension Requested September 2022**	Overdue	Request to extend deadline to September. In progress to be completed by September in line with the policy completion - clear procedure in place in interim
Matther arising 3	Matter arising 3: Out of Date Countersignatory (Operating effectiveness) 3.1 The Trust should update its DBS countersignatories and ensure this remains up to date in the future.	Low	3.1 Action: The Trust will contact DBS to update countersignatories for the Trust.	Sarah Morley, Director of OD and Workforce	Sarah Morley, Director of OD and Workforce	May-22	Complete	**Completed.** DBS has beem contacted to update countersignatories for the Trust
Matther arising 4	4.1 b. formally document the process carried out by the Workforce team to check that appropriate pre-employment checks are completed by NWSSP.	Low	b. Action: A standard operating procedure will be written for monthly checks of new starter files undertaken within the workforce team.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager	Jun-22	Complete	**Complete.** Delay in completing as awaiting on files from NWSSP, to be completed by July
			Total Number of Actions	6				

Audit Action Plan

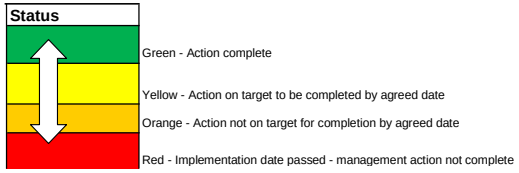




Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matther arising 2	Matter arising 2: Retrospective Purchase Orders (Operation) 2.1 Management should remind requisitioners and approvers that purchase orders should be placed on the Oracle system prior to the goods and services being ordered and received.	Medium	2.1 Accepted – This is policy and should be followed. The Charitable funds finance manager will review monthly reports shared by NWSSP Accounts Payable team and specifically target repeat offenders. A reminder will be sent to all Fund holders and requisitioners.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	May-22	Complete	Complete - An e-mail has been sent to all Fundholders and requisitioners reminding them of their responsibilities. The e-mail referred to the relevant policy and included a quick guide to procuring the supply of goods and services. Repeat offenders will also continue to be targeted as part of the review process of retrospective orders.
Matther arising 3	Matter arising 3: Appropriate evidence for, and timely claiming of, expenses (Operation) 3.1 Management should: a. communicate to relevant individuals and authorisers the requirement for timely submission of expense claims supported by appropriate evidence; and	Low	3.1 a. Accepted. Whilst we do request a timely submission of claims, the reason this was held up was due to Covid, and this has been confirmed by the consultant in question when asked for the reason in the delay. We do however recognise that this delay is excessive and the employee has been reminded of the importance in submitting claims in a timely manner.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Complete	Complete - Consultant was contacted as part of the audit.
Matther arising 3	3.1 b. ensure that expenses submitted late or without appropriate evidence are appropriately challenged before payment and the challenge and justification for payment are clearly documented.	Low	3.1 b. Accepted. This is linked to the above and it is not uncommon for receipts to go missing, however we were aware that the named individual went by flight to Sierra Leone and the cost of the ticket / reclaim was in line with what you would expect to pay. We do however recognise that this needs to be clearly documented, such as printing off an illustration of the cost of a flight to Sierra Leone in order to accompany and support the claim, and articulating this with the employee at the time.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Complete	Complete - Consultant was contacted as part of the audit.
Matther arising 4	Matter arising 4: Acknowledgement letters (Operation) 4.1 Management should update the 'Database Donation Entry instructions' document to detail when acknowledgment letters are not issued.	Low	4.1 Accepted – the manual will be updated	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Complete	Complete - The manual has been updated to include examples of when acknowledgment letters will not be issued. These include circumstances where no contact details are provided by donors are a specific request not to receive a letter.
Matther arising 4	4.2 Management should review the 13 receipts identified above to satisfy itself that it was appropriate that an acknowledgement letter was not issued.	Low	4.2 Accepted – review is being undertaken	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Complete	Completed - Audit on database has been undertaken. Satisfied that acknowledgement letters were not required?

Audit Action Plan

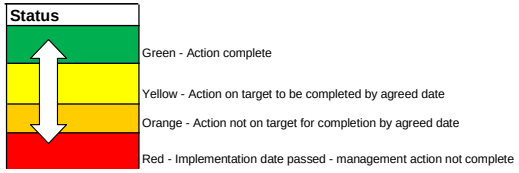


Priority
Low
Medium
High

Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matther arising 5	Matter arising 5: Allocation of funds (Operation) 5.1 Management should: a. develop guidance on when funds should be allocated to funds other than the general-purpose fund and what supporting evidence should be retained in such circumstances;	Low	5.1 a. Accepted – All funds are donated into the General funds unless specifically requested from a Donor or a fundraising event / activity is raising money for that particular fund. We can develop a quick guide to demonstrate this. It will be in the guidance that we expect written confirmation when donations are requested to be received into another fund, and we will make every effort to ensure that the guidance is followed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Complete	Complete - Donor must indicate in writing that they would like the donation to be attributed outside the general fund. This is included within the 'how to enter a donation on database' guidance
Matther arising 5	5.1 b. confirm that the four above receipts have been posted to the correct fund number code and update the donation database as necessary; and	Low	5.1 b. Accepted – All donations have been reviewed and confirmed that they are in the correct place.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Complete	Complete - All donations have been reviewed and confirmed that they are in the correct place.
Matther arising 5	5.1 c. consider whether a review of the accuracy of the information in the database is required.	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Complete	Complete - Review of the database accuracy has been undertaken, remedial action needed in 14 cases the outcome was minor. Going forwards weekly reports are produced to ensure accurate assigment of funds to each donor
Matther arising 6	Matter arising 6: Incorrect fundraising event noted (Operation) 7.1 Management should: a. remind staff of the need for accurate recording of fundraising events in the donation database;	Low	7.1 a. Accepted - the Fundraising team are aware and have been reminded that it is important that information is recorded accurately in the database.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Complete	Complete - the Fundraising team are aware and have been reminded that it is important that information is recorded accurately in the database. There are now weekly reports to ensure that all donor's and event funds are allocated correctly
Matther arising 6	7.1 b. confirm that the four above receipts have been allocated to the correct fundraiser and update the donation database as necessary; and	Low	7.1 b. Accepted - A review will be undertaken to ensure that the receipts have been allocated to the correct fundraiser, however we are confident that they are in the correct fund for accounting purposes.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	May-22	Complete	Complete - review of reciepts undertaken, there were 2 changes to be made. Weekly reports are now undertaken to ensure funds are allocated correctly
Matther arising 6	7.1 c. consider whether a review of the accuracy of the information in the database is required (see also MA5).	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Complete	Complete - Daily reports are now completed for fundraisers to check assignment. New sytem being procured will allow for greater transparency

Audit Action Plan



Priority
Low
Medium
High

Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee
Matther arising 7	Matter arising 7: Advancing Radiotherapy Fund Board Terms of Reference (Operation) 8.1 Management should ensure the ARF Board ToR is formally approved and kept under review.	Low	8.1 Accepted – The ToR has been reviewed and regularly updated, however due to the lack of meetings which were stood down for a period during Covid it has delayed formal approval for the latest version. The latest version of the ToR is going to ARF Board on 27th April for approval.	Matthew Bunce, Executive Director of Finance	Moondance Programme Manager / ARF Programme Manager (Elizabeth Crompton) / ARF Admin Support (Hannah Fox)	Apr-22	Complete	Complete - Revised ToR were discussed at the 27/04/22 ARF Board at which no ammendments were identified, however it was agreed to re-circulate to ARF Board members to allow one further opportunity for members who were not in attendance at the April meeting to suggets changes. The ToR were circulated on 03/05/22 with one member seeking clarification on clinical membership which was responded to. The revised ToR will be ratified at the next ARF Board meeting on 18th July 2022. So status has been shown as green as whilst formal ratification will be at July ARF meeitng, in reality the revised ToR were agreed in the April ARF Board as no changes have been made to the version presented at that meeitng
Previous matter arising 3	Previous matter arising 3: Desktop Procedure - Monies Received (Control design) 3.1 Management should draw up a desktop procedure that details the processes to be followed by the fundraising staff and finance staff for recording, safeguarding and banking of Charitable Funds income.	Medium	3.1 Accepted – a new procedure will be developed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Complete	Complete - All new proceedures have been completed and embedded
Previous matter arising 3	3.2 Management should ensure that the original recommendation is reinstated on the Trust's audit tracker.	Medium	3.2 Accepted – original recommendation will be reinstated.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Complete	Complete - original recommendation has been re-instated on Tracker.
			Total Number of Actions	14				

AUDIT COMMITTEE

LEGISLATIVE AND REGULATORY COMPLIANCE REGISTER

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Emma Stephens, Head of Corporate Governance
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**

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSPC	Quality, Safety and Performance Committee
NIS	Network and Information Systems
ISO	International Organisation for Standardisation
HTM	Health Technical Memorandum
PCR	Public Contract Regulations
SFI	Standing Financial Instructions
VfM	Value for Money
IG	Information Governance
SIRO	Senior Information Responsible Officer

MHRA	Medicines and Healthcare products Regulatory Agency
UKAS	United Kingdom Accreditation Service
WASPS	Welsh Assessment of Serological Proficiency Scheme

1. SITUATION

1.1 The statutory requirements of Velindre University NHS Trust (VUNHST) are wide ranging and complex with compliance with general law as well as NHS specific legislation required. The Trust is also subject to accreditation and regulatory review by a number of inspection and regulatory bodies.

1.2 The purpose of this report is to outline the actions being taken to ensure that the Trust is complying with existing requirements and that the Trust has a comprehensive and up-to-date list of the legislative and regulatory requirements that applies to it (ref. ***Appendix 1***).

1.3 The Legislative and Regulatory Compliance Register also provides a mechanism which demonstrates that the Trust can ensure that by regular updating and monitoring of the register there is a process in place that ensures compliance with legislation and regulatory requirements is being managed effectively.

2. BACKGROUND

2.1 As outlined above the Trust statutory requirements are wide ranging and complex. In order to provide the Board with a level of assurance of compliance, the Legislative and Regulatory Compliance Register has been reviewed by Trust Officers focusing on those matters that present the highest risk in terms of likelihood and impact of non-compliance. This is consistent with the approach adopted across NHS Wales informed by a benchmarking exercise via the Deputy Board Secretaries Group, as has been previously reported to the Trust Audit Committee.

2.2 Quarterly reviews of the register are undertaken to ensure it is kept up to date. This process requires the identified lead officer/responsible individual to provide an update report for their respective areas with management and oversight by the various Operational Management Groups across the Trust and Executive Management Board.

2.3 The Legislative & Regulatory Compliance Register provides the following details:

- All regulatory bodies which inspect the Trust
- The regulatory standard which is being inspected

- Date last inspected, together with any associated recommendations / inspection outcome
- Management response, together with status of any resulting actions
- The Assurance Committee where the outcome of any inspection reports will be presented
- The date of the next inspection – where this is **not** known, but forms part of an established cycle, the month and year anticipated is included. Where inspection is not routine and undertaken on an 'ah hoc' / unplanned basis the year only is included.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The Legislative and Regulatory Compliance Register has received a number of updates / amendments during the reporting period, these are tracked in **red** for ease of reference and recorded in full on the register at ***Appendix 1***. A high level summary of the key updates / amendments received is outlined below:

3.1.1 Trust-wide: Digital Services

The Regulatory Framework requirements for Digital Services are now included within the register (ref. Row 6). Digital Services are required to align with the Network and Information Systems Regulations (NIS Regulations) Directive, although this is not currently formally assessed or subject to a routine inspection programme. Digital Services are currently considering working towards ISO accreditation (ISO27001) and estimate this will take 2-3 years to achieve. This will be incorporated into the Trust register at the appropriate time. It should be noted that the Cyber Information Security & Resilience requirements are captured via the Information Governance entries held on the register.

3.1.2 Trust-wide: Estates, Environment & Capital

The Estates, Environment & Capital Directorate are required to adhere to the **Construction Design & Management Regulations 2015**. This is not currently subject to an independent routine inspection programme, however, is recommended by Trust officers to conduct an internal audit programme as good practice. A planned audit in August 2021 has been deferred 12 months in order to prioritise other areas and is currently reported as overdue (ref. – Row 7). This risk is currently mitigated through the appointment of external consultants for the delivery of large construction and design schemes, and an audit is currently underway that is due to be completed by the end of August 2022. The Estates, Environment & Capital Directorate are also required to adhere to the **Health Technical Memorandum (HTM) Medical Gases** (ref. – Row 13). Following an audit by Welsh Health Estates in March 2021, two actions are outstanding

linked to the recruitment of specialist technical staff. There is mitigation in place through provision of 3rd Party Supplier to undertake the role on behalf of the Trust as an interim measure. The initial recruitment campaign was unsuccessful in securing a suitable candidate. A second recruitment campaign is due to launch imminently.

3.1.3 **Trust-wide: Fundraising**

Two new entries have been incorporated to ensure that the Trust regulatory responsibilities as a registered charity are recorded on the register (ref. – Rows 24 & 25). These relate to the requirements sets by the Charity Commission and the Fundraising Regulator; these are not currently subject to an independent routine inspection programme. However, assurance is overseen by the Trust Charitable Funds Committee appointed by the Trust Board to provide advice and recommendations.

3.1.4 **Trust-wide: Procurement**

One new entry has been added to the Trust register to reflect the Trust requirements in respect of the Public Contract Regulations 2015 (PCR 15), Managing Welsh Public Money (2016) and Trust Standing Financial Instructions (SFI). The Trust has in place Standing Orders and Standard Financial Instructions which adhere to the Value for Money (VfM) principles outlined in Public Contract Regulations 2015 and Managing Welsh Public Money (2016). Trust contractual activity (including appropriate supporting documentation) is undertaken in line with thresholds and delegation levels established within SFI's with records kept of all decisions taken in relation to public procurement activity. Reports on Procurement activity over the threshold of £5k are reported to the Audit Committee for scrutiny. A review has also been undertaken by the Executive Director of Finance in conjunction with Procurement colleagues to strengthen the Trust Procurement Compliance Report received as a standard separate report by the Trust Audit Committee. This strengthened report will be reported from the July 2022 meeting onwards.

3.1.5 **Trust-wide: Information Governance (IG)**

Several new entries have been added to the register following an assessment against the Trust IG toolkit (ref. Rows 29 – 51). This aligns with an assurance report provided to the July 2022 Quality, Safety & Performance Committee. The new entries reflect a comprehensive review of the IG Toolkit self-assessment by the recently newly appointed Head of Information Governance together with the Senior Information Responsible Officer (Executive Director of Finance).

3.1.6 **Trust-wide: Nursing, Quality and Safety**

The Nursing, Quality and Safety Directorate received an inspection of the First Floor Ward on the 12th and 13th July 2022 (ref. Row 54). The formal inspection report is pending at the time of preparing this report, however preliminary feedback has indicated that this is a highly positive report.

3.1.7 **Welsh Blood Service**

The outcome of two recent inspections i.e. review of north Wales arm of the Welsh Blood Service by the Medicines and Healthcare products Regulatory Agency (MHRA), and the United Kingdom Accreditation Service (UKAS) Welsh Assessment of Serological Proficiency Scheme (WASPS) of the laboratories (ref. Rows 6 & 14). The results of which were both positive and reported via the Quality, Safety & Performance Committee for assurance.

3.1.8 **Velindre Cancer Service**

The recent inspection by Natural Resources Wales (ref. Row 11) has been added as a new entry to the register. No non-conformities were identified through the inspection and actions following a previous audit were assessed as fully complete.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	In meeting its legislative and regulatory requirements the Trust ensures that it provides a safe and secure environment for staff, service users and stakeholders as appropriate
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	Yes (Include further detail below)
	Ensuring the Trust has a robust process for monitoring its legislative and regulatory requirements prevents the risk of any potential non-compliance which could incur financial penalties.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	Ensuring the Trust has a robust process for monitoring its legislative and regulatory requirements prevents the risk of any potential non-compliance which could incur financial penalties.

4. RECOMMENDATION

4.1 The report is open to the Audit Committee for **NOTING** and **DISCUSSION** and to examine any entries on the Register in full.

	Blue - Actions complete
	Green- Actions on target to be completed by agreed date
	Amber - Actions not on target for completion by agreed date
	Red - Implementation passed management action not complete

Directorate	Regulatory Body / Inspector	Legislations or Standards	Date last inspected	Recommendation / Inspection Outcome	Management Response	Lead Executive	Responsible Manager	Assurance Committee	Actions Due By	Status	Date of Next Inspection
Digital	Welsh Government	Network and Information Systems Regulations (NIS Regulations)	N/A	N/A	N/A	Director of Strategic Transformation, Planning & Digital	Chief Digital Officer	Quality, Safety and Performance Committee	N/A		No formal Inspection Schedule
Estates, Environment & Capital	Health and Safety Executive	Construction Design & Management Regulations 2015	N/A	Risk Assessments for Health & Safety Management in place across the Trust.	**Internal H&S Audit (Trust H&S Manager) pushed back from August 2021 to Q2 of 2022 to prioritise other areas. Schemes currently delivered through appointment of external consultants to mitigate risk to Trust. Audit to take place during Q2 2022 (date to be confirmed), review currently underway by Gleeds H&S Manager.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	30/08/2021		Deferred from August 2021 to August 2022
Estates, Environment & Capital	Health and Safety Executive	Control of Asbestos Regulations 2012	03/12/2021	Management Plan Updated	**Recommendations complete. Re-inspection survey planned for 2022, date to be confirmed.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2022		03/12/2022
Estates, Environment & Capital	Environment Agency	F Gas Regulations	12/05/2022	Compliant	**Annual Review planned for 2022.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	N/A		12/05/2023
Estates, Environment & Capital	Natural Resources Wales	Energy Performance of Building Regulation 2007	11/11/2021	Display Energy Certificate (DEC) to be reissued	**Display Energey Certificate completed**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2022		11/11/2022
Estates, Environment & Capital	ISO Audit 14001	Energy Performance of Building Regulation 2007 TM44	16/12/2021	Compliant	**Recertification undertaken in 2021**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2022		16/12/2026
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM) Decontamination	2019	Limited Assurance	**Authorised and Competent Persons no longer required as Autoclave no longer used by the Trust.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	**N/A**		**N/A**
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM) Medical Gases	01/03/2021	Resonable Assurance	**Audit completed and an action plan developed to address identified issues. Two actions outstanding which are linked to recruitment of technical staff. There is mitigation in place for outstanding actions through provision of 3rd party supplier to undertake this role on behalf of the Trust, as an interim measure. First recrutiment campaign was unsuccessful in securing a suitable candidate. A second recruitment campaign is currently due to launch in July 2022.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2022		31/03/2023
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM)Ventilation	25/04/2022	Reasonable Assurance	**All validations completed during 2021 and actions addressed.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	30/03/2021		25/04/2022
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM) Water	01/12/2019	Reasonable Assurance	**NWSSP recently appointed an Authorising Engineer who has been accepted by the Trust. Audit planned for Q3 2022**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	30/08/2022		30/08/2022
Estates, Environment & Capital	**Fire and Rescue Services, NWSSP - SES**	**Fire [RRO, DSEAR, WHTM05]**	**FRAs [rolling programme] / Annual audit [May 2022] / NWSSP Independent Review [2021]**	Reasonable Assurance	***a)* Trust Fire safety Manager reviews fire risk assessments on scheduled basis [or following major change to buildings and/or occupancy]; *b)* Trust undertake and submit annual audit to WG through NWSSP-SES [last audit May 2022]; *c)* NWSSP-SES undertake Independent review of fire precautions [VCC only] every three years [last review 2021]; *d)* Fire Service have statuary rights to undertake fire safety audits on ad-hoc basis; *e)* DSEAR assessment in place for VCC [2018] but review required, formal DSEAR required for WBS HQ [to be arranged for 2022]; *f)* Trust FSM undertook Trust wide Gap Analysis for fire safety [2021] and *Improvement/Development* plans in place which are updated following any assessments, audits or inspections, Plans monitored at divisional level with upward reporting / assurance given to Trust Health and Safety Board through divisional reporting. Highlight report presented to Quality Safety and Performance Committee**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2023		01/04/2023
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM)High Voltage	01/04/2022	Reasonable Assurance	**Actions identified with planned response. Outstanding actions still to be addressed but there is an updated action plan in place, which is managed and overseen by the Trust Estates Assurance meeting, which provides a highlight report to Quality safety and Performance Committee.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2023		01/04/2023
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM) Low Voltage	01/01/2018	Limited assurance	**Progress has been made over the past few years with agreed actions. NWSSP Audit scheduled for 2022. Capital programme being delivered over years 2021/2022 on track. Outstanding actions still to be addressed, which have been captured on an updated action plan which is managed and overseen by the Trust Estates Assurance meeting, which provides a highlight report to Quality safety and Performance Committee.**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	30/04/2022		01/08/2022
Estates, Environment & Capital	Natural Resources Wales	Enforces Environmental Legislation	16/12/2021	Trust successfully accredited to ISO14001;2015 standard following external audit from BM Trada of Trust HQ, VCC and WBS divisions and their Environmental Management System. The Trust was successful in gaining the new accreditation and will maintain it through annual external compliance audits.	**Reaccreditation achieved November 2021. No nonconformities identified**	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	N/A		Surveillance audit for ISO14001:2015 - December 2022

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5	**Directorate**	**Regulatory Body / Inspector**	**Legislations or Standards**	**Date last inspected**	**Recommendation / Inspection Outcome**	**Management Response**	**Lead Executive**	**Responsible Manager**	**Assurance Committee**	**Actions Due By**	**Status**	**Date of Next Inspection**
20	**Estates, Environment & Capital**	Health and Safety Executive	Health and Safety at Work ect. Act 1974 • Provision and Use of Work Equipment Regulations 1998. • Manual Handling Operations Regulations 1992 • Workplace (Health, Safety and Welfare) Regulations 1992. • Health and Safety (Display Screen Equipment) Regulations 1992 • The Health and Safety (First Aid) Regulations 1981 • Confined Spaces Regulations 1997 • Lifting Operations and Lifting Equipment Regulations 1998 • Electricity at Work Regulations 1989 • Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 • Working at Height Regulations 2005 • Personal Protective Equipment at Work Regulations 1992	New process was initiated In March 2021 to develop and align Health and Safety Gudance (HSG 65) audits Trust wide	N/A	Independent review carried out of Health and Safety Management across the Trust **in March 2021.** Gap analysis produced. Paper to EMB recommending strengthening of health and safety governance to include a Trust Health and Safety Management Board and provision of Health and Safety Management Groups (or incorporation into existing meetings) in each of the divisions Production of a Priority Improvement Plan to address issues raised in the Gap analysis. Priority Improvement Plan to be monitored by Health and Safety Management Board. Planned implementation of a HSG65 H&S Audit schedule for the Trust	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/03/2023		Rolling inspection programme to be established annually aligned to HSG 65
21	**Estates, Environment & Capital**	Welsh Water (waste)	Authorisations to discharge to Sewer Radio-nucleurised waste. Authorisations to discharge partially drained fluids bag to Sewers. Disposal of Disinfectants and Radadvantage.	16/12/2021	Trust successfully accredited to ISO14001;2015 standard following external audit from BM Trada of Trust HQ, VCC and WBS divisions and their Environmental Management System. The Trust was successful in gaining the new accreditation and will maintain it through annual external compliance audits.	N/A	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	N/A		Surveillance audit for ISO14001:2015 - December 2022
22	**Finance**	NHS Counter Fraud Authority	s83 of Government of Wales Act 2006	Quarter 3 2019	Positive report. Recommendations being taken forward through Audit Committee.	The Annual Counter Fraud Workplan in place, approved by the DOF and LCFS and the Trust Audit Committee Update July 2022: The CF Annual Plan outlining the proposed work for 2022/2023 has been completed, reviewed & approved by the Trust Audit Committee. The Counter Fraud Annual Report and the Counter Fraud Authority Functional Standard return have both been completed and provide assurance that the work carried out for the year 2021/2022 by the CF department has been compliant with the Cabinet Office Standard requirements.	Executive Director of Finance	Local Counter Fraud Specialist	Audit Committee			To be determined, by NHS Counter Fraud Authority, as part of the agreed 3 year review cycle
23	**Finance**	HM Customs & Excise	Established by Act of Parliament in 2005 with responsibility for administration of tax system.	Ad hoc inspections - last one was in January 2018.	Review ongoing	Continuing to respond to any findings	Executive Director of Finance	Head of Financial Operations	Audit Committee	In line with HMRC requests		No formal inspection Schedule. HMRC had hoped to visit again in late 2020, but this was postponed due to pandemic. Work appears to have paused from a HMRC perspective
24	**Fundraising**	Charity Commission	Regulation of Charities in England & Wales	N/A	N/A	N/A	Executive Director of Finance	Charity Director	Charitable Funds Committee	N/A		No formal inspection scheduled
25	**Fundraising**	Fundraising Regulator	Independent Regulator of Charitable Fundraising	N/A	N/A	N/A	Executive Director of Finance	Charity Director	Charitable Funds Committee	N/A		No formal inspection scheduled
26	**Procurement**	Public Accounts Committee - Welsh Government	Public Contract Regulations 2015 (PCR 15). Managing Welsh Public Money (2016) and Trust Standing Financial Instructions(SFI)	TBC	**Managing Welsh Welsh Public Money Principles (Sections 1.1.1 - 1.1.3) state that:** *Everyone who works in the public service in Wales shares a personal responsibility for the stewardship of taxpayers' money, whether they manage budgets, assets or simply their own time. Managing Welsh Public Money sets out the framework and principles which must be applied in the National Health Service in Wales, Everyone working in public services in Wales must be aware of the need to manage and deploy public resources responsibly and in the public interest*. **These principles sit along side the Public Contract Regulations 2015, in which Part 2, Chapter 1, Section 1(1) states:** *This Part establishes rules on the procedures for procurement by contracting authorities with respect to public contracts and design contests which—* *(a)have a value estimated to be not less than the relevant threshold mentioned in regulation 5, and* *(b)are not excluded from the scope of this Part by any other provision in this Section.*	The Trust has in place Standing Orders and Standard Financial Instructions which adhere to the Value for Money (VfM) principles outlined in Public Contract Regulations 2015 and Managing Welsh Public Money (2016). Trust contractual activity (including appropriate supporting documentation) is undertaken in line with threshholds and delegation levels established within SFI's with records kept of all decisions taken in relation to public procurement activity. Reports on Procurement acitivity over the threshhold of £5k are reported to the Audit Committee for scrutiny.	Executive Director of Finance	Head of Procurement	Audit Committee	N/A		Audits are included in the Internal Audit Plan
27	**Information Governance**	Information Commisioners Office	Data Protection (Charges and Information) (Amendment) Regulations 2019	The last annual review was undertaken during Qtr 3 2021/22 and fee paid	N/A	A review of the Trust's Data Protection Register entry takes place in Q3 of each Financial Year.	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Nov-22		Q3 2022/23
28	**Governance**	Information Commissioners Office	Freedom of Information Act 2000 Links to Data Protection Act, General Data Protection Regulation	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	N/A. However, for completeness - IG Toolkit Level 3 states: There is a review process in place for FOIA and EIR processes and compliance with the procedures is regularly monitored and reported via the Executive Management Board & Quality, Safety and Performance Committee.	FOIA compliance is reported by the Director of Corporate Governance and Chief of Staff with compliance figures to the EMB and QSP Committee, it sits outside the IG function although HOIG acts as policy owner and is the reviewer for FOIA complaints.	Director of Corporate Governance & Chief of Staff	Head of Information Governance	Quality, Safety and Performance Committee	N/A		Internal Audit expected 2023/24
29	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1(b)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	To ensure that policies remain fit for purpose and that staff have appropriate direction and information to avoid the risk of data protection breaches, the organisation should ensure that they are subject to timely routine review. IG Toolkit states for level 3 - Compliance with policies and procedures are regularly monitored to ensure they have been adopted in practice throughout the organisation	Policies submitted to QSP for approval on 14th July 2022. Self assessment of Level 2 on IG Toolkit 2021/22.	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Action Plan to further increase level and work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
30	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1)(a)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	Ensure that staff are fully aware of the responsibilities regarding IG, the organisation should consider means by which assurance can be given that staff have read appropriate policies and therefore are aware of organisational requirements and their responsibilites. IG Toolkit states for level 3 - Compliance with policies and procedures are regularly monitored to ensure they have been adopted in practice throughout the organisation	IG responsiblities are achieved via mandatory level 1 IG traniing to be attained every two years. The Training attainment statistics are producedmonthly and presented quarterly to QSP for assurance. As of Jan 22 the Trust achieved 83.05%, the target is 85%. The HOIG deliver training on a risk based approach. Self assessment of level 2 on IG Toolkit 2021/22. HOIG is part of an all-wales IG traniNg review group to re-vitalise IG training across NHS Wales.	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24

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5	Directorate	Regulatory Body / Inspector	Legislations or Standards	Date last inspected	Recommendation / Inspection Outcome	Management Response	Lead Executive	Responsible Manager	Assurance Committee	Actions Due By	Status	Date of Next Inspection
31	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1(b)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	In order to ensure that specialised roles with IG responsibility have received appropriate training to carry out their role effectively, a training needs analysis for these roles should be undertaken.To ensure that training requirements for staff with specialised DP roles are recognised and formalised, these should be included in all job descriptions of roles with IG responsibilities. This should ensure that staff can carry out their roles effectively. IG Toolkit states: Level 3 - The organisation has a high level of mandatory IG training compliance. Training content is regularly reviewed and updated. Feedback is requested where appropriate.	HOIG has begun scoping work to upskill certain roles with the trust to Data Practiioner foundation level. TNA needs to be undertaken to provide similar upskilling for SIRO, Caldicott Guardians and individuals whose role exposes them to Information Governance requirements. Training assessed as level 2 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
32	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1(b)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should provide detailed information about how compliance with data protection policies and procedures is to be monitored to give assurance regarding observance. IG Toolkit states for level 3 - Compliance with policies and procedures are regularly monitored to ensure they have been adopted in practice throughout the organisation	This activity is planned to be part of the audit programme for 2022/23. Assessed as level 1 in IG Toolkit 2021/22.	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
33	**Information Governance**	Information Commissioners Office and Welsh Government	Freedom of Information Act Section 46 - Records Management NHS Wales Records Management Code of Practice for Health and Social Care 2022	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	To ensure that management have a complete picture of performance and compliance, and provide assurance that the organisation is complying with the relevant legislation, the reporting of compliance relating to records management should be instated. IG Toolkit level 3 states that: Procedures are regularly reviewed and maintained and spot checks are made to ensure the procedures are enforced across the organisation	The Trust is creating a T&F Group, the upcoming lesson slearned document will assist in putting together an action plan which can be follow by VCC. Records Management assessed as Level 2 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
34	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 5 - Data Protection Principles	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should ensure that all areas have carried out comprehensive data mapping exercises to ensure that the there is a clear understanding and documentation of information processing,in line with the requirements of the organisation's IG policy and national legislation. The IG Tollkit level 3 states that: 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date	the Trust has in place a wide and varied IAR. Assessed as Level 1 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
35	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 30	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should ensure that it has a complete ROPA which includes all the information required by the legislation, so they are aware of all information held and the flows of information within the organisation, and have assurance that the record is an accurate and complete account of that processing. The IG Tollkit level 3 states that: 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date	The Trust has in place full ROPA which is also doubling as an information asset register. Assessed as level 1 in the IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
36	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 30	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should ensure that there is an internal record which documents all processing activities in line with the legislation. This will provide assurance that all information processed is recorded as required by the appropriate legislation. The IG Tollkit level 3 states that: 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date	The Trust has in place full ROPA which is also doubling as an information asset register. Assessed as level 1 in the IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
37	**Information Governance**	Information Commissioners Office	Data Prorection Act 2018 UK GDPR Articles: 6 - lawful basis for processing 25 - Data Processing by Design and Default 35 - Data Protection Impact Assessments	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should review the purposes of processing activities to ensure that they identify and document a lawful basis for general processing and an additional condition for processing criminal offence data, and therefore obtain assurance that they meet their obligations under the current legislation. The organisation should ensure that it documents the reasons for determining the lawful bases for each processing activity. Otherwise they risk failing to correctly identify the lawfull basis for processing and not meeting their obligations under the relevant legislation.The organisation should ensure that there are clear procedures in place to ensure that the lawful basis is identified before starting any new processing of personal data or special category data. This will provide assurance that the organisation is relying on the correct lawful bases as required by the legislation. IG Toolkit Level 3 states that: 3 - DPIA documentation is regularly reviewed and compliance with the process is reported to the Board/Committee	The Trust has in place a DPIA process which is being used. This process seeks to identify the risks to the rights and freedoms of data subjects using the principles of Articles 25 and 35 of UK GDPR. The Trust is recreating historical records based on the further applicability of systems in the medium to long term. All new systems and processes undergo the DPIA process which allows the Trust to identify emergent risk. Assessed as Level 2 in the 2021/22 IG Toolkit	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
38	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR: Article 13 - information to be provided where personal data are collected from the data subject Article 14 - Information to be provided where personal data have not be obtained from the data subject	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	In order to be sure that it is keeping to data protection legislation by providing accurate processing information, the organisation should ensure that only current and accurate privacy information containing all the information as required under Articles 13 & 14 of the GDPR is available on its website. To ensure that it is upholding the requirement for data subjects to be properly informed of ho their information is being processed, the organisation should ensure there is a clear link to the general privacy notice from the front page of its website The IG Toolkit level 3 states: All privacy information is regularly reviewed to ensure they remain fit for purpose to reflect the current nature of all the processing undertaken by the organisation Privacy information is approved by the relevant person with responsibility, IG team/department and documented and linked to the Information Asset Register	The Trust has an in date Privacy Notice available on its website, in addition the new leaflet "your information, your rights" has been sent to Communications to be published on the website. Right to be informed assessed as Level 2 in the IG Toolkit for 2021/22. For bespoke projects leaflets are produced and made available to data subjects.	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
39	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR: Article 13 - information to be provided where personal data are collected from the data subject Article 14 - Information to be provided where personal data have not be obtained from the data subject	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should consider additional means in which privacy information can be promoted or made available to individuals, to ensure that it does not rely on passive communication which risks individuals not being made aware of how their data is processed. This would help ensure that the a organisation is not in breach of UK GDPR. The IG Toolkit level 3 states: All privacy information is regularly reviewed to ensure they remain fit for purpose to reflect the current nature of all the processing undertaken by the organisation Privacy information is approved by the relevant person with responsibility, IG team/department and documented and linked to the Information Asset Register	The new leaflet "your information, your rights" has been sent to Communications to be published on the website. An all-Wales approved Privacy Notice is on the VUNHST website. Right to be informed assessed as Level 2 in the IG Toolkit for 2021/22.	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
40	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR: Article 13 - information to be provided where personal data are collected from the data subject Article 14 - Information to be provided where personal data have not be obtained from the data subject	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	To ensure that privacy information is available to all areas of the population the organisation must consider means of providing information to those who may not understand the standard notice. This would help ensure that the a organisation is not in breach of legislation, and all data subjects can understand the provided Privacy Information. The IG Toolkit level 3 states: All privacy information is regularly reviewed to ensure they remain fit for purpose to reflect the current nature of all the processing undertaken by the organisation Privacy information is approved by the relevant person with responsibility, IG team/department and documented and linked to the Information Asset Register	This is an area which requires more consideration so that differeing communication methods are considered. HOIG will review this requirement and report back to QSP via EMB during an assurance report. Assessed as level 2 in the IG Toolkit for 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
41	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR: Article 13 - information to be provided where personal data are collected from the data subject Article 14 - Information to be provided where personal data have not be obtained from the data subject	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	In order to ensure that the privacy information is effective, the organisation should consider means to evaluate how effective it is by means of user testing or evaluation of complaints. This would provide the organisation with assurance that they were effectively providing privacy information as required by the legislation.A log of historical Privacy Notices should be maintained to allow a review of what privacy information was provided to data subjects on what date. This would provide the organisation with assurance that it has carried out effective reviews of privacy information.The IG Toolkit level 3 states: All privacy information is regularly reviewed to ensure they remain fit for purpose to reflect the current nature of all the processing undertaken by the organisation Privacy information is approved by the relevant person with responsibility, IG team/department and documented and linked to the Information Asset Register	Other Trust's use a privacy notice log, HOIG will review this subject element. The new CIVICA survey application is intended for this use, HOIG has access from 8/7/22 with the intent to survey IG activity including training and information made available to patients, service users, staff and donors. Assessed as level 2 in the IG Toolkit for 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
42	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1)(a)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should ensure that all staff receive regular training and refresher training on fair processing policies and privacy information. The IG Toolkit Level 3 states: The organisation has a high level of mandatory IG training compliance. Training content is regularly reviewed and updated. Feedback is requested where appropriate.	All staff receive regular IG Training via ESR (level 1 mandatory training) and via briefing delivered by the Head of IG. Assessed as level 2 in the IG Toolkit for 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24

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5	**Directorate**	**Regulatory Body / Inspector**	**Legislations or Standards**	**Date last inspected**	**Recommendation / Inspection Outcome**	**Management Response**	**Lead Executive**	**Responsible Manager**	**Assurance Committee**	**Actions Due By**	**Status**	**Date of Next Inspection**
43	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 33	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should ensure that it has documented what information needs to be given to the ICO in the event of a reportable data breach. This will provide assurance that breaches are being reported in accordance with the legislation. The IG Toolkit Level 3 states: Improvements are made to reduce the chance of re-occurrence and are reported to the Board. A review process is in place to ensure the notification procedure remains relevant and works in practice	The Trust has a full data Breach reporting policy in operation and updated. Due approval at QSP on 14th July 2022. Breach reporting assessed as level 3 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Achieved, but need to maintain the standard year on year.		Internal Audit expected 2023/24
44	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 33	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	To ensure that the organisation notifies individuals appropriately where there their personal data has been breached, the organisation should ensure that there is a documented procedure to ensure that the following is included in all breach reporting:the DPO details, a description of the likely consequences of the breach and a description of the measures taken to deal with the breach (including mitigating any possible adverse effects). This will help the organisation keep to the legislation when informing individuals about a data breach.The IG Toolkit Level 3 states: Improvements are made to reduce the chance of re-occurrence and are reported to the Board. A review process is in place to ensure the notification procedure remains relevant and works in practice	The Trust has a full data Breach reporting policy in operation and updated. Due approval at QSP on 14th July 2022. Breach reporting assessed as level 3 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Achieved, but need to maintain the standard year on year.		Internal Audit expected 2023/24
45	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 5 - Data Protection Principles NHS Wales Records Management code of practice for health and social care 2022	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	Retained data should be reviewed on regular basis to identify any opportunities for minimisation or pseudonymisation of data to provide assurance for the organisation that they process the least information possible in line with the legislation. The IG Toolkit Level 3 states: 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date	the Trust has in place a wide and varied IAR. Reviews of the IAR will mean that IAO's review their data holdings regularly. Assessed as Level 1 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
46	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 5 - Data Protection Principles NHS Wales Records Management code of practice for health and social care 2022	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	To ensure that the IAO function is effective, the organisation should formalise the appropriate level of access which IAOs have to the SIRO and DPO, and ensure that designated IAO responsibility is included in job descriptions. This will provide assurance to the organisation that the IAOs are able to effectively carry out their role in the risk management process as required in legislation.When IAO responsibility has been included in job descriptions, the organisation should ensure that all staff are aware of this and what the responsibility entails. This will provide further assurance to the organisation that the IAOs will effectively carry out their role in the risk management process. The IG Toolkit Level 3 states: 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date	IAO's are not aware of their reponsiblities, the information asset register regime and information asset owner training is on the IG workplan for 2022/23. Assessed as Level 1 in IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
47	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1)(a)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The organisation should ensure that all staff with specific information risk roles receive regular training to provide assurance that they are able to carry out their roles effectively with regard to information risk.The IG Toolkit Level 3 states: The organisation has a high level of mandatory IG training compliance. Training content is regularly reviewed and updated. Feedback is requested where appropriate.	It is understood that other Trust's are contributing to a national piece of work in this area. Training is delivered, but SIRO/Caldicott Guardians and Project Manafers do require some specific IG training to enable them to undertake their roles effectively. Assessed as level 2 in the IG Toolkit for 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
48	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Art 39(1)(a)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	To ensure that staff with specific risk management roles are fulfilling those roles effectively, the organisation should formalise means by which IAOs are routinely consulted on project and change management processes s and attend or are able to feed into IG meetings. This will provide assurance that they are carrying out their roles in relation to risk management effectively and thereby reduce the risk of a breach of legislation through information risk not occuring. The IG Toolkit Level 3 states: 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date	Risk management training is being delviered at level 2 across the Trust, the HOIG deliver IG Risk management awareness at the project manager level regularly. Risk assessed as level 1 in the IG Toolkit for 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
49	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 5(1)(f)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	Staff are aware of and encouraged to maintain security measures. The IG Toolkit Level 3 states: All reasonable steps have been taken to ensure the premises is secure by undertaking regular checks/audits and any improvements are considered and implemented where necessary.	The Trust has in place physical security measures, policies and procedures at the operational level. CCTV requires specific attention, Assessed as Level 2 in the IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
50	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 5(1)(f)	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	The IG Toolkit Level 3 states: There is an effective review process and audit mechanisms are in place to ensure legal requirements, policies and standards are complied with in practice. Compliance reports and issues of concern are reported to the appropriate forum	The new DPIA is in draft for Body Worn Cams for the buikding site and CCTV cameras on the existing site. Completion of the DPIA is aligned with Data Protection and Surveillance System legislation. Assessed as level 1 in the IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
51	**Information Governance**	Information Commissioners Office	Data Protection Act 2018 UK GDPR Article 28 - Processor	No formalised inspection regime by the Regulator, but does form part of the internal audit plan.	IG Toolkit Levels 3 states: A review process is in place to ensure that all contracts and agreements are regularly reviewed and any changes are communicated appropriately	The Trust has in place BRAVO System for all contracts over £25k. Must be noted that it is a wide area of estate and will be an ongng improvement process year on year. In practical terms it means that the Trust puts in place, contracts that are supported by Data Processing/Sharing Agrements after due diligence is completed by the DPIA process. Assessed as level 1 in the IG Toolkit 2021/22	Executive Director of Finance	Head of Information Governance	Quality, Safety and Performance Committee	Actions to to further increase level to work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022.		Internal Audit expected 2023/24
52	**Medical**	Health Education Inspectorate Wales (HEIW) on behalf of General Medical Council (GMC)	Following the merger of the Postgraduate Medical Education and Training Board (PMETB) with the General Medical Council (GMC) on 1 April 2010, the GMC is now responsible for regulating all stages of medical education in the UK.	14th January 2020	HEIW Annual Faculty appraisal : This is formal review meeting with HEIW to discuss the quality and outcome of training delivered at VCC. It also assesses the feedback of the GMC survey for training doctors and how any negative issues or good practice points are taken forward in the organisation	2020 Report submitted & formal meeting undertaken with no concerns reported from HEIW	Executive Medical Director	Assistant Medical Director for Education and Training & Assistant Medical Director for Workforce	Quality, Safety and Performance Committee	N/A		TBC
53	**Medical**	General Medical Council /Postrgraduate Medical Education Training Board	Revalidation of Non-Training Doctors	N/A	No formal visits as an independent regulator however the Executive Medical Director meets every 6 Months with the Regional GMC representative. The purpose of the meeting is to discuss any national issues that may relate to VUNHST and is an opportunity to discuss local specific issues to obtain advice and support.	2020/2021 Report was submitted to HEIW in April 2021	Executive Medical Director	Medical Directorate Manager	Quality, Safety and Performance Committee	N/A		2021-22 Report submitted April 2022
54	**Nursing and Quality & Safety**	Healthcare Inspectorate Wales (HIW)	Monitors legislation and Standards for Healthcare	Quality Check of 1st floor ward undertaken on 03/03/2021. An IRMER inspection was planned within nuclear medicine for 25th/26th Jan 2022. **This was deferred to 15th & 16th March 2022 but subsequently cancelled by the inspection team. The inspection took place on 14th & 15th June 2022.** An IRMER inspection was undertaken in Radiotherapy in November 2019. **HIW inspection of first floor ward took place 12th & 13th July 2022.**	No improvements identified from 03/03/2021 remote inspection. **Receipt of report following IRMER inspection within nuclear medicine still pending.** **6 recommendations identified and the service is required to complete an improvement plan detailing actions being taken to address areas for improvement.** **Outcome of first floor ward inspection (12th & 13th July 2022) pending.**	Noted at Senior Leadership Team March 2021. Executive Management Board and Quality, Safety and Performance Committee to be informed of the positive result. **Radiotherapy IRMER inspection- Closure of all actions has not been received to date. There are a couple of outstanding actions from 2019 which will be updated imminently.**	Executive Director of Nursing, AHPs and Health Scientists	Cancer Centre Head of Nursing for the in-patient audit. **Head of Nuclear Medicine for Nuclear Medicine.** **Radiotherapy Service Manager for Radiotherapy.**	Quality, Safety and Performance Committee	**Report for Nuclear Medicine IRMER inspection still pending.** **Outstanding actions following Radiotherapy IRMER inspection to be completed by July 2022 (revised date).**		HIW will undertake unannounced inspection visits/spot checks, special reviews, and investigations on a planned and unannounced basis.

	Directorate	Regulatory Body / Inspector	Legislations or Standards	Date last inspected	Recommendation / Inspection Outcome	Management Response	Lead Executive	Responsible Manager	Assurance Committee	Actions Due By	Status	Date of Next Inspection
55	**Nursing and Quality & Safety**	HIW, Internal Audit and Self-assessment	Health and Care Standards (2015)	May 2021	Substantial assurance. No recommendations or actions required.	N/A	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Quality, Safety and Performance Committee	N/A		TBC
56	**Nursing and Quality & Safety**	Nursing and Midwifery Council (NMC)	Mandatory requirement for individual nurses to renew their registration every year and Revalidate every three years. All registrants must comply with the NMC Code of Conduct, including standards of conduct, performance and ethics for nurses and midwives.	N/A	N/A	The Annual NMC registration paper was provided to Executive Management Board on 5/7/2021 and Quality, Safety & Performance Committee on 15/7/2021. Since this time, one lapsed NMC registration has occurred. Revised registration check protocol is being developed and revised ESR procedures are required. **July update - New protocol devised and signed off by Professional Nursing Forum 11th March 2022.**	Executive Director of Workforce, and the Executive Director of Nursing, AHPs and Health Care Scientists	Senior Nurse for Professional Standards & Digital	Quality, Safety and Performance Committee	N/A		**No formal inspection schedule.**
57	**Nursing and Quality & Safety**	Welsh Government	Nurse Staffing Levels (Wales) Act 2016	3rd March 2021 - safe staffing levels reviewed as part of the HIW inspection of the First Floor Ward. Additionally on the 3rd November 2021, First Floor establishment review took place with all nursing areas included, which was conducted through October and into November 2021. **All nursing areas reviewed June 2022.**	HIW inspection undertaken regarding stafing levels and the process around ensuring safe staffing levels. No requirements for any improvements.	6 monthly internal reviews of safe staffing levels will continue as per the national safe staffing Act.	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse for Professional Standards & Digital, and Head of Nursing VCC	Quality, Safety and Performance Committee	N/A		**Next review will take place September 2022.**
58	**Nursing and Quality & Safety**	Welsh Government	Mental Capacity Act	N/A	No formal visits as an independent regulator however compliance and any issues are monitored through the safeguarding and vulnerable adults group quarterly.	N/A	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse Safeguarding & Public Protection	Quality, Safety and Performance Committee	N/A		N/A
59	**Nursing and Quality & Safety**	Welsh Government	Deprivation of Liberty Safeguards	N/A	No formal visits the Trust is not a supervisory body and reports into Cardiff & Vale Supervisory body.	N/A	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse Safeguarding & Public Protection	Quality, Safety and Performance Committee	N/A		N/A
60	**Nursing and Quality & Safety**	Welsh Government	Liberty Protection Safeguards	N/A	Not yet in force awaiting date.	N/A	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse Safeguarding & Public Protection	Quality, Safety and Performance Committee	N/A		N/A
61	**Nursing and Quality & Safety**	Welsh Government	Social Service & Wellbeing Wales Act 2014	2019	**Substantial Assurance with Safeguarding arrangements. Three low priority recommendations identified.** **Management should ensure that safeguarding issues raised via Datix are supported by a narrative that states the involvement and any further action undertaken by the lead nurse to provide a clear trail of evidence to support the outcome or escalation of the investigation undertaken.** **Management should ensure that a formal structured action plan be implemented to target departments identified as having low compliance rate for Safeguarding Adults and Children Level 1 and 2.** **Where members cannot regularly attend the Safeguarding & Public Protection Management Group, consideration should be given to either ensure a deputy attends in their place or withdrawing from the Group's membership and an appropriate member is sought to replace them to ensure robustness and delivery of the group's objectives.**	**A new Datix system has been adopted across the Trust.** **Identify areas of low compliance and report through the Safeguarding Management Group. All were low priority.** **Membership has been reviewed and deputies identified for key members. This has been reflected in the Terms of Reference and will be reviewed as part of the cycle of business.**	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse Safeguarding & Public Protection	Quality, Safety and Performance Committee	N/A		N/A
62	**Nursing and Quality & Safety**	NHS Wales Shared Services Partnership - Specialist Estates Services/MDT	ALL WALES ENDOSCOPE DECONTAMINATION SURVEY 2018	Jul-18	It is recommended the Trust holds a workshop to raise awareness of decontamination within the organisation. It is proposed that the day covers items such as the principles of decontamination, manual cleaning, infection control and trace-ability. The idea is to enhance awareness but not replace dedicated training supplied by individual manufacturers. NWSSP/SES will endeavour to assist the Trust on this venture.	A workshop will be arranged post implementation of the high level disinfection systems & ultraviolet light environmental decontamination system.	Executive Director of Nursing, AHPs and Health Scientists	Head of Infection Prevention & Control	Trust Infection Prevention & Control Management Group	**Training conducted on 16/06/2022.**		**Date of next inspection not confirmed.**
63	**Workforce & OD**	Health Professions Council (HPC)	HPC has robust systems in place to ensure their registrants remain fit to practise inc. registration renewals; Continuing Professional Development standards and fit to practise processes.	No formal Trust inspections have previously taken place.	N/A	N/A	Executive Director of OD & Workforce - Systems and Process Executive Director of Nursing, AHPs and Health Scientists - Professional Management of the Standards	Deputy Director OD & Workforce	Quality, Safety and Performance Committee	N/A		None due- individuals' compliance are randomly audited by HPC. Complaince lists provided from WOD to Exec Director
64	~~**Workforce & OD**~~	~~Institute of Leadership and Management (ILM)~~	~~Quality standards adopted by the Trust upon accreditation as a Centre by ILM.~~	~~June 2020 Accreditation Status reviewed - status not updated due to insufficient number of learners.~~	~~Accreditation as an ILM accredited centre not pursued, qualifications obtained via local providers.~~	~~Agreed~~	~~Executive Director of Organisational Development & Workforce~~	~~Head of Organisational Development~~	~~Quality, Safety and Performance Committee~~	~~N/A~~		~~We are no longer an accredited centre so this can be removed~~
65	**Workforce & OD**	Corporate Health Standard	Standards	PLATINUM achieved October 2016 GOLD achieved 2020		The Trust is due to seek reaccreditation of its gold status in 2022. The Platinum re-Accreditation has been postponed due to the pandemic.	Executive Director of Organisational Development & Workforce	Head of Organisational Development	Quality, Safety and Performance Committee	Confirmation by 27th July action plan then to be agreed		Awaiting confirmation of reviews - to be confirmed 27th July
66	**Workforce & OD**	Welsh Language Commissioner	Welsh Language (Wales) measure 2011	21-Jun	Reasonable Assurance	4 Recommendations accepted - Audit actions being driven and monitored by the WL Development group	Executive Director of Organisational Development & Workforce	Welsh Language Manager	Quality, Safety and Performance Committee	Audit actions completed		No formal inspection scheduled

	A	B	C	D	E	F	G	H	I	J	K	L
1									Blue - Actions complete			
2									Green - Actions on target to be completed by agreed date			
3									Amber - Actions not on target for completion by agreed date			
4									Red - Implementation passed management action not complete			
5	**Division**	**Regulatory Body / Inspector**	**Legislations or Standards**	**Date last inspected**	**Recommendation / Inspection Outcome**	**Management Response**	**Lead Executive**	**Responsible Manager**	**Assurance Committee**	**Actions Due By**	**Status**	**Date of Next Inspection**
6	**WBS**	MHRA, (Medicines and Healthcare products Regulatory Agency)	The Blood Safety and Quality Regulations,2005 (and amendments) Council of Europe - Good Practice Guidelines for Blood Establishment Required to Comply with Directive 2005/62/EC BLOOD ESTABLISHMENT AUTHORISATION (BEA):17853 WHOLESALE DISTRIBUTION AUTHORISATION:17853	08-09 Jun 2022 (North Wales)	1 'major', 3 'other' non-conformances were identified during inspection. MHRA require a formal response (within 28 days of their notification letter being received) containing the WBS proposals for dealing with these matters, together with a timetable for completion.	Formal reposnse letter (action plan) to be submitted to MHRA by 11th July 2022. WBS QA Team will work with the relevant operational managers to resolve these issues. Action plan to be formally accepted by MHRA. Progress of actions will be monitored by the WBS Regulatory Assurance and Governance Group (RAGG).	Chief Operating Officer	Head of Quality Assurance & Regulatory Compliance	Quality, Safety and Performance Committee	Actions expected to be completed by 31-August-2022		North Wales Jun 2024 (Awaiting MHRA confirmation)
7				15-17 Jun 2020 (South Wales - Remote Audit)	1 Major, 2 others which require objective evidence to be submitted.	QA team are working with the relevant operational managers to resolve the issues or produce an action plan for investigation and closure.	Chief Operating Officer	Head of Quality Assurance & Regulatory Compliance	Quality, Safety and Performance Committee	Actions complete		South Wales May 2023 (Awaiting MHRA confirmation)
8				10-13 May 2021 (South Wales)	23 others which require objective evidence to be submitted.	QA team are working with the relevant operational managers to resolve the issues or produce an action plan for investigation and closure.	Chief Operating Officer	Head of Quality Assurance & Regulatory Compliance	Quality, Safety and Performance Committee	Actions complete		
9	**WBS**	HTA, Human Tissue Authority	Human Tissue (Quality and Safety for Human Application) Regulations 2007 (EU Directives 2004/23/EC, 2006/17EC, 2006/86/EC)	Apr-19	No critical or major non-compliances reported. 5 minor non-compliances	Action plan submitted to HTA which addressed all minor issues reported.	Chief Scientific Officer	Head of Welsh Bone Marrow Donor Registry	Quality, Safety and Performance Committee	Actions complete		HTA Inspection being scheduled for Aug 22 (Inspection is late should have occurred in May 21)
10	**WBS**	European Federation of Immunogenetics	EFI standards, Peer review	Dec-21	N/A	N/A	N/A Accreditation only	Head of Welsh Transplantation and Immunogenetics Laboratory	Quality, Safety and Performance Committee	No Actions		Dec-22
11	**WBS**	World Marrow Donor Association	WMDA standards to comply with EU regulations Peer review	Feb-20	N/A	N/A	N/A Accreditation only	Head of Welsh Bone Donor Registry	Quality, Safety and Performance Committee	Completed & fully compliant		Surveillance audit was due Jan 2022 (Yet to occur) Accreditation not due until Jan 2024
12	**WBS**	UKAS (United Kingdom Accreditation Service)	ISO/IEC 17043:2010 Conformity assessment -- General requirements for proficiency testing; Accreditation Regulations 2009 (SI No 315/2009) EC 765/2008	16/09/2021 to 17/09/2021	**NEQAS for H&I** 3 Mandatory findings that require objective evidence. (Surveillance Audit)	Findings cleared following submission of satisfactory evidence	N/A Accreditation only	UK NEQAS for H&I Manager	Quality, Safety and Performance Committee	Completed & fully compliant		Sep-2022
13	**WBS**	UKAS	ISO 15189/IEC:2012 Medical Laboratories - requirements for Quality and Competence Accreditation Regulations 2009 (SI No 315/2009) EC 765/2008	16/07/2021 and 20-23/07/2021 (4 days)	**AT / RCI / WTAIL Labs** 27 Mandatory findings that require objective evidence and 12 recommendations. (Full Re-Assessment)	An action plan was agreed at the audit meeting and corrective actions completed within 30 days	N/A Accreditation only	Chief Scientific Officer	Quality, Safety and Performance Committee	Completed and fully compliant		Jul-22 (Potential that this might be delayed by UKAS, no date recived as yet)

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5	**Division**	**Regulatory Body / Inspector**	**Legislations or Standards**	**Date last inspected**	**Recommendation / Inspection Outcome**	**Management Response**	**Lead Executive**	**Responsible Manager**	**Assurance Committee**	**Actions Due By**	**Status**	**Date of Next Inspection**
14	**WBS**	UKAS	ISO/IEC 17043:2010 Conformity assessment -- General requirements for proficiency testing; Accreditation Regulations 2009 (SI No 315/2009) EC 765/2008	15-16 Mar 2022	Welsh Assessment of Serological Proficiency Scheme (**WASPS)** 7 Mandatory findings, 2 recommendations (Surveillance\Reassessment)	An action plan was created to address inspection findings	N/A Accreditation only	Head of Rell Cell Immunology	Quality, Safety and Performance Committee	Completed and fully compliant		Mar-23 (Awaiting UKAS confirmation)
15	**WBS**	H&S Practitioner A review of the high level Health and Safety management arrangements at Velindre University NHS Trust WBS or VUNHST has not been audited by HSE. Shared Services Audited Risks Management which included H&S incident	Health and Safety at work Ect. Act 1974 Management of Health and Safety Regulations 1999	Internal audits and inspections throughout the financial year 2021/2022	All internal audit/inspection findings are actioned through the Cynefin Group (Refer to BCM-013 Procedure for the Health & Safety Inspection of the Welsh Blood Service, and QAD-117 Health Safety and Environmental Audit Procedure)	Health and Safety a standing agenda item in Cynefin Group. Development of Priority Improvement Plan.	Director of Strategic Transformation Planning and Digital Corporate Services	General Services Manager	Trust Health and Safety Management Board	Actions monitored through the Cynefin Group		Internal Audits and Inspections throughout the Financial Year 2022/23. Health and Safety Management Arrangements Audits planned for 2022/2023 by Health and Safety and Environmental Compliance Manager □

									Blue - Actions complete			
									Green - Actions on target to be completed by agreed date			
									Amber - Actions not on target for completion by agreed date			
									Red - Implementation passed management action not complete			
	Division	**Regulatory Body / Inspector**	**Legislations or Standards**	**Date last inspected**	**Recommendation / Inspection Outcome**	**Management Response**	**Lead Executive**	**Responsible Manager**	**Assurance Committee**	**Actions Due By**	**Status**	**Date of Next Inspection**
	VCC	Environmental Health Office (Food standards)	General Food Regulations 2004. Food Hygiene (Wales) Regulations 2006. Regulation (EC) 852/2004.	26th April 2021	Food Hygiene Rating of 5	The maximum hygiene rating was received, therefore no action plan in place.	Chief Operating Officer	Deputy Operational Services Manager	Quality, Safety and Performance Committee	N/A		2022 - unannounced visit
	VCC	IR(ME)R inspectorate (HIW)	Enforces Legislation	26 & 27 November 2019	Satisfactory	No immediate concerns identified in the inspection, therefore no immediate improvement plan required. An improvement plan is in place for more minor improvements and this is being monitored by the service.	Interim Director and Chief Operating Officer have operational oversight and Executive Director of Nursing, AHPs and Health Sciences has professional oversight for staff.	Radiotherapy Services Manager	Quality, Safety and Performance Committee	Improvement plan is monitord by the Radiotherapy Management Group. Actions to conclude by October 2022.		To be determined (unannounced visits every 2-3 years).
	VCC	British Standard Institute - Radiotherapy	ISO9001 - 2015 International Quality Management Standard	Radiotherapy - April 2022	All previous non-conformities closed. No new non-conformities identified.	Report to be considered to VCC Senior Leadership Team when available. Report will subsequently be made available to the Quality, Safety and Performance Committee.	Interim Director and Chief Operating Officer have operational oversight and Executive Director of Nursing, AHPs and Health Sciences has professional oversight for staff.	Radiotheapy Services Manager	Quality, Safety and Performance Committee	N/A		2023
	VCC	British Standard Institute - Medical Physics	ISO9001 - 2015 International Quality Management Standard	Medical Physics - February 2022	No minor or major non-conformities. 5 opportunities for improvement were identified.	Report to be considered to VCC Senior Leadership Team when available. Report will subsequently be made available to the Quality, Safety and Performance Committee.	Chief Operating Officer	Medical Physics Manager	Quality, Safety and Performance Committee	N/A		2023
	VCC	Lloyds Register Quality Assurance our ISO 9001:2008 external auditors (Radiology)	Standards	Inspection - February 2022	All previous major non-conformities closed. No new major non-conformities identified. 7 new minor non-conformities were identified. The auditor did not conclude that any would affect the delivery of patient care and will re-assess in 12 months.	Report presented to VCC Senior Leadership Team in March 2022.	Chief Operating Officer	Radiology Manager	Quality, Safety and Performance Committee	Actions to be concluded prior to next inspection (likely February 2023).		Feb-23
	VCC	Natural Resources Wales	Environmental Permitting Regulations - Radioactive Subsatnces Regulation Compliance Assessment Report (RSRCAR)	Inspection - July 2022	No non-conformities identified. All actions required following previous RSRCAR acknowledged to have been completed.	Report to be considered to VCC Senior Leadership Team (August 2022). Report will subsequently be made available to the Quality, Safety and Performance Committee.	Interim Director and Chief Operating Officer have operational oversight.	Head of Radiation Protection Service	Quality, Safety and Performance Committee	N/A		2023
	VCC	Health Education and Improvement Wales (HEIW) Formerly known as The Deanery of Wales	Generic Standards for Training	Annual visit expected - no date yet.	N/A - not yet scheduled		Medical Director	Medical Director	Quality, Safety and Performance Committee	N/A	N/A	N/A
	VCC	All Wales Quality Assurance Pharmacist (on behalf of WG)	Medicines and Healthcare products Regulatory Agency for standard regulations. Compliance with QAAPS (Quality Assurance of Aseptic Sevices).	26th and 27th April 2022	Outcome was as follows: Red deficiencies - 0 Amber Deficiences -12 Yellow Deficiencies - 47 Green Compliance - 412 An action plans for all of the deficiencies has been added to the iQAAPS website, a high number of deficiencies are linked and they have been linked into the relevant action plans and is overseen by Martin Rees-Milton, who submits 6 monthly progress reports on line via the iQAAPS website. Action plan resolution times and reminder alerts have been set up, as the action plans are resolved they will be closed on iQAAPS.	Progress monitored via Medicines Management Group	Medical Director	Chief Pharmacist	Quality, Safety and Performance Committee	Good progress has been made against the proposed action plan. The National Pharmacy QA Lead has approved the action plan.		2023

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5	**Division**	**Regulatory Body / Inspector**	**Legislations or Standards**	**Date last inspected**	**Recommendation / Inspection Outcome**	**Management Response**	**Lead Executive**	**Responsible Manager**	**Assurance Committee**	**Actions Due By**	**Status**	**Date of Next Inspection**
14	**VCC**	Health and Safety Executive	Health and Safety at Work etc. Act 1974 Management of Health and Safety Regulations 1999			Production of Priority Improvement Plan Proposal to establish a Health and Safety Management Group Proposal for additional resources to support health and safety within VCC	Director of Strategic Transformation, Planning and Digital	Head of Operational Services and Delivery	Quality, safety and Performance Committee	To be determined	N/A	N/A
15	**VCC**	Operational Management Arrangements for Medical Gas Pipeline Systems (MGPS) - INTERNAL AUDIT	Audit	4th March 2021	Reasonable assurance received. 17 recommendations were identified.	For noting at VCC SLT on 20th December 2021	Executive Director of Nursing, AHPs and Health Sciences	Head of SACT and Medicines Management	Quality, Safety and Performance Committee (Annual Assurance Report from the VCC Medical Gas Group - May 2022).	Follow up audit - to be determined. Action plan developed to address recommendations (monitored by the Estates Complaince Group).		To be determined.
16	**VCC**	Medicines and Healthcare products Regulatory Agency	SI 2004/1031 as amended	13 Aug 2019 to 14 Aug 2019	MHRA site inspection of the Trust as a host organisation of a research study. This constituted part of a larger MHRA Good Clinical Practice Inspection of the research study Sponsor, under SI 2004/1031 as amended. Report contained 3 findings (one major and two other) that were satisfactorily addressed via an action plan. There were no critical findings.	Recommendations agreed and action plan established.	Executive Medical Director and Board Lead for RD&I	Head of Research & Development	Quality, Safety and Performance Committee	Completed		Unscheduled inspections

AUDIT COMMITTEE

AUDIT WALES AUDIT COMMITTEE UPDATE

DATE OF MEETING	19/07/2022

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 June 2022 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.

Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: June 2022

Document reference: APS202206

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

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

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

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

Contents

Audit Committee update:

Audit Committee Update

About this document

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2020-21 Charitable Funds Financial Statements	This audit is complete, and the Auditor General certified the accounts on 31 January 2022. A number of issues arose on the audit which delayed its completion. These issues have been discussed with management and positively responded to.
Audit of S1 and S2 forms	We have completed our audit of the S1 and S2 forms in relation to the transfer of assets and liabilities between the Trust and Digital Health and Care Wales (formerly NWIS). The certified forms were submitted to the Welsh Government on 16 March 2022.
Audit of 2021-22 Financial Statements	Complete. We reported our conclusions to the Audit Committee on 13 June 2022, ahead of the accounts submission deadline of 15 June 2022.

Area of work	Current status
Audit of 2021-22 Charitable Funds Financial Statements	This work will be undertaken later in 2022.

Performance audit update

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

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

Exhibit 2 – Performance audit work

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
2020 Audit Plan		
Quality Governance Executive Director of Nursing, Allied Health Professionals and Health Science	A thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. Including detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting. Scoping was informed by the Joint Review of Quality Governance at Cwm Taf Morgannwg UHB.	**Ongoing** Report due to the Trust for clearance. Review was postponed in 2020 due to the pandemic. Fieldwork was restarted in 2021, although progress impacted due to continuing need for the Trust to respond to the pandemic. Interviews and staff survey were delayed at the request of the Trust.

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
2021 Audit Plan		
Structured Assessment Director of Corporate Governance	Work focused on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically.	**Complete** Phase 1 – final report issued, presented to July 2021 Audit Committee Phase 2 – final report issued, presented to January 2022 Audit Committee
Local study	The budget for this work has been consumed by the Quality Governance (2020) work.	See above
2022 Audit Plan		
Structured Assessment Director of Corporate Governance	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	**Commenced** April – October 2022
All-Wales Thematic work Director of Corporate Governance / Executive	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to	September 2022 – January 2023

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
Director of Organisational Development & Workforce	manage those risks and address short-, medium- and longer-term workforce needs.	
Local study	Short piece of work either to review setting of Wellbeing and Future Generation Objectives or for a deeper dive module in an area covered by Structured Assessment.	Timing dependent on work undertaken

Good Practice events and products

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

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

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

NHS-related national studies and related products

9 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. **Exhibit 3** provides information on the NHS-

related or relevant national studies published in the last twelve months. It also includes all-Wales summaries of work undertaken locally in the NHS. The **bold** reports have been published since our last Audit Committee update.

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

Title	Publication Date
Tackling the Planned Care Backlog in Wales	**May 2022**
Unscheduled Care in Wales	**April 2022**
Joint working between Emergency Services	January 2022
Care Home Commissioning for Older People	December 2021
Taking Care of the Carers?	October 2021
A Picture of Healthcare	October 2021
Infographic on the NHS (Wales) summarised accounts for 2020-21	September 2021
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

Title	Publication Date
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021

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

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

Title	Indicative publication date
Orthopaedic services	2022
Unscheduled care	2022
NHS waiting times tool	2022
Recovery planning	2022
Welsh Community Care Information System follow up	2022
NHS quality governance	2022
Collaborative arrangements for managing local public health resources	2022
Covid-19 response and recovery – third sector support;	2022

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We welcome correspondence and telephone calls in Welsh and English.
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AUDIT COMMITTEE

AUDIT WALES – AUDIT OF ACCOUNTS REPORT ADDENDUM (MANAGEMENT LETTER) FOR 2021-2022

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Steve Wyndham, Financial Audit Manager, 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	
AW	Audit Wales

1. SITUATION/BACKGROUND

1.1 Audit Wales' Audit of Accounts Report Addendum for the financial year 2021-2022 is attached for the Committee's information.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report has been prepared by Audit Wales to set out the recommendations arising from their audit of the 2021-2022 accounts, and an update on the progress made by the Trust against the previous year's recommendations.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

Archwilio Cymru
Audit Wales

Audit of Accounts Report Addendum– Velindre University NHS Trust

Audit year: 2021-22

Date issued: June 2022

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

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

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

Contents

Audit of accounts report addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to the Audit Committee and Trust Board on 13 and 14 June 2022. The report sets out the recommendations arising from our audit of the 2021-22 accounts and an update on the progress the Trust has made upon our previous years' recommendations.

2 We would like to take this opportunity to once again thank all your staff who supported us throughout the audit this year.

Recommendations from this year's audit

3 We summarise in **Exhibit 1** our recommendations arising from this year's audit.

Exhibit 1: Recommendations from 2021-22 audit of accounts

Matter Arising 1

NWSSP IT assets with a gross book value of £570,000 that were disposed of in year remained in the Trust's Financial Statements in error	
Findings	The procedures established by the Trust and operated by NWSSP for the removal of assets from the Trust's Fixed Asset Register (FAR) following their disposal were not successful in removing these NWSSP IT assets from the FAR. This was due to the paperwork for the disposal approval and removal from the FAR not being processed by the IT department in time for the production of the Trust's Financial Statements. As a result of this NWSSP IT assets with a gross book value of £570,000 remained in the Trust's fixed asset register. Although these assets were fully depreciated, and so had no net book value, the gross book value and accumulated depreciation in the Property Plant and Equipment and Intangible Assets notes were overstated.
Priority	High

NWSSP IT assets with a gross book value of £570,000 that were disposed of in year remained in the Trust's Financial Statements in error	
Recommendation	Procedures for recording and approving the disposal of IT assets should be reviewed to ensure that all disposed assets are removed from the FAR on a timely basis, and prior to the production of the Trust's Financial Statements.
Benefits of implementing the recommendation	This should ensure that the FAR is accurate and only includes assets in the possession of the Trust and its hosted bodies.
Accepted in full by management	Yes
Management response	It is agreed that all assets should be disposed in a timely manner in line with the Trust Financial Control Procedure (FCP), "management of non-current / fixed assets and maintenance of asset register". This procedure will be reviewed in line with the recommendation and amended as appropriate. We will then ensure all staff across the Trust are familiar with the procedure and any amendments resulting from the review. NWSSP will in addition provide awareness sessions to all staff with responsibility for capital asset verification during 2022/23 to ensure they are fully aware of their obligations with regard to the disposal and reporting of fixed assets.
Implementation date	31/12/2022

Matter Arising 2

Our analysis of the FAR has identified that a significant percentage of some classes of asset have been fully depreciated but are still in use

Findings

Using data provided by our Data Analytics team obtained from the FAR, we have identified that some classes of asset have significant amounts of assets fully depreciated and are hence held on the Balance Sheet at a nil net book value.

Class of Asset	Gross Book Value £m	Nil NBV £m	%
IT	21.2	9.1	43%
Plant and Machinery	43.4	9.6	22%
Transport	7.9	1.7	22%
Software purchased	7.8	1.7	22%
Licences	1.3	0.6	46%

Although the assets lives used by the Trust are in line with the suggested asset lives within the Manual for Accounts' , paragraph 7.77 states that the suggested lives in the MFA could be used unless there is evidence at an organisational level that a different life applies.

Priority

Medium

Recommendation

A review of the asset lives should be undertaken and consideration given as to whether there is sufficient evidence to depart from the suggested asset lives in the Manual for Accounts.

Benefits of implementing the recommendation

More accurate depreciation charged in year and net book values.

Our analysis of the FAR has identified that a significant percentage of some classes of asset have been fully depreciated but are still in use	
Accepted in full by management	Yes
Management response	A review will be undertaken to see whether there is significant evidence to warrant departing from the manual of accounts.
Implementation date	31/08/2022.

Matter Arising 3

There are weaknesses in the process for producing the TFR6 and we anticipate this will may impact on the LMS2 return for the Whole of Government Accounts.	
Findings	The Trust has developed a coding structure within the ledger which requires officers to record transactions against these codes at source so that the TFR6 and LMS2 returns can be efficiently produced directly from the ledger. Last year we reported to you that there were significant amounts of income and expenditure with Welsh NHS bodies and the Welsh Government which had not been posted to these codes, resulting in a manual trawl of transactions to produce the returns. This year we note that there are again a significant number of transactions for which this coding was not used. In addition, this year we note that as part of the manual trawl there were £12m of transactions with LHBs which the Velindre Finance team were not able to identify in the ledger and therefore the FR6 return included this as a balancing figure. We anticipate that this may also impact on the production of the LMS2 return.

There are weaknesses in the process for producing the TFR6 and we anticipate this will may impact on the LMS2 return for the Whole of Government Accounts.	
Priority	Medium
Recommendation	The process of identifying the NHS Matrix agreed transactions in the ledger needs strengthening so that the production of the TFR6 can be produced more efficiently and reduce the risk of any balancing figures being needed. This should include once again reminding colleagues to ensure that transactions are coded to the appropriate codes.
Benefits of implementing the recommendation	More efficiently produced and accurate TFR6 and LMS2 returns
Accepted in full by management	Yes
Management response	We will continue to build on the work done last year to improve coding of transactions in the financial ledger. This will include reminding colleagues to ensure that the transactions are coded to the appropriate codes.
Implementation date	31/03/2023

Matter Arising 4

The Accounts Receivable Control account reconciliation has had an unreconciled difference of £141,000 since October 2021.	
Findings	The monthly reconciliation of the Accounts Receivable control account provides assurance that entries from the Accounts Receivable module have been correctly posted in the ledger. Since October 2021, the reconciliation has shown a reconciling difference of £141,000 due to a reporting issue with the aged debtors report in relation to a posting of the WBS stock feeder in October.
Priority	Low
Recommendation	This reporting issue should be investigated to see if this issue can be resolved to remove this reconciling item from future reconciliations.
Benefits of implementing the recommendation	Ensures that the Accounts Receivable reconciliation is completed with no reconciling items.
Accepted in full by management	Yes
Management response	This reporting issue has been subject to ongoing investigation since it occurred in October, and discussions will continue to identify both the cause and the action required to correct the AR reconciliation going forward.
Implementation date	31/03/2023

Recommendations from previous years' audits

4 We summarise in **Exhibit 2** recommendations arising from previous years' audits along with our comments on the progress you have made against those recommendations.

5 Our original report, together with your responses to the recommendations in the report, were presented to the Audit Committee on 14 October 2021.

Exhibit 2: progress against previous years' recommendations

Audit Year	Recommendation	Progress
2020-21	**Losses relating to a Structured Settlements have not been correctly recorded in the Trust's accounts** Note 26.3 within the Trust's 2021-22 Financial Statements should include losses relating to Structured Settlement cases and discussions should be held with Welsh Government for the prior year figures to be restated.	Addressed in the 2021-22 Financial Statements Recommendation implemented
2020-21	**Coding of transactions for the production of the FR6 return and WGA (LMS2) return** We recommend that those officers posting transactions are reminded of the need to use the appropriate coding	Not fully addressed Recommendation included in the 2021-22 recommendations above. See Matter arising 3

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AUDIT COMMITTEE

2022/23 INTERNAL AUDIT PROGRESS UPDATE

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR OF CORPORATE GOVERNANCE

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Progress report to be considered by the Audit Committee as part of its ongoing responsibility to oversee the work of Internal Audit.

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

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

2022/23 Internal Audit Progress and KPI Dashboard

Velindre University NHS Trust

June 2022

Contents

Summary of Progress and KPI Performance

Alert / Escalate

1 KPI is RAG rated RED:

- KPI 4 Management Response - 0% (1/1 reports breached the KPI target)

Advise

There have been no changes to the 2022/23 Internal Audit Plan except that we have agreed to move the review of Clinical Audit from quarter 1 to quarter 3. We intend to deliver 22 outputs as part of the 2022/23 Internal Audit Plan.

Since the previous Audit Committee meeting we have finalised:

- the four final reports from the 2021/22 Internal Audit Plan; and
- one advisory review report from the 2022/23 Internal Audit Plan.

These reports will be presented to the July 2022 Audit Committee.

Assure

Progress is being made on the 2022/23 Internal Audit reviews.

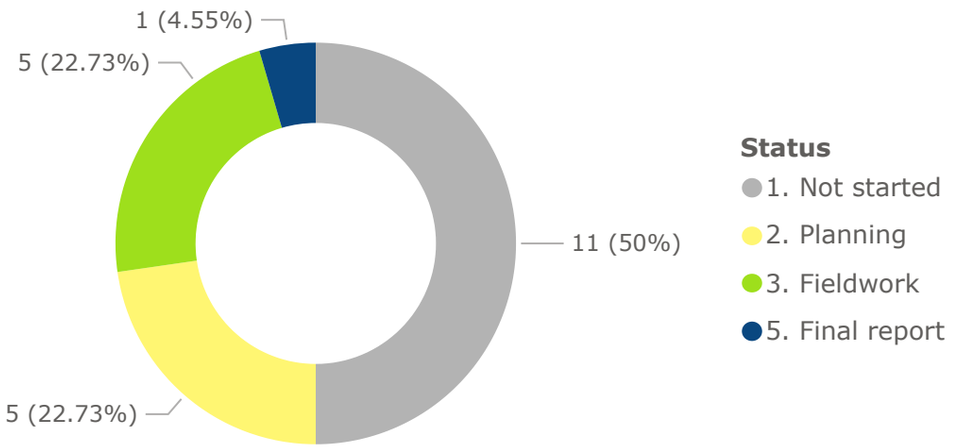
We have undertaken the following activity regarding the engagement issues raised at the May 2022 Audit Committee meeting:

- discussions with the Director of Corporate Governance and Director of Finance;
- lessons learned exercise, including identifying mechanisms to support improved engagement - these mechanisms are already being implemented on the 2022/23 audits in progress; and
- scheduled attendance at the August EMB Run meeting to further discuss the identified mechanisms and support ongoing improvement in engagement.

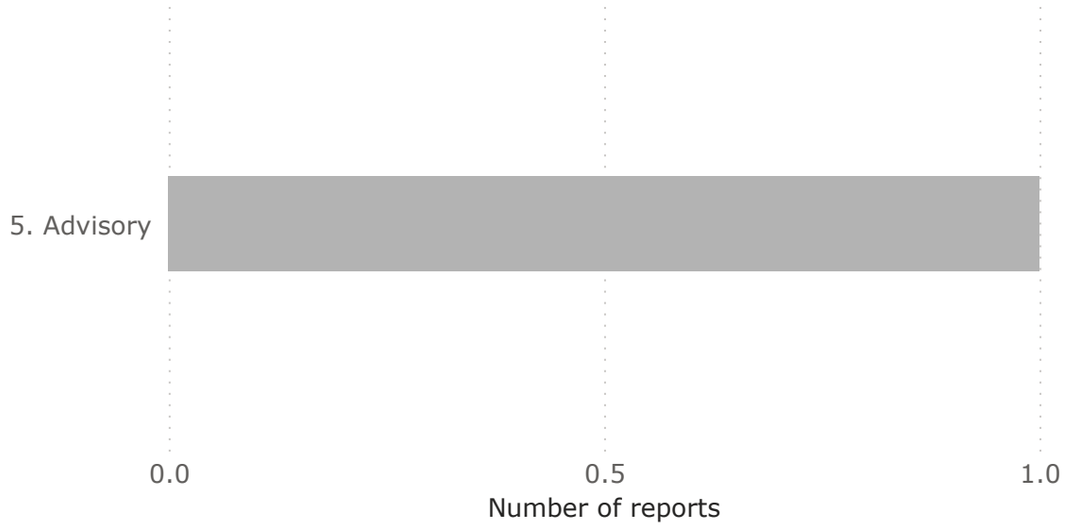
Since the May 2022 Audit Committee meeting, we have continued our regular meetings with the Director of Finance and Director of Corporate Governance and met with other Executive Directors. We have also attended Trust Board and Committee meetings.

Overview

2022/23 Audit Status



2022/23 Reports by Assurance Rating



Key Performance Indicators

KPI	RAG rating	KPI %	KPI Target	KPI Definition
KPI 1 - Annual Plan		100%	Apr-22	Timely approval of Annual Plan
KPI 2 - Month of Delivery		100%	80%	Review delivered in planned month
KPI 3 - Draft Report		100%	80%	Report turnaround: time from fieldwork completion to draft reporting (10 days)
KPI 4 - Management Response		0%	80%	Report turnaround: time taken for management response to draft report (15 days)
KPI 5 - Final Report		100%	80%	Report turnaround: time from management response to issue of final report (10 days)
KPI 6 - Planned Audit Committee		100%	80%	Report delivered to planned Audit Committee

Audits in Progress

Qtr	Audit	Status
2	Capital Provision	2. Planning
3	Cyber Security (VT)	2. Planning
2	Digital Health Record	2. Planning
2	Estates Assurance - Decarbonisation (VT)	2. Planning
	nVCC Enabling Works (22/23)	2. Planning
2	Divisional Review (Deep Dive)	3. Fieldwork
1	Finance & Service Sustainability	3. Fieldwork
1	nVCC Enabling Works (deferred from 21/22)	3. Fieldwork
2	Research & Development	3. Fieldwork
2	Staff Wellbeing (Advisory)	3. Fieldwork

Audits Not Yet Started

Qtr	Audit
	nVCC MIM Approvals
2	nVCC MIM Design & Change Management
3	Clinical Audit (VT)
3	nVCC MIM Procurement
3	nVCC Validation of Management Actions
3	Patient & Donor Experience
3	Performance Management F/w
3	Quality & Safety Framework
4	Follow Up (VT)
4	nVCC MIM Planning
4	Strategic Transformation Assurance

Changes to the 2022/23 Internal Audit Plan

There have been no changes to the 2022/23 Internal Audit Plan except that we have agreed to move the review of Clinical Audit from quarter 1 to quarter 3. This is to allow for sufficient time for the Trust's clinical audit activities to return to 'business as usual' after the Covid-19 pandemic.

Final Reports by Assurance (includes 2021/22 reports presented to the July 2022 Audit Committee)

Substantial Assurance Reports	High	Medium	Low
nVCC Financial Reporting (included in 21/22 opinion)	0	1	2
nVCC MIM Procurement (included in 21/22 opinion)	0	0	0

Reasonable Assurance Reports	High	Medium	Low
Follow Up: Previous Recommendations (included in 21/22 opinion)	1	1	1

Limited Assurance Reports

No limited assurance reports have been issued

No Assurance Reports

No 'no assurance' assurance reports have been issued

Advisory Reviews

nVCC EW Security Contract
Wellbeing of Future Generations Act (included in 21/22 opinion)

2022/23 KPI Performance by Audit

Audit	Status	Assurance rating	Assurance RAG	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6
nVCC EW Security Contract	5. Final report	5. Advisory						
Divisional Review (Deep Dive)	3. Fieldwork							
Finance & Service Sustainability	3. Fieldwork							
nVCC Enabling Works (deferred from 21/22)	3. Fieldwork							
Research & Development	3. Fieldwork							
Staff Wellbeing (Advisory)	3. Fieldwork							
Capital Provision	2. Planning							
Cyber Security (VT)	2. Planning							
Digital Health Record	2. Planning							
Estates Assurance - Decarbonisation (VT)	2. Planning							
nVCC Enabling Works (22/23)	2. Planning							
Clinical Audit (VT)	1. Not started							
Follow Up (VT)	1. Not started							
nVCC MIM Approvals	1. Not started							
nVCC MIM Design & Change Management	1. Not started							
nVCC MIM Planning	1. Not started							
nVCC MIM Procurement	1. Not started							
nVCC Validation of Management Actions	1. Not started							
Patient & Donor Experience	1. Not started							
Performance Management F/w	1. Not started							
Quality & Safety Framework	1. Not started							
Strategic Transformation Assurance	1. Not started							

Wellbeing of Future Generations Act

Final Advisory Review Report

May 2022

Velindre University NHS Trust

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

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

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Review reference:	VT-2122-06
Report status:	Final
Fieldwork commencement:	7th January 2022
Fieldwork completion:	27th April 2022
Draft report issued:	3rd May 2022
Management response received:	19th May 2022
Final report issued:	23rd May 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit
Executive sign-off:	Carl James, Director of Strategic Transformation, Planning & Digital
Distribution:	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development Rhiannon Freshney, Environmental Development Officer
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

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

Disclaimer notice - please note

This advisory review 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.

Advisory review 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

Our review aimed to support the Trust in developing its Sustainability Strategy and creating an environment to effectively embed the Wellbeing of Future Generation Act's (FGA) Sustainable Development Principle (SDP) and 5 ways of working (5WoW) through implementation plans.

What the Trust is doing well

The following factors put the Trust in a good position to begin embedding and implementing the SDP and 5WoW throughout the organisation:

Strategy	•The Trust's overarching and enabling strategies clearly set the context for, and demonstrate commitment to, embedding the SDP and 5WoW.
Leadership	•The Trust has an identified Executive Lead for the FGA and an Independent Member who is the Board Chamion for sustainability. •The Trust's Board is supportive of the Trust's sustainability goals and desire to embed the SDP and 5WoW.
Accountability & Ownership	•Strategy development has been reported to the Strategic Development Committee and implementation progress will be reported to the Quality, Safety & Performance Committee. •The Trust has an Estates Management Group which provides leadership in the implementation of the FGA.
Operational Lead	•The Trust's Environmental Development Officer role incorporates the wider sense of sustainability encompassed by the FGA. The individual in the role is passionate about sustainability and knowledgable about the FGA.
TCS Gap Analysis	•A comprehensive FGA gap analysis has been undertaken on the development of the new Velindre Cancer Centre. Areas for improvement are being identified and the analysis is being revisited at key stages of the project to demonstrate improvements made and identify further action required.

Areas for strengthening and enhancement

The Trust acknowledges it is not yet at a point where the SDP and 5WoW are consistently embedded into the organisation's operations and decision making. We identified the following key areas for the Trust to strengthen and enhance its position to effectively implement these throughout the organisation:

Organisational Culture

Matter arising: Whilst there are pockets of positive, proactive attitudes towards sustainability, the Trust does not currently have an overarching understanding of the level to which sustainability is embedded in its culture.

Recommendation: The Trust should consider undertaking analysis to identify its current sustainability culture to support development of effective actions to enhance its current position.

Why? Whilst strategy, plans, policy and procedure can support sustainable decision-making and actions, ultimately sustainability is a mindset driven by an organisation's culture.

Monitoring & Measurement

Matter arising: A common theme arising from our discussions with the Trust and other NHS Wales organisations was how to capture and report on work, projects and activities that contribute towards the wellbeing goals. All organisations saw this as a key challenge to be addressed.

Recommendation: The Trust should work with other NHS Wales organisations to identify and develop mechanisms to effectively capture and report on contributions to the wellbeing goals.

Why? Without clearly defined means to monitor and measure progress, an organisation will not be able to determine if actions taken are effective in achieving its goals and objectives.

Joined Up Working

Matter arising: Our discussions with other organisations highlighted that there is significant opportunity for joined-up working, both across NHS Wales and the wider public sector that the Trust has yet to take advantage of.

Recommendation: The Trust should seek further opportunities to pursue joined up working within NHS Wales and throughout the wider Welsh public sector

Why? The FGA is the first of its kind, therefore all affected organisations are developing approaches for the first time. It is important to share ideas and good practice, and to implement 'once for Wales' solutions where appropriate to ensure efficiency and success.

All recommendations identified throughout the report are detailed in Appendix Three. Additionally, we have provided guidance around assessing organisational culture in Appendix Six.

1. Introduction

1.1 The Wellbeing of Future Generations Act (FGA) requires public bodies in Wales to:

a. think about the long-term impact of their decisions;

b. work better with people, communities and each other; and

c. prevent persistent problems such as poverty, health inequalities and climate change.

1.2 The FGA defines sustainable development as:

> *The process of improving the economic, social, environmental and cultural wellbeing of Wales by acting in accordance with the sustainable development principle, aimed at achieving the wellbeing goals.*

1.3 Placing a duty on Velindre University NHS Trust (the Trust) to carry out sustainable development, the FGA requires the Trust to think about the five ways of working (5WoW, set out in figure 1) to demonstrate the application of the sustainable development principle (the SDP).

Long-term	Balancing short-term needs whilst safeguarding the ability to meet long-term needs.
Integration	Considering how an organisation's wellbeing objective may impact upon its own objectives, the objectives of other public bodies and the well-being goals.
Involvement	Involving people with an interest in achieving the wellbeing goals. Ensuring those people reflect the diversity of the area the organisation serves.
Collaboration	Acting in collaboration with others to help the organisation meet its wellbeing objectives.
Prevention	Acting to prevent problems occurring or getting worse.

Figure 1: Five ways of working

1.4 To act in accordance with the SDP, the Trust must act in a manner which seeks to ensure the needs of the present are met without compromising the ability of future generations to meet their own needs.

1.5 During 2020 and 2021, the Trust developed its new Trust Strategy, which was approved by the Board in January 2022. New overarching divisional and research, development and innovation strategies are also being developed.

1.6 In support of the overarching strategies, the Trust has also developed enabling strategies, including a Sustainability Strategy. These are scheduled for approval by the Board in May 2022.

1.7 The FGA, wellbeing goals and 5WoW have underpinned the development process for all these strategies.

1.8 The Sustainability Strategy will support the Trust's aim to become a sustainable organisation which contributes to a better world for future generations within its locality and across the globe.

Advisory review

1.9 The overarching objective of the review was to support the Trust in its development of the Sustainability Strategy and supporting implementation plan.

1.10 The review involved discussions with Trust senior management and key individuals and high-level review of relevant documents, including the Trust Strategy, Sustainability Strategy and the Transforming Cancer Services (TCS) Gap analysis. Additionally, we interviewed representatives from six other NHS Wales organisations to ascertain their approach to embedding the SDP and the 5WoW.

1.11 Further details of the scope of the review and the work undertaken are included in Appendices One and Two.

1.12 This is an advisory review therefore we have **not provided an assurance rating**. We have identified learning and provided recommendations to strengthen and improve the Sustainability Strategy and its implementation. Our recommendations are set out in Appendix Three.

2. Detailed Review Findings

Approach to developing the Sustainability Strategy

Timeline and leadership

2.1 The Trust used an agile approach to developing the overarching and enabling strategies, including the Sustainability Strategy. There was an indicative timeline which indicated key outputs and deadlines for each phase of the development process – see figure 2.

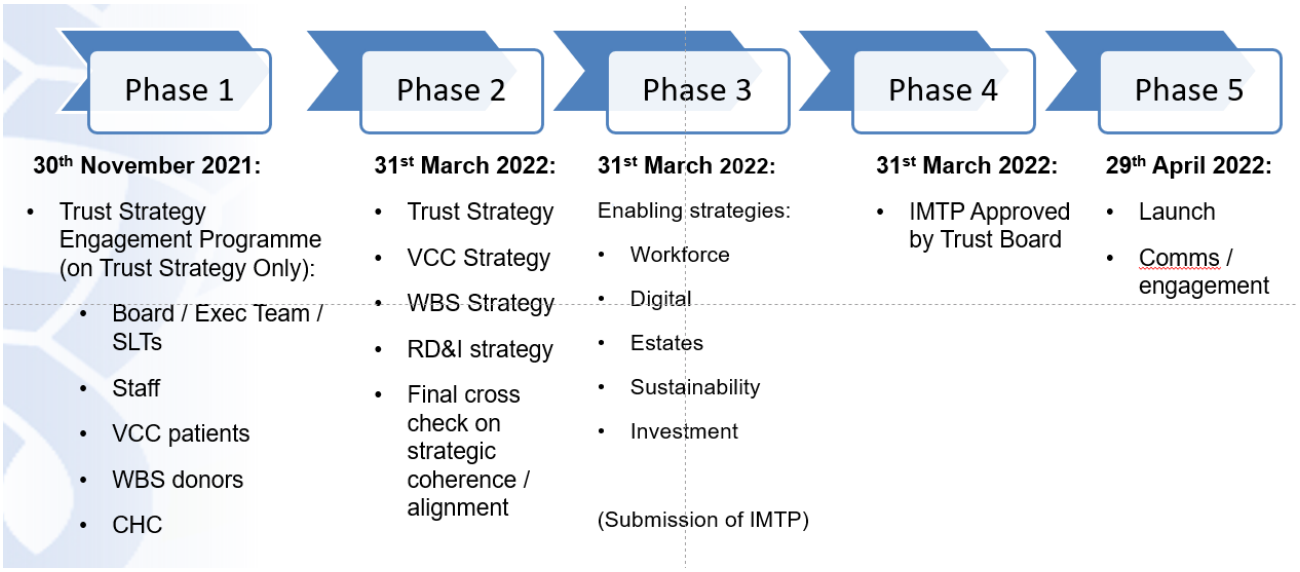


Figure 2: Example indicative timeline

2.2 Due to the impact of the Covid-19 pandemic, the timeline was changed throughout the process. Revisions were clearly reported to the Strategic Development Committee (SDC), along with an explanation for any changes.

2.3 The Trust identified a lead for the development of each strategy. Development of the Sustainability Strategy was led by the Environmental Development Officer, with support from the Director of Strategic Transformation, Planning & Digital, Assistant Director of Estates, Environment & Capital Development and Director of Commercial & Strategic Partnerships. All individuals involved had a clear knowledge and understanding of the FGA.

Joined-up approach

2.4 We were informed that the strategy leads have met regularly as a group throughout the development process to ensure the strategies are joined up and that common themes are effectively addressed throughout.

2.5 Additionally, we understand the Environmental Development Officer, in her capacity as the lead for the Sustainability Strategy, also met informally with individual strategy leads to ensure the FGA, SDP and 5 ways of working underpinned strategy content.

2.6 The Environmental Development Officer developed an interlinking themes document, which linked these themes to the FGA wellbeing goal they contribute to, identified commitments the Trust has made and demonstrated the enabling strategy in which the commitments are addressed.

2.7 Whilst we concur with the agile approach taken to developing the strategies, we note there was limited evidence of the meetings undertaken between strategy leads.

Recommendation 1: When an agile approach is used, the Trust may wish to consider, and identify up front, the level of evidence needed to demonstrate the process and support the actions taken. See further details in Appendix Three.

Stakeholder consultation

2.8 The Trust undertook stakeholder engagement and consultation during the strategy development process in two stages:

1. Overarching strategy engagement – Summer through Winter 2021

   Engagement on the Trust Strategy, which included a strategic goal around sustainability (goal 5: a sustainable organisation that plays its part in creating a better future for people across the globe), took place through a variety of means:

   - internal and external engagement videos;
   - discussions with the Trust's local Community Health Council (CHC), who we were informed then engaged with CHCs on an all-Wales basis on behalf of the Trust;

- Microsoft Teams engagement sessions for staff;
- Board development sessions; and
- a stakeholder (internal and external) survey asking participants about the proposed mission, vision and strategic goals – the results of this were presented to the November 2021 SDC meeting.

2. Enabling strategy engagement – Spring 2022

   The Trust subsequently decided to undertake further engagement around the enabling strategies. This was undertaken throughout March 2022 through a stakeholder survey which was advertised externally through social media channels and internally through the Trust's Communications team.

   The survey asked participants' opinions on the content of each of the enabling strategies and closed on 6th April 2022.

2.9 The Trust took the feedback received during the overarching strategy engagement process into account and changed aspects of the Trust Strategy as a result. Feedback from the enabling strategy engagement was being analysed at the time of writing this report.

Progress reporting

2.10 Progress on the development of the overarching and enabling strategies has been regularly reported to the SDC.

2.11 We were also informed that the development process was regularly discussed at the Executive Management Board (EMB) Shape meetings, which specifically set aside monthly time for EMB to discuss the Trust's strategic direction.

2.12 As noted previously, progress was delayed due to the impact of the Covid-19 pandemic. The initial intention was to present all strategies (overarching and enabling) for approval by the Board in January 2022. Whilst the Trust Strategy was approved at that point as planned, the Trust decided to allow additional time for development the enabling strategies to mitigate the pandemic impact.

2.13 The revised timeline was for the enabling strategies to be approved at the March 2022 Board meeting. However, the Trust subsequently took the decision to undertake further engagement on the enabling strategies, so extended the timeline for approval to May 2022 to enable meaningful consultation to take place.

2.14 Revisions to the indicative timeline were reported to the SDC.

Conclusion: The Trust used an agile approach to developing its overarching and enabling strategies, with clearly identified strategy leads, outputs and an indicative timeline. The joined-up approach supported the threading of common themes throughout the strategies, underpinned by the principles of the FGA. Engagement was undertaken with staff, the public and other stakeholders and was taken seriously by the Trust; changes made to the Trust Strategy as a result. Progress on strategy development has been regularly reported to the Strategic Development Committee.

Application of the Sustainable Development Principle and 5 Ways of Working

Trust Strategy: Destination 2032

2.15 The Trust Strategy sets out that the FGA forms a guiding principle for the Trust, with everything it does contributing to the seven wellbeing goals. Additionally, it outlines the 5 ways of working as the way in which the Trust intends to work.

2.16 Strategic goal 5 states the Trust's goal to be "a sustainable organisation that plays its part in creating a better future for people across the globe". This underpins the Trust's commitment to sustainability in the wider context of the FGA (i.e., wider than environmental sustainability). The Trust Strategy sets out the objectives and high-level actions it intends to achieve this goal.

Sustainability Strategy

2.17 Through discussions with the Future Generations Commissioner (FGC), we were informed the Trust felt it appropriate to have a separate Sustainability Strategy, as it was not yet at a level of maturity that sustainable ways of working are embedded throughout the organisation. We further understand the FGC supports this approach for the Trust.

2.18 The draft Sustainability Strategy (version 12) covers a ten-year period (2022-2032). It clearly sets out why a separate sustainability strategy is needed, the baseline position and what the Trust wants to achieve. It identifies ten key themes and, for each theme, sets out the objectives and high-level actions the Trust intends to undertake. The document also demonstrates the wellbeing goals the theme, objectives and actions contribute to.

2.19 The draft Sustainability Strategy identifies several performance indicators for each theme. At the time of writing this report, the Trust had set targets for key areas (e.g., waste, recycling, carbon reduction). We were informed these will be supported by targets in the tactical implementation plans, for example, the IMTP.

Recommendation 2: Where not yet set, the Trust should ensure clear targets and milestones for the performance indicators identified in the Sustainability Strategy are clearly defined in the tactical implementation plans.

Current position

2.20 In its January 2020 report 'Implementing the Well-being of Future Generations Act – Velindre University NHS Trust', Audit Wales (AW) set out 'positive indicators' to help identify and assess the extent to which bodies may be applying the SDP and 5 ways of working.

2.21 The FGC has also issued 'Journey to' trackers (the FGC Trackers) for each of the seven wellbeing goals. Each FGC Tracker identifies actions which demonstrate contribution to the relevant wellbeing goal. The actions are split into three categories, each more challenging than the previous: Making Simple Changes, Being More Adventurous and Owning Your Ambition.

2.22 Given the descriptive (rather than prescriptive) nature of the FGA, neither the AW positive indicators nor the FGC Trackers are prescriptive or exhaustive. They are simply tools to support organisations on their FGA journeys.

2.23 We undertook an analysis of the Trust's current position for a sample of the AW positive indicators and actions contained within the FGC Trackers. We excluded examples from the new Velindre Cancer Centre development process, because the Trust has already undertaken an FGA gap analysis in this area – see the TCS gap analysis section below for further details.

2.24 For the five AW positive indicators selected, the Trust was able to demonstrate on a high-level that it is taking action against each indicator in the sample.

2.25 We selected a sample of 14 FGC Tracker actions – two for each of the seven wellbeing goals across the Making Simple Changes and Being More Adventurous Categories, recognising the Trust is early on in its FGA journey. We assessed the Trust's position using a RAG (red-amber-green) rating approach. The results are summarised in figure 3.

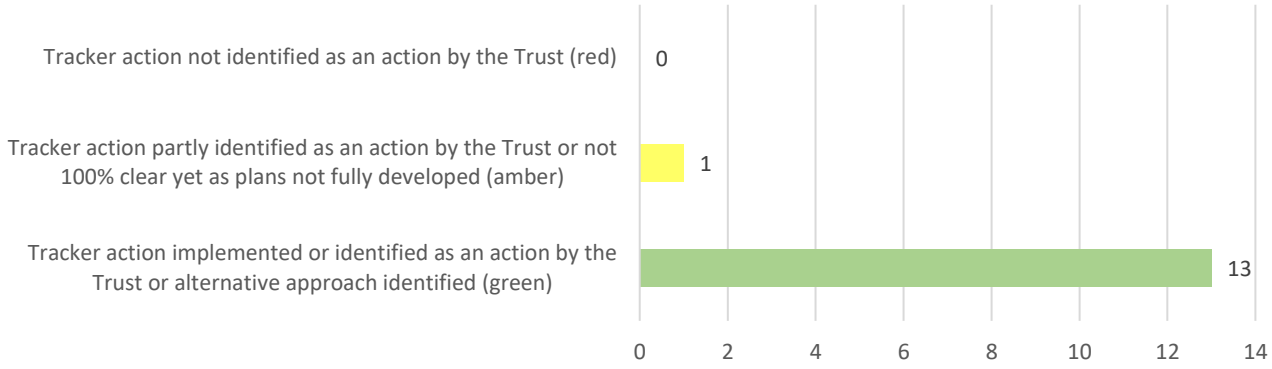


Figure 3: RAG status of FGC Tracker actions selected for analysis

2.26 Full details of the analysis against the AW positive indicators and FGC Trackers are included in Appendices Four and Five.

2.27 Whilst our analysis shows the Trust can demonstrate contribution to the FGA and the intention to embed the 5WoW on a high-level, it recognises it is not yet at a point where this is consistently embedded throughout the organisation.

Recommendation 3a: The Trust may wish to undertake a wider self-assessment of its baseline position against the FGA. See further details in Appendix Three.

Conclusion: The Trust is demonstrating a clear commitment to embedding the SDP and 5 ways of working. Whilst it can demonstrate contribution to the wellbeing goals and application of the SDP in places, the Trust acknowledges it is not yet at a point where this is consistently embedded into the organisation's ways of working and decision making. Recommendations made throughout this report aim to support the Trust on its FGA journey.

The FGA across NHS Wales

2.28 The FGA is the first act of its kind in the world and, as such, public bodies across Wales are leading the way in implementing its requirements.

2.29 Below (figure 4), we identify critical success factors needed to successfully embed the SDP and 5 ways of working.

2.30 We have considered the Trust's position against the critical success factors and, where appropriate, have identified common themes, ideas and recommendations from other NHS Wales organisations that may support the Trust's development in these areas.

Factor	Importance	Trust position
Strategy	Sets out the longer-term direction for an organisation, so if sustainability is not at the heart of the strategy, it is unlikely to be considered in key decisions made for the duration of the strategy.	
Leadership	Leadership is hugely influential in shaping an organisation's culture and sets the tone for the organisation. Lack of support from leaderships or a culture of indifference will impact the organisation's ability to achieve its goals and embed a culture of sustainability.	
Clear Lines of Accountability and Ownership	Blurred lines of accountability and ownership will impact on an organisation's ability to effectively monitor progress and hold teams to account for implementing agreed actions.	
Organisational Culture	Whilst strategy, plans, policy and procedure can support sustainable decision-making and actions, ultimately sustainability is a mindset driven by an organisation's culture.	
Operational Lead	Continuing from the clear lines of accountability and ownership, clear operational leadership at an appropriate level will ensure sustainability receives the right level of focus within the organisation.	
Monitoring and Measurement	Without clearly defined means to monitor and measure progress, an organisation will not be able to determine if actions taken are effective in achieving its goals and objectives, including around sustainability.	
Policy and Procedure	Policy and procedure underpin how an organisation does things. Embedding sustainability into policy and procedure will support and empower staff to work in a sustainable manner.	
Joined Up Working and Learning Across Wales	The FGA is the first of its kind, therefore all affected organisations are developing approaches for the first time. It is important to share ideas and good practice, and to implement 'once for Wales' solutions where appropriate to ensure efficiency and success.	
Key:	Processes in place	
	Processes in place, recommendations for enhancement identified below	

Figure 4: Critical success factors for embedding the SDP and 5 ways of working

2.31 Due to the impact of the Covid-19 pandemic, most NHS Wales organisations we interviewed stood down work around the FGA in early 2020. They were in the process of restarting this work at the time of our review, focussing initially on developing decarbonisation plans in line with Welsh Government requirements.

Success Factor: Strategy

2.32 The Trust's overarching and enabling strategies, including the Sustainability Strategy, clearly set the context for embedding sustainability (in the wider concept of the FGA) and the 5 ways of working throughout the organisation.

2.33 Other organisations interviewed were in the process of determining their approach to sustainability. Some felt they may be at a point where a separate strategy was not needed, whilst others were looking at using strategies, frameworks or action plans, although many focused mainly on environmental sustainability rather than the wider concept implied by the FGA.

Success Factor: Leadership

2.34 Whilst all directors have a responsibility for implementing the FGA, the Director of Strategic Transformation, Planning & Digital is the FGA lead for the Trust. Additionally, we understand the Trust has an Independent Member who is the Board Champion for sustainability (we note that not all organisations had such a champion in place).

2.35 We were informed that the Trust's Board is supportive of the Trust's sustainability goals and desire to embed the SDP and 5 ways of working throughout the organisation.

2.36 We note that one NHS Wales organisation has recently appointed a Director of Environment to ensure increased focus on environmental sustainability.

Recommendation 4a: The Trust may wish to consider whether increased focus on the FGA and sustainability at an Executive or senior management level would be beneficial in supporting its FGA journey.

Ideas identified through other NHS Wales organisations

- Embedding sustainability into corporate thinking and decision-making through inclusion of sustainability risks in Board papers.

Success Factor: Clear Lines of Accountability and Ownership

2.37 The Trust's strategy development process is being reported to the SDC. After approval, progress monitoring will take place through the Quality, Safety & Performance Committee.

2.38 In June 2021, the Trust set up an Estates Management Group (EMG). As part of a wider remit, the EMG will monitor and manage the Sustainability Strategy and provide leadership in the implementation of the FGA. Divisional representatives

are required to provide update reports to each meeting. The EMG reports formally to the Quality Safety and Performance Committee.

2.39 We were informed that there is an intention to establish a Sustainability Management Board (SMB). We understand the Director of Strategic Transformation, Planning and Digital is discussing this with the Executive Management Board as part of the organisational development programme currently being taken forward.

2.40 We reviewed an initial draft of the terms of reference for the SMB, noting that whilst it included representation from most areas of the Trust, there are no finance or communications representatives listed in the intended membership.

Recommendation 5: Whichever forum the Trust decides to use to provide oversight, accountability and leadership for the FGA, it should consider including finance and communications representation in the membership. See further details in Appendix Three.

2.41 All organisations interviewed during our review had similar forums in place. Some included the FGA in their remit, whilst others had more of an environmental sustainability focus.

Ideas identified through other NHS Wales organisations

- Using the SMB or other means to undertake deep dives to verify if the SDP and 5WoW are being implemented and embedded throughout the organisation.

Success Factor: Organisational Culture

2.42 We did not specifically undertake any work around the Trust's sustainability culture as part of this review. However, whilst there are pockets of positive, proactive attitudes towards sustainability, the Trust does not currently have an overarching understanding of the level to which sustainability is embedded in its culture. Therefore, it is not clear what action is needed to ensure success in fully embedding the SDP and 5 ways of working.

2.43 We concur with the Trust's intention to establish a network of sustainability champions, whilst noting that key individuals interviewed recognised the need to move away from reliance upon enthusiastic individuals to an organisation where sustainability is embedded within its ways of working, thinking and decision-making.

Recommendation 3b: The Trust should consider undertaking analysis to identify its current sustainability culture to support development of effective actions to enhance its current position. See further details in Appendices Three and Six.

2.44 Discussions with other organisations highlighted that they have found staff can get confused by the terminology of the FGA and overwhelmed by its requirements.

Recommendation 6: The Trust should ensure it has a coordinated FGA communications plan and that all communications avoid the use of, or clearly explain, any jargon and terminology used.

Ideas identified through other NHS Wales organisations

- Incorporating sustainability into job descriptions.
- Engaging all staff in developing action plans, whether it be those that support implementation of the strategies or those arising from any self-assessment undertaken.
- Embedding the FGA and sustainability into staff awards.
- E-guides covering different themes (e.g., biodiversity, travel, procurement) to get staff thinking and empower them to make individual choices.
- Online workshops encouraging teams to look at their impact (e.g., around biodiversity, travel, emissions, etc) and how they can improve in these areas to support positive actions.
- FGA / sustainability webpage to increase visibility internally and externally.
- Running divisional / directorate workshops or undertaking staff surveys to ascertain awareness levels and establish a baseline position.
- Developing FGA delivery plans on a divisional / directorate level.

Success Factor: Operational Lead

2.45 The Trust has an Environmental Development Officer (currently a band 6 role) who sits within the Estates department. The role originally focused on environmental sustainability but has more recently been widened to incorporate the wider sense of sustainability encompassed in the FGA.

2.46 Whilst the current individual in the role recognises and embraces the wider remit, the job description had yet to be updated. We were informed there is an intention to revisit the job description and to consider whether the role moves into the Strategy function of the Directorate.

2.47 The Trust's position regarding an operational lead is largely consistent with other NHS Wales organisations, with these individuals largely being at a band 6 level but organisations looking to revisit job descriptions in light of the FGA. Whilst the lead sits within Estates for some organisations, the FGA is led through Public Health in others. We note that one organisation has recently created and recruited to a band 7 role that covers all aspects of sustainability under the FGA; this role sits within the organisation's strategy team.

Recommendation 4b: In reviewing the job description of the Estates Development Officer, the Trust should consider what other NHS Wales organisations have in place in terms of operational leadership and support.

Success Factor: Monitoring and Measurement

2.48 Alongside nationally defined performance measure (for example, under the decarbonisation plan), the Trust has developed performance indicators for each of the ten themes within the Sustainability Strategy (although we note target have yet to be set for these – see recommendation 2 in Appendix Three).

2.49 The Trust has undertaken a gap analysis on the development of the new Velindre Cancer Centre (see TCS Gap Analysis section below for details). However, it has yet to undertake a wider self-assessment on its other activities and operations – see recommendation 3 in Appendix Three.

2.50 A common theme arising from our discussions with the Trust and other NHS Wales organisations was how to capture and report on work, projects and activities that contribute towards the wellbeing goals. All organisations saw this as a key challenge to be addressed and recognised the need to identify and connect dots to acknowledge and celebrate change and support further change.

Recommendation 7: The Trust should work with other NHS Wales organisations to identify and developing mechanisms to effectively capture and report on contributions to the wellbeing goals.

Ideas identified through other NHS Wales organisations

- Maintaining / publishing a directory of projects identify which wellbeing goals, ways of working and organisational wellbeing objectives the projects contribute to.

Success Factor: Policy and Procedure

2.51 This area was out of scope for this review, so we have not reviewed the Trust's policies and procedures to see how the FGA and sustainability are incorporated. However, we have included it here for completeness and make the following recommendation:

Recommendation 8: As the Trust reviews its policies and procedures during the normal course of business (i.e., when each document is next due for review), it should ensure the FGA (including the SDP and 5 ways of working) is considered during the review process. The updated document should clearly link to the wellbeing objectives and 5WoW.

Success Factor: Joined Up Working and Learning Across Wales

2.52 The Trust's Environmental Development Officer attends the Welsh Health Environmental Forum (WHEF). This forum has an environmental focus, and we were informed it does not cover the wider implications of the FGA at present.

2.53 Our discussions with other organisations highlighted that there is significant opportunity for joined-up working, both across NHS Wales and the wider public sector that the Trust has yet to take advantage of:

- Public Health Wales Health & Sustainability Hub (the PHW Hub): Part of the PHW Hub's remit is to support implementation of the FGA across Wales, for example through sharing good practice and working with the FGC. The Hub could also provide opportunity for greater influence through joined up working, for example, regarding procurement within NHS Wales, which would be of particular benefit to smaller organisations.
- Sustainable Development Coordinators Cymru Plus (SDCC+) network: SSDC+ is a professional network of policy makers and practitioners embedding sustainable development in public sector organisations, responding to the FGA. We were informed that, previously, the only NHS Wales organisation invited to the network was PHW. However, membership is now open to all NHS Wales organisations and we understand one Health Board has already taken up this opportunity.
- Public Service Boards (PSB): Cardiff & Vale University Health Board shared the work it has been involved in with its local PSB around developing charters for the local area, for example, around healthy travel. We were informed the Trust is joining the Cardiff Health Travel Charter within its Travel Plan. Whilst the Trust is not formally invited to join PSBs (under section 51 of the FGA), there may be further opportunity for joined up working with PSBs where appropriate.

Recommendation 9: The Trust should seek further opportunities to pursue joined up working within NHS Wales and throughout the wider Welsh public sector. See further details in Appendix Three.

Conclusion: The Trust is generally in a positive position regarding the success factors. We have identified recommendations for further enhancement, the key areas being around understanding the organisation's sustainability culture, developing mechanisms to capture and report on contributions to the wellbeing goals and SDP, and seeking further opportunities for joined up working across Wales.

TCS Gap Analysis

2.54 The Trust is undertaking an analysis of the main part of its Transforming Cancer Services (TCS) Strategy (i.e., the development of the new Velindre Cancer Centre) against the FGC Trackers.

2.55 An initial analysis exercise was undertaken in June 2020, where the project design brief, Green Ambition Strategy and Cardiff Council requirements were assessed against the potential actions outlined in the Trackers under the Making Simple Choices and Being More Adventurous categories.

2.56 Each potential action within these categories was RAG rated (green = system/process already implemented, amber = considered, red = has not been considered). The results of the gap analysis, including areas identified for

improvement, were presented to an informal meeting of Trust senior management in August 2020 and to the FGC in September 2020.

2.57 The identified gaps were then provided to the TCS team to enable inclusion within the design and development process.

2.58 At the time of our review, the Trust had entered the competitive dialogue stage of the development process. As part of this process, the Trust is revisiting the TCS gap analysis to demonstrate progress made since the previous analysis and identify areas for further enhancement. This was undertaken through workshops with the various project workstreams in January 2022. We understand the update will continue throughout the competitive dialogue process and the results will be reported to the TCS Scrutiny Committee upon completion.

2.59 We were informed that the analysis will be revisited the analysis again throughout the project, for example, once the final bid has been chosen.

Recommendation 10: The Trust should consider how it can efficiently and effectively incorporate FGA considerations / gap analysis into its projects and bidding processes for expenditure (capital and non-capital) going forward, including where the spend does not meet the criteria for more formal project management processes.

Conclusion: A comprehensive FGA gap analysis has been undertaken on the development of the new Velindre Cancer Centre. Areas for improvement are being identified and the analysis is being revisited at key stages of the project to demonstrate improvements made and identify further action required.

Appendix One: Terms of Reference

Scope and Objectives

The review aimed to support the Trust in its development of the Sustainability Strategy and supporting implementation plan.

Regarding the content and development of the Sustainability Strategy, we:

a. identified what the Trust is doing well; and

b. identified areas for development and improvement.

We also provided an independent review of the sustainability gap analysis undertaken by the Trust on its Transforming Cancer Services (TCS) Strategy.

Limitation of scope

We did not consider:

a. the wider requirements of the FGA, including achievement of the seven wellbeing goals or the Trust's wellbeing objectives; and

b. implementation of the Sustainability Strategy (the Trust will not be at implementation stage at the time of the review).

Associated Risks

The key risk considered in this review was failure to apply (or demonstrate the application of) the Sustainable Development Principle, potentially resulting in:

a. non-compliance with the FGA;

b. failure to achieve the seven wellbeing goals and / or the Trust's wellbeing objectives;

c. failure to become a sustainable organisation;

d. poor patient / donor / local population experience (now or in the future); and

e. financial and / or reputational damage.

Appendix Two: What we did

Our approach was to:

a. review and assess the Trust's approach to developing the Sustainability Strategy, including how the Trust ensured a joined-up approach to its wider strategy development activities;

b. assess the content of the draft Sustainability Strategy against the five ways of working using:

- the Future Generations Commissioner's 'Journey to' trackers for the wellbeing goals; and
- the Audit Wales 'positive indicators' for the five ways of working, set out in its January 2020 report, Implementing the Wellbeing of Future Generations Act – Velindre University NHS Trust;

c. compare the Trust's approach to embedding sustainability and the content of the draft Sustainability Strategy to other NHS Wales organisations; and

d. review the TCS Strategy sustainability gap analysis, including consideration of the resulting actions and how progress is evidenced.

To achieve this, we undertook the following review activity:

Interviews with:

- Key Trust staff:
  - Director of Strategic Transformation, Planning & Digital;
  - TCS Director;
  - Assistant Director of Estates, Environment & Capital Development;
  - Deputy Director of Planning & Performance;
  - Environmental Development Officer; and
  - Interim Head of Communications.
- Representatives from six other NHS Wales organisations.

High-level review of:

- Strategic Development Committee papers from November 2020 to March 2022;
- xxx
- Trust Strategy (Destination 2032) and Sustainability Strategy, including comparison to a sample of:
  - Audit Wales positive indicators; and
  - FGC 'Journey to' Tracker suggestions;
- Key sustainability documents from the six other NHS Wales organisations interviewed;
- The detailed FGC Tracker comparisons used in the TCS gap analysis;
- Evidence of reporting and presentation of the initial analysis results for the TCS gap analysis; and
- Evidence of the recent workshops held to update the TCS gap analysis for the competitive dialogue stage of the new Velindre Cancer Centre project.

Appendix Three: Recommendations

Reference	Recommendation
Recommendation 1 (paragraph 2.7)	When an agile approach is used, the Trust may wish to consider, and identify up front, the level of evidence needed to demonstrate the process and support the actions taken. Examples include maintaining a list of meeting dates (identifying the meeting purpose), retaining informal meeting notes, and maintaining an action log.
Recommendation 2 (paragraph 2.19)	Where not yet set, the Trust should ensure clear targets and milestones for the performance indicators identified in the Sustainability Strategy are clearly defined in the tactical implementation plans.
Recommendation 3 (paragraphs 2.27 and 2.41-2.42)	a. The Trust may wish to undertake a wider self-assessment of its baseline position against the FGA. The AW positive indicators and FGC Trackers can be used to support this process, recognising these tools are neither prescriptive nor exhaustive, therefore the Trust may be taking actions not included in either whilst still contributing to the seven wellbeing goals and implementing the SDP. b. As part of the self-assessment process, the Trust should consider undertaking analysis to identify its current sustainability culture to support development of effective actions to enhance its current position. See Appendix Six for guidance on how this could be carried out.
Recommendation 4 (paragraphs 2.36 and 2.46)	a. The Trust may wish to consider whether increased focus on the FGA and sustainability at an Executive or senior management level would be beneficial in supporting its FGA journey. b. In reviewing the job description of the Estates Development Officer, the Trust should consider what other NHS Wales organisations have in place in terms of operational leadership and support.
Recommendation 5 (paragraph2.39)	Whichever forum the Trust decides to use to provide oversight, accountability and leadership for the FGA, it should consider including finance and communications representation in the membership: • finance representation: to support the Trust's goal to triangulate performance reporting and to consider the impact sustainability has on finance and the need to ensure financial sustainability; and • communications representation: to support clear, coordinated organisational communication on FGA / sustainability matters and support increased visibility throughout the organisation.

Reference	Recommendation
Recommendation 6 (paragraph 2.43)	The Trust should ensure it has a coordinated FGA communications plan and that all communications avoid the use of, or clearly explain, any jargon and terminology used.
Recommendation 7 (paragraph 2.49)	The Trust should work with other NHS Wales organisations to identify and developing mechanisms to effectively capture and report on contributions to the wellbeing goals.
Recommendation 8 (paragraph 2.50)	As the Trust reviews its policies and procedures during the normal course of business (i.e., when each document is next due for review), it should ensure the FGA (including the SDP and 5 ways of working) is considered during the review process. The updated document should clearly link to the wellbeing objectives and 5WoW.
Recommendation 9 (paragraph 2.52)	The Trust should seek further opportunities to pursue joined up working within NHS Wales and throughout the wider Welsh public sector. Examples include: • making links with the Public Health Wales Health & Sustainability Hub; • joining the Sustainable Development Coordinators Cymru Plus network (SDCC+); and • making links, and developing relationships with, the Public Service Boards in the areas the Trust works.
Recommendation 10 (paragraph 2.58)	The Trust should consider how it can efficiently and effectively incorporate FGA considerations / gap analysis into its projects and bidding processes for expenditure (capital and non-capital) going forward, including where the spend does not meet the criteria for more formal project management processes.

Appendix Four: Comparison to Audit Wales Positive Indicators

Positive indicator selected for analysis	Trust response
What would show a body is fully applying the **long-term way of working**?	
There is a clear understanding of what "long term" means in the context of the Act	The overarching Trust Strategy and enabling strategies cover a ten-year period (2022-2032).
What would show a body is fully applying the **preventative way of working**?	
The body allocates resources to preventative action that is likely to contribute to better outcomes and use of resources over the longer term, even where this may limit the ability to meet some short-term needs	The Sustainability and Estates Strategies highlight both reactive and preventative action (e.g., the Decarbonisation Plan) which ensures the Trust will address the climate emergency and mitigate our footprint so address long term issues.
What would show a body is **taking an integrated approach**?	
Individuals proactively work across organisational boundaries to maximise their contribution across the wellbeing goals and minimise negative impacts	All enabling strategy leads met continuously throughout the development of the strategies to ensure they proactively embed key areas into the documentation. Each strategy has a focus and direct reference on well-being.
What would show a body is **collaborating effectively**?	
The body is focused on place, community and outcomes rather than organisational boundaries	The strategies focus on collaboration within the Trust divisions, other NHS providers, third sector bodies and the FGC office.
What would show a body is **involving people effectively**?	
Seeing the views of stakeholders as a vital source of information that will help deliver better outcomes	The Trust sought engagement with internal and external stakeholders during the development of its strategies.

Appendix Five: Comparison to the 'Journey to' Trackers

Wellbeing Goal	FGC Tracker suggestion selected for analysis	Addressed by Trust in	RAG	Trust response
Making Simple Changes				
A more equal Wales	ME90: Ensure your organisation supports festivals that promote diversity and inclusion, such as Gwanwyn, Refugee Week Age Cymru.	People Strategy		Full equality events and link in with national festivals under creation with new Head of Equality. Previously the Trust has run All Wales events for Pride / Welsh Pride etc.
Resilient Wales	RS90: On land you own, manage or work with identify, assess and map existing important trees for protection.	Sustainability Strategy External Biodiversity Audit		Sustainability Strategy Theme 7 has an objective to protect and enhance natural assets. The Trust also has undertaken external audits of all sites (as per requirements under the Environment (Wales) Act which informed the Biodiversity Enhancement Plan.
Healthier Wales	H128: Map social prescribing activities across your communities and explore opportunities to support or create further activities. As well as facilitating the use of nonclinical support for people, social prescribing also means health care professionals can develop wider relationships with their communities and the third sector and vice versa.	Sustainability Strategy Weekly Sessions		Sustainability Strategy Theme 7 has an objective around green social prescribing. The Trust has also launched a weekly green social prescribing project in partnership with Ray of Light.
Prosperous Wales	P154: Create functional platforms or channels for dialogue and information exchange between management and staff.	Digital Strategy		This is in the Digital Strategy and is embedding into the new hospital design – it will be a 'smart' hospital.
A Wales of Cohesive Communities	CC110: Find ways of involving community anchor organisations to strengthen their ability to work with local communities on the things that matter to them, using a variety of accessible, inclusive engagement methods and formats	Sustainability Strategy		Sustainability Strategy Theme 1 contains an action to "Play an active role as an Anchor Institution…".
Vibrant Culture & Thriving Welsh Language	VC2: Make Cysill and Cysgeir (Welsh grammar/spellcheck resource available to staff)	People Strategy Welsh Language Plan		The Trust has hired extra Welsh Translation Officers and has a full Welsh Language Plan to support and achieve compliance obligations under the Welsh Language Regulations.

Wellbeing Goal	FGC Tracker suggestion selected for analysis	Addressed by Trust in	RAG	Trust response
Globally Responsible Wales	GR5: Use only Recycled Paper, set a date to be paper free, and when printing move towards using only soy-based inks.	Sustainability Strategy		Sustainability Strategy Theme 6 contains objectives to reduce waste and achieve zero waste to landfill by 2025.
Being More Ambitious				
A more equal Wales	ME37: Ensure that flexible working policies are communicated to your staff, and monitor and report on flexible working requests and outcomes.	People Strategy Sustainability Strategy Digital Strategy Agile Working Policy		The People Strategy, Sustainability Strategy and Digital Strategy all directly reference flexible / agile working. There is an Agile Working Group to create the policy and communicate options to staff. There has been, and continues to be, extensive engagement.
Resilient Wales	R125: Reduce all plastic products and packaging that you use; if its use is unavoidable, choose plastic that is reusable, recyclable and with recycled content where technically possible.	Sustainability Strategy		Sustainability Strategy Theme 6 contains objectives to reduce waste and achieve zero waste to landfill by 2025.
Healthier Wales	H19: Provide mindfulness/meditation spaces in your buildings for quiet reflection.	People Strategy Sustainability Strategy		Sustainability Strategy Theme 4 contains actions around prioritising access to nature, natural light, ventilation, green space and an active travel infrastructure. Theme 7 contains actions around maximising the quality and benefits of green space, buildings and facilities to enhance nature, biodiversity and wellbeing. The Trust is currently undertaking a project to create a Well-being Centre for all staff in the Velindre Cancer Centre which includes meditation / quiet zones as well as a staff psychologist.
Prosperous Wales	P121: Support and incentivise staff and visitors using active travel, public transport, agile working options, and the use of ultra-low emission vehicles (via charging point infrastructure and fleet/ procurement arrangements) at your facilities.	Sustainability Strategy		Sustainability Strategy Theme 8 includes actions around active travel, public transport and decarbonising transport and travel options. Theme 8 also has an objective around care and services at home and closer to home. Sustainability Strategy Theme 3 has an action to accelerate the approach to agile working.

Wellbeing Goal	FGC Tracker suggestion selected for analysis	Addressed by Trust in	RAG	Trust response
A Wales of Cohesive Communities	CC24: Support the development of community networks that bring engaged people and organisations together around common themes and issues and help to develop peer networks of support. Ensure you find ways for these networks to feed into strategic policies plans and approaches to service delivery	Value Add Sponsorship Programme Sustainability Strategy		Sustainability Strategy Theme 1 includes actions around playing an active role as an Anchor Institution and working with stakeholders to identify how people can use the Trust's buildings as a community asset. Theme 7 includes actions around creating community activities, which will include arts programmes, allotments and nature trails on the Trust's estate.
Vibrant Culture & Thriving Welsh Language	VC18: Adopt 'Be Creative' alongside the 5 ways to well-being as a mechanism to improve the wellbeing of staff and communities.	Value Add Sponsorship Programme Sustainability Strategy		Sustainability Strategy Theme 1 includes actions around playing an active role as an Anchor Institution and working with stakeholders to identify how people can use the Trust's buildings as a community asset. Theme 7 includes actions around creating community activities, which will include arts programmes, allotments and nature trails on the Trust's estate.
Globally Responsible Wales	GR114: Offset 100% of carbon emissions through your organisation's travel, and communicate any increase in carbon neutral travel.	Sustainability Strategy Decarbonisation Plan		Sustainability Strategy Theme 3 objective is to be a Net Zero carbon organisation by 2030. Decarbonisation Strategy long term plan (7-10 years) includes investing in carbon offsetting schemes.

RAG status key

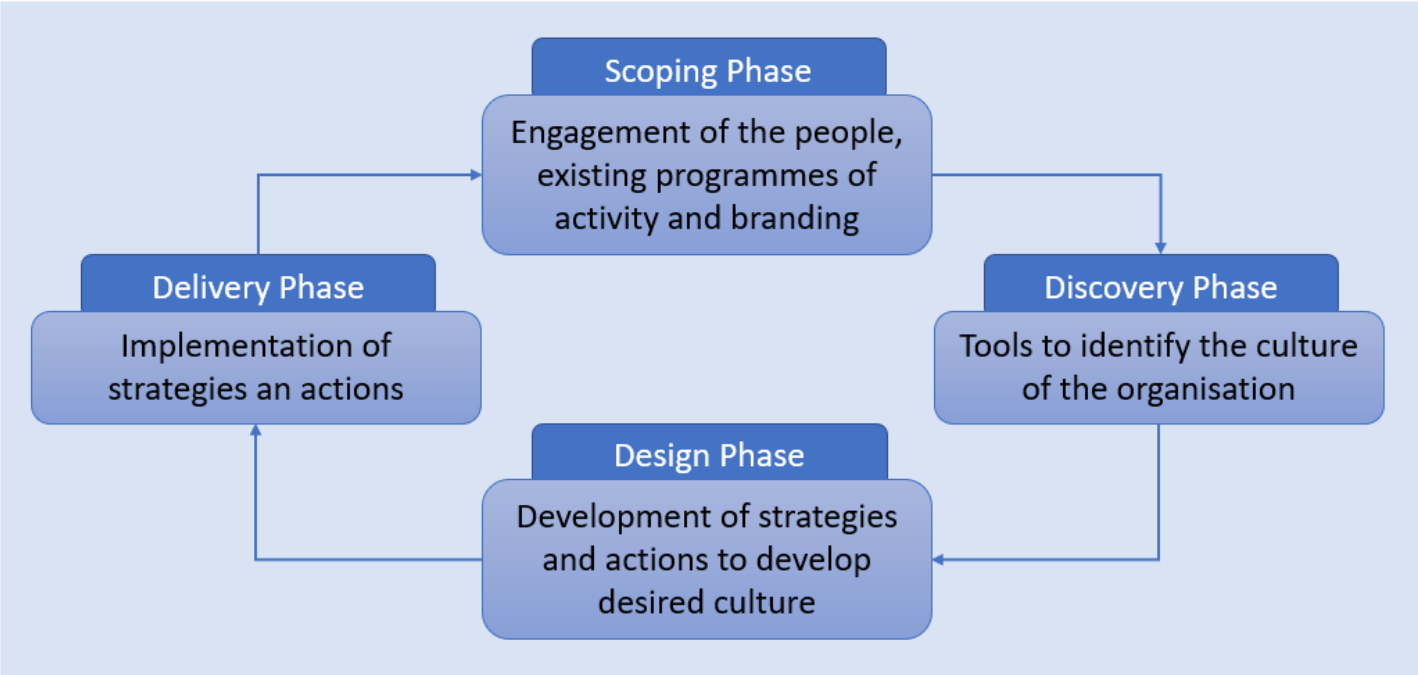
- FGC Tracker action implemented or identified as an action by the Trust or alternative approach identified
- FGC Tracker action partly identified as an action by the Trust or not 100% clear yet as plans not fully developed
- FGC Tracker action not identified as an action by the Trust

Appendix Six: Assessing Organisational Culture

Organisational culture is crucial to the achievement of an organisation's goals. NHS Improvement has developed a Culture and Leadership Programme. The Programme provides a practical, evidence-based approach to assist organisations in understanding how staff perceive the current culture and how this can be changed.

Whilst the Programme is aimed at compassionate and collective leadership, it can be adapted / expanded to assess any aspect of organisational culture.

The programme is split into four phases:



NHS Improvement provides detailed guidance on each phase of the process on its website. We have provided a high-level summary for information in figure 5 (next page), with links to the detailed NHS Improvement guidance.

Scoping Phase

This involves:

- Obtaining senior leadership support;
- Communicating with the organisation;
- Project planning, including identifying the purpose, setting objectives and styles of working, identifying milestones, outcomes and benefits to measure success, etc; and
- Creating and developing a change team.

Discovery Phase

Engaging with the organisation to ascertain how the culture is currently perceived and gaining views from staff on how to move forward.

Examples of tools to achieve this include:

- Senior leadership interviews, for example, Independent Members, Executive Directors, Assistant Directors, divisional leadership teams;
- Culture focus groups, engaging staff from across the organisation on different topics pertaining to culture;
- Surveys, for example, leadership behaviour surveys;
- Consideration of patient and donor experience; and
- Leadership workforce analysis, undertaking a talent review and gap analysis to support the desired culture.

Synthesis Stage

This is the bridge between the Discovery and Design Phases, encompassing the following components:

Design Phase

Development of strategies and actions based on the outputs of the Discovery Phase.

Delivery Phase

Engagement and communication of strategies and actions identified during the Design Phase.

Evaluating the Design Phase.

Delivery of the strategies and actions

Figure 5: overview of Culture and Leadership Programme Phases

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

Follow Up: Previous Recommendations

Final Internal Audit Report

May 2022

Velindre University NHS Trust

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

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

Contents

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Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Krisztina Kozlovszky, Principal Auditor John Cundy, Principal Auditor
Executive sign-off:	Matthew Bunce, Director of Finance
Distribution:	Lauren Fear, Director of Corporate Governance & Chief of Staff Executive Team
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

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

Executive Summary

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance that recommendations are implemented appropriately and in a timely manner.

Overview of findings

We have provided **reasonable assurance** over the follow-up of previous recommendations.

Throughout 2021/22, we followed up on the implementation of 18 recommendations, five within this report and 13 throughout other 2021/22 Internal Audit Reports. We found that:

- ten recommendations have been implemented in full;
- progress had been made on a further six (three partially implemented, three superseded) with further work required to reduce the risk to an acceptable level; and
- two had not been implemented.

Of the eight recommendations that remain open, six are currently rated as medium priority and two are low priority. Two are detailed in this report at Appendix A and the residual six have been reported through other 2021/22 Internal Audit reports, as set out in Appendix B.

We also identified areas for improvement with the Trust's Audit Action Tracker process. Full details can be found in Appendix A.

Follow-up Report Classification[1]

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.

Assurance summary (by prior year priority)

	High	Medium	Low	Total
Closed	2	5	3	**10**
Partially implemented	1	2	-	**3**
Superseded	1	2	-	**3**
Not implemented	-	2	-	**2**
Total	**4**	**11**	**3**	**18**

Key matters arising (this report only)

	Report	Recommendation	Control Design or Operation	Recommendation Priority
1	2021/22 Follow Up: Previous Recommendations	Trust Audit Action Tracker (new recommendation)	Design	High
2	2020/21 Welsh Language Standards	Velindre Cancer Centre Working Group	Operation	Medium

[1] The scope of this follow-up review provides assurance against the implementation of the agreed actions from the sampled recommendations from prior years' audit reports. It does not provide assurance against the full scope and objectives of the original audits.

1. Introduction

1.1 We undertook a follow-up review of previous Internal Audit recommendations. The review sought to provide Velindre University NHS Trust (the Trust) with assurance that recommendations are implemented appropriately and in a timely manner.

1.2 For Internal Audit reports issued during 2020/21, we reviewed all high priority recommendations[2] and a sample of medium priority recommendations[2] to provide assurance on:

i. the level of implementation;

ii. the completeness and accuracy of Internal Audit action updates provided to the Audit Committee via the Audit Action Tracker (the Tracker); and

iii. where necessary, the appropriateness of requested extensions to deadlines for implementation.

1.3 Additionally, for completeness, we have summarised our findings on follow up work undertaken as part of other 2021/22 Internal Audit reports in section 2, with an overview provided at Appendix B.

1.4 A total of 18 previous recommendations have been followed up during 2021/22, five through this report and 13 through other 2021/22 Internal Audit reports.

Associated risks

1.5 The potential risks considered in the review were:

i. failure to implement agreed audit recommendations in a timely manner;

ii. increased financial, clinical, statutory and reputational risk for the Trust; and

iii. inaccurate reporting of the Tracker within the Trust.

2. Detailed Findings

2021/22 Follow Up Work

2.1 Between this review and other audits undertaken during 2021/22, we have undertaken followed up testing on 18 prior year findings, 14 from 2020/21 reports and four from 2018/19.

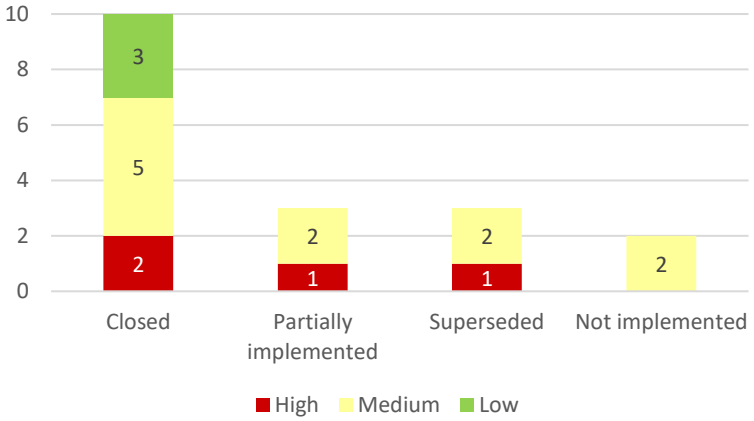
2.2 Of the 18 recommendations:

- ten have been implemented in full and are considered closed;
- eight remain open, of which:

[2] Excluding recommendations already followed up as part of other 2021/22 Internal Audit report.

- three have been partially implemented, with progress made sufficient to reduce the priority rating but with further work required to reduce the risk to an acceptable level;
- three have been superseded by new recommendations – we noted progress against each of the original recommendations, but new recommendations were required to reduce the risk to an acceptable level; and
- two had not been implemented, i.e., no or minimal progress had been made, or implementation could not be evidenced.

Figure 1: status of all recommendations followed up by previous years' priority



2.3 Of the eight open findings, six are now considered to be medium priority and two low priority.

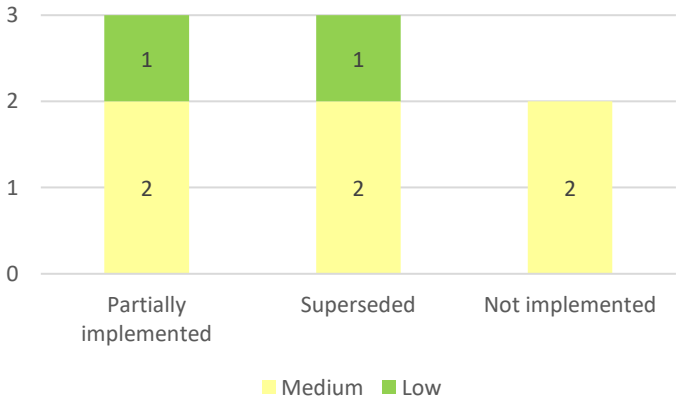


Figure 2: status of open recommendations by current year priority

2.4 Six of the open findings have been reported in other 2021/22 Internal Audit reports (as set out in Appendix B), therefore are not repeated here.

2.5 The two findings included in this report relate to:

i. **2020/21 Welsh Language Standards report:** the previously high priority recommendation relating to ensuring the Velindre Cancer Centre (VCC) Welsh Language Development and Working Groups were regularly meeting and that meetings were evidenced has been superseded. The original recommendation was closed on the basis that a cycle of meetings

had been established. However, the Covid-19 pandemic has significantly impacted meeting frequency throughout 2021/22 and we identified further recommendations around enhancing the Groups' Terms of Reference and action tracking processes. See **matter arising 2** in **Appendix A**.

ii. **2020/21 Workforce Planning Follow up report:** the prior year medium priority recommendation relating to medical workforce action plans was not included in the Tracker and the individual responsible for implementing the recommendation was not aware of it. However, the original recommendation has been superseded because the Trust has developed a Clinical Service and Quality Review Programme to review clinical services, including medical workforce planning, as part of the Velindre Futures programme. See **matter arising 3** in **Appendix A**.

2.6 Full details of the open recommendations in this report can be seen at Appendix A. All recommendations followed up during 2021/22 (in this report and other 2021/22 Internal Audit report) are summarised in Appendix B.

Trust Audit Action Tracker

2.7 The Trust's Tracker is maintained by the Business Support Officer for Finance (BSFO) with oversight from the Director of Finance as the Executive Lead for the Audit Committee.

2.8 We identified several areas for improvement in the Tracker process, including:

- providing clarity for oversight of the Tracker updates by Executive Leads for Internal Audit reports (we note that future action is intended in this area);
- ensuring appropriate authority for the requesting of updates (we note action has recently been taken on this);
- providing enhanced information in the Audit Committee Tracker reports; and
- maintaining a clear update history in the supporting Tracker spreadsheets.

2.9 For the findings followed up throughout 2021/22, we identified the recommendation status per the Tracker (as of the January 2022 update) and compared this to our audit findings. In summary, of the 18 recommendations followed up:

- ten had been closed on the Tracker which we also considered to be closed;
- seven had been closed on the Tracker, but our audit work found them to be partially implemented (three recommendations), superseded (two recommendations) or not implemented (two recommendations); and

- for one recommendation (noted in paragraph 2.5.ii), which we classed as superseded based on our work, we could not locate it on the Tracker spreadsheet or Tracker reports to the Audit Committee.

2.10 Additionally, as part of the 2021/22 Follow Up: Previous Recommendations review, we traced the five recommendations sampled through to the Tracker progress updates, noting the following:

- there is often a lack of clarity in updates provided where deadlines have passed and in the justifications for closing recommendations down;
- some actions went missing from the Tracker without explanation;
- some updates provided were against the incorrect recommendation and did not address the required actions;
- identical responses to multiple recommendations have been treated differently; and
- common themes across Internal Audit recommendations are not being addressed.

2.11 Our findings and recommendations on the Tracker are detailed in full in **matter arising 1** in **Appendix A**.

Appendix A: Management Action Plan

Report: 2021/22 Follow up: Previous Recommendations (VEL-2122-16)

1. New Matter Arising: Trust Audit Action Tracker (Design)	Impact
We identified several areas for improvement in the Tracker process. Some action has been taken to address parts of these areas since the January 2022 Audit Committee. We have included all areas here for completeness: • **Clarity of Executive oversight for updates:** The Executive Leads for Internal Audit reports have not been sighted on the requests for updates, or the updates provided, to the Tracker, therefore are unable to effectively hold responsible individuals to account to provide clear, appropriate responses or ensure timely implementation of actions. We were informed that, going forward, Executive Leads will be copied into update request emails and informed of the expectation that they should review the responses for appropriateness and clarity. • **Authority to request updates:** The individual who was responsible for requesting updates (the BSOF) does not have sufficient authority to request updates to the Tracker, which has led to difficulty in obtaining timely and adequate updates for reporting to the Audit Committee and, in some instances, has led to no responses being reported against some recommendations. We understand that going forward, the update request emails will be sent from the Director of Finance's email address. • **Enhancing information for Audit Committee reporting:** – **Recommendations included in reports:** The Audit Committee only receives the full Tracker annually. At other meetings it only receives updates on overdue (red) and closed (green) recommendations. There is a risk the Audit Committee is not able to effectively hold the Trust to account on timely implementation of recommendations not yet completed or past the target date. – **Tracker cover report:** The Tracker cover report only details the key to the status of recommendations on the Tracker. It does not provide sufficient information to give an overview of the status of recommendations on the Tracker, e.g., it does not give an indication of the number of recommendations on the tracker or an analysis of those recommendations and changes since the previous update. • **Maintenance of clear update history:** – **Ability to effectively monitor progress / trends:** The Tracker only contains the current and previous update, all updates prior to this are deleted (although are maintained through previous iterations of the	Potential risk of: • failure to implement agreed audit recommendations in a timely manner; • increased financial, clinical, statutory and reputational risk for the Trust; and • inaccurate reporting of the Tracker within the Trust.

Tracker). It is difficult to trace continued progress against recommendations through to completion and trends in lack of progress may not be identified. We understand that, going forward, all previous updates will be now retained on the Tracker spreadsheets.

- **Loss of information:** Through our audit work, we noted that the approach to deleting recommendations once they have been completed and reported to the Audit Committee means the audit trail for completed recommendations is difficult to trace. Additionally, important information may be lost from the spreadsheet for recommendations with multiple management responses where part of the response is closed but part remains open.

Comparing the January 2022 Tracker status for the 18 recommendations followed up during our 2021/22 to the findings of our audit work (overview provided in Appendix B), we identified:

- **Tracker status differs to our findings:** seven recommendations had been closed on the Tracker, but our audit work found them to be partially implemented (three recommendations), superseded (two recommendations) or not implemented (two recommendations); and
- **Recommendation not on Tracker:** for one recommendation (noted in paragraph 2.5.ii and **matter arising 3**), which we classed as superseded based on our work, we could not locate it on the Tracker spreadsheet or Tracker reports to the Audit Committee.

We traced the five recommendations sampled as part of the 2021/22 Follow up: Previous Recommendations audit to the Tracker progress updates, noting:

- **Lack of clarity in updates and closure justification:** Updates where deadlines have passed often do not include clear requests or justifications for an extension to the deadline or indicate the updated target date. Similarly, explanations for closing recommendations often do not clearly state the action taken or justification for action closure.
- **Actions going missing from Tracker:** For two recommendations, actions sometimes went missing from the Tracker spreadsheets and Audit Committee reports without explanation, despite deadlines having passed and the recommendation not being closed. Sometimes (but not always), these actions reappeared in subsequent Tracker spreadsheets / reports.
- **Incorrect update:** For one recommendation, the updates provided in the Tracker spreadsheet and Audit Committee reports referred to another recommendation and did not address the recommendation they had been provided against.
- **Differing treatment of identical responses:** For one recommendation, one part of the four-part management response was identical to a management response on another recommendation but was treated differently on the

Tracker (similar updates were provided, but one action was closed on the July update whilst the other remained open until the October 2021 update).

- **Common themes not being addressed:** Through our review of the Tracker spreadsheets / reports and the findings of 2021/22 Internal Audit reports, we note there appears to be a commonly recurring theme regarding Datix training in our audit findings, both in current and previous years.

These findings demonstrate a need to strengthen Executive oversight and accountability in the Audit Action Tracker process.

Recommendations	Priority
1.1 a. The Trust should develop a documented process for the governance of its Audit Action Tracker, considering the findings of this report and covering: i. roles and responsibilities of: • the Board and Audit Committee; • Internal and External Audit (and other reporting bodies where appropriate); • Executive Leads and responsible individuals identified in reports, including the requirement for oversight, accountability and scrutiny by the Executive Leads; and • those charged with maintaining the Tracker. ii. the process for providing management responses to audit recommendations, including expectations on the quality of the responses; iii. mechanisms to ensure all recommendations are included within the Tracker, including recommendations raised in follow up reports; iv. the process for managing updates to recommendations on the Tracker; v. expectations on the quality of updates and justifications for extensions to deadlines or recommendation closure; vi. clarity on the expectations of Internal and External Audit (and other reporting bodies, for example Healthcare Inspectorate Wales) on what is required to close a recommendation;	High

vii. regular review of the Tracker to identify themes, e.g., lack of progress in implementing recommendations or common issues occurring which may benefit from a Trust-wide solution or an alternative approach to ensure effective resolution; and

viii. Audit Committee reporting requirements – this should consider the appropriate level of information required by the Audit Committee to provide an overview of implementation status and to hold the Trust to account for timely implementation of recommendations.

b. The Audit Committee should approve the Audit Action Tracker Governance process.

c. The approved process should be communicated to all relevant staff, for example, through inclusion of a link when Internal Audit (or other reports) are sent out.

Note: We have provided the Trust with examples from other NHS Wales organisations and will provide guidance as the Trust develops this process.

1.2 The Trust should undertake a thorough review of the current Tracker to ensure:

- all recommendations are included as appropriate;
- action updates and justifications to deadline extensions are clear and appropriate; and
- all relevant information is included in the Tracker where parts of recommendations with multi-part responses have been closed.

1.3 We concur with the decision to keep all action updates (not just the previous two) to create a more robust audit trail and allow for effective trend monitoring.

Going forward, the Trust should also ensure the Tracker spreadsheet includes closed recommendations / actions rather than deleting them (filters or separate worksheets could be used to achieve this effectively).

Management response	Target Date	Responsible Officer
1.1 a. <u>Recommendation accepted</u> Meeting held with Internal Audit on 5th May to discuss to the governance process for the Audit Action Tracker and how this process can be improved. **Action:** A paper to be presented to Division SLT/SMT and EMB identifying learning and recommending improvements to the Audit Action Tracker process including a	June 2022	Director of Finance

Management response (continued)	Target Date	Responsible Officer
documented process covering items set out in 1.1(a) and using other learning from examples provided from other NHS Wales organisations		
b. Recommendation accepted **Action:** Paper to be presented to EMB and documented process for Audit Action Tracker to be approved by Audit Committee.	19th July 2022 Audit Committee	Director of Finance
c. Recommendation accepted **Action:** The approved process will be communicated to all relevant staff	By end July 2022	Director of Finance
1.2 Recommendation accepted **Action:** The DoF Business Support Officer has already undertaken an initial review of the action tracker and sought from action owners clarity on specific actions and target dates as well as formal request to close actions requiring a summary confirming the key actions taken to justify closure. The DoF will ask a senior member of the Finance Team to undertake a further review of the current Tracker specifically in relation to the 3 points identified.	19th July 2022 Audit Committee	Director of Finance
1.3 Recommendation accepted **Action:** As the report states the Trust has already decided it would be more helpful to keep all action updates (not just the previous two) to create a more robust audit trail, assist the action lead in the quality & consistency of their action updates and enable effective trend monitoring.	Already Actioned	Director of Finance
Action: The Trust has already agreed that going forward the Tracker spreadsheet will include closed recommendations / actions rather than deleting them.	Already Actioned	Director of Finance

Report: Welsh Language Standards (VEL-2021-03)

2. Previous Matter Arising: Velindre Cancer Centre Working Group (Operation)

Original recommendation and management response	Original priority
Management should ensure that the Velindre Cancer Centre (VCC) takes appropriate action with regards to the working group and/or other divisional management arrangements so that they are effective in achieving the targeted compliance rate, including retaining evidence of meetings, actions and timescales. **Management response:** The VCC working group is now meeting regularly. A system will be established to record meeting notes and actions with agreed timescales at those meetings. This group will provide details of this system to the WL Trust Development group in June 2021. *Paul Wilkins, Director of Velindre Cancer Centre/ Jeff O'Sullivan, Planning and Service Development Manager / Jo Williams, Welsh language Manager* *Process 30th June 2021*	High

Current findings				Residual risk
Follow up audit status	Superseded	Audit Tracker status	Closed	The potential for financial penalties and reputational damage because the Trust is unable to comply with the Regulations within the timescales stipulated in the compliance notice.

The original recommendation was closed on the Tracker report presented to the October 2021 Audit Committee, after a cycle of meetings had been established.

Currently there are two forums in place within VCC: the Welsh Language Working Group (WLWG) and the Welsh Language Development Group (WLDG). Both forums have a formal Terms of Reference (ToR). However, the quality of these documents varied (see updated recommendation 2.2). The WLWG maintains an action log at its meetings, whilst the WLDG maintains formal minutes.

We found that, because of the Covid-19 pandemic, meetings for both forums have been held infrequently throughout 2021/22, with the frequency not in line with the ToR requirements. Whilst we understand the effect of the pandemic is recognised by the Welsh Language Commissioner and there is a new schedule of meetings in place for both Groups (WLWG proposed to be monthly, WLDG quarterly), it remains important that these meetings are reinstated and take

place at an appropriate frequency. We were also informed that the WLWG ToR needs to be updated to include more practical meeting frequencies going forward.

During our review of evidence relating to this recommendation, we noted that compliance with the Welsh Language Standards is formally monitored as part of a RAG-rated document. However, we found that neither the meeting action logs/minutes nor the RAG-rated compliance document included formal deadlines to complete actions.

Recommendations	Priority
2.1 The VCC WLWG and WLDG should ensure formal deadlines and actions are set to support compliance with the Welsh Language Standards, both in the meeting action logs and the RAG-rated compliance document. 2.2 The ToR for the WLWG and WLDG should be updated and approved, including: • ensuring reference to appropriate group names throughout the ToR; • clearly defining roles and responsibilities of Group members; and • completing the quorum section (or deleting if not considered necessary). 2.3 The Trust should ensure the WLWG and WLDG meetings now take place at an appropriate frequency and attendance is monitored, with action taken to address issues with meeting frequency or non-attendance.	Medium

Management response	Target Date	Responsible Officer
2.1 <u>Recommendation accepted</u> The Action plan for VCC WLWG is being developed along with the introduction of new meetings and attendances. Deadlines for compliance against WL actions are set by the WL Standards document itself and the RAG rating demonstrates these timescales. Internal timescales will be set by the WLWG once the action plan has been finalised. **Action**: Action plan including deadlines to be agreed by VCC WLWG and WLDG.	July 2022	Planning & Service Development Manager / Welsh Language Manager
2.2 <u>Recommendation accepted</u> **Action:** The TOR for the VCC WLWG and WLDG will be updated in line with recommendations	June 2022	Planning & Service Development Manager / Welsh Language Manager

Management response (continued)	Target Date	Responsible Officer
2.3 <u>Recommendation accepted</u> WLDG meetings have been formally agreed and a timeline for this year set. VCC WLWG meetings as stated above will now be held every month with the next meeting on the 30th of May.		
Action: WLDG and VCC WLWG to agree attendance monitoring process	June 2022	Planning & Service Development Manager / Welsh Language Manager

Report: Workforce Planning Follow up (VEL-2021-18)

3. Previous Matter Arising: Medical Workforce Planning – Action Plans (Design)

Original recommendation and management response	Original priority
Medical workforce planning should continue, and progress should be monitored by the Velindre Cancer Centre SMT accordingly. *Note: this is an updated recommendation to our original finding in our 2019/20 Workforce Planning report (VEL-1920-13). The original recommendation was high priority. Based on progress made by the time of the 2020/21 Workforce Planning Follow up audit, the updated recommendation was reduced to medium priority in the Workforce Planning Follow up report.* **Management response:** Specific Medical Workforce considerations will be progressed via local implementation groups (Urology Workforce Programme and Sustainability Groups) and an update provided to VCC SMT in May. General medical workforce considerations are incorporated into the Trust IMTP submission in 2021/22, provided to HEIW in March 2021. *Medical Business Manager, May 2021*	Medium

Current findings				Residual risk
Follow up audit status	Superseded	Audit Tracker status	Not on Tracker	The Trust does not have arrangements in place to ensure that staff are based in the right place with the right skills to meet current and future requirements.

This recommendation was not included in the Audit Action Tracker (neither the spreadsheets nor the Audit Committee reports). Additionally, we identified that, prior to the 2020/21 Workforce Planning Follow up audit, the original recommendation (from the VEL-1920-13 Workforce Planning report) was closed on the Tracker. The justification provided did not support closure of the original recommendation. See **matter arising 1**.

Our discussions with the Interim Medical Directorate Business Manager (appointed June 2021), who is responsible for the implementation of this recommendation, highlighted that they were not made aware of the recommendation.

However, the original recommendation has now been superseded because the Trust has developed a Clinical Service and Quality Review (CSQR) Programme (the Programme) to review clinical services, including medical workforce planning, as part of the Velindre Futures programme. Due to start in June 2022, the Programme is a clinical

transformation programme aimed at reviewing the full clinical model for the Velindre Cancer Centre over a two-year period. Following a clinical transformation model used in NHS England, the Programme will seek to create a framework to work with site specific teams and core clinical services to strengthen clinical service provision, patient pathways and quality of care. The CSQR Programme will be reported to the Velindre Futures Board.

Recommendations	Priority
3.1 We concur with the approach taken by the Trust to incorporate workforce planning into the Velindre Futures programme. To provide assurance to the Audit Committee that medical workforce planning is in hand going forward, the CSQR Programme's Senior Responsible Officer should provide the Audit Committee an update report on work undertaken around medical workforce planning, for example, annually. This should be included on the Audit Committee Cycle of Business.	Low

Management response	Target Date	Responsible Officer
3.1 <u>Recommendation accepted</u> **Action:** The CSQR Programme / medical workforce planning update report will be added to the Audit Committee Cycle of Business to be presented annually.	June 2022	Director of Workforce / Director of Corporate Governance / Senior Responsible Officer

Appendix B: Overview of recommendations followed up during 2021/22

Recommendations followed up and included in other 2021/22 reports:

Prior year finding	Audit Tracker Status	Our findings	Previous rating	Direction of travel	Current rating
2020/21 Financial Systems report (followed up in 2021/22 Financial Systems report)					
1. Private Patient Debt	Closed	Partially implemented	High	↑	Medium
2. Unallocated and Unidentified Receipts	Closed	Partially implemented	Medium	↑	Medium
3. Management of Aged Debts	Closed	Partially implemented	Medium	↑	Low
2018/19 Charitable Funds report (followed up in 2021/22 Charitable Funds report)					
1. Moondance Programme Board – Attendance	Closed	Closed	Medium	↑	Closed
2. Procedure for the Management of Fundraising Events is out of date	Closed	Closed	Medium	↑	Closed
3. Desktop Procedure – Monies Received	Closed	Not implemented	Medium	↔	Medium
4. Trust Guidance for Donations	Closed	Not implemented	Medium	↔	Medium
2020/21 New Velindre Cancer Centre: Advisors report (followed-up in 2021/22 nVCC Development: Contract Management report)					
1. Procurement Route: Single Tender Actions	Closed	Closed	Medium	↑	Closed
2. Letters of Intent	Closed	Closed	Low	↑	Closed
3. Contract Documentation	Closed	Superseded	Medium	↔	Medium
4. Contract Documentation	Closed	Closed	Medium	↑	Closed
2020/21 nVCC: Governance & Financial Management report (followed-up in 2021/22 nVCC Development: MIM Governance report)					
1. Governance – nVCC Project Initiation Document	Closed	Closed	Low	↑	Closed
2. Governance – Succession Planning	Closed	Closed	Low	↑	Closed

Recommendations followed up in this report:

Prior year finding	Audit Tracker Status	Our findings	Previous rating	Direction of travel	Current rating
2020/21 Welsh Language Standards report					
1. Velindre Cancer Centre Working Group	Closed	Superseded	High	↑	Medium
2020/21 Velindre Cancer Centre – Divisional Review report					
1. Risk Management – Medical Physics	Closed	Closed	High	↑	Closed
2. Incident Management – Medical Physics	Closed	Closed	High	↑	Closed
2020/21 Annual Quality Statement report					
1. AQS Content	Closed	Closed	Medium	↑	Closed
2020/21 Workforce Planning Follow-up report					
1. Medical Workforce Planning – Action Plans	Unable to locate on tracker	Superseded	Medium	↑	Low

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

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

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

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

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New Velindre Cancer Centre Development: Financial Reporting

Final Internal Audit Report

June 2022

Velindre University NHS Trust

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

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Distribution:	Carl James, Director of Strategic Transformation, Planning, Performance & Estates David Powell, Project Director, TCS Mark Ash, Assistant Project Director (Commercials & Finance) Huw Llewellyn, Director of Commercial & Strategic Partnerships Andrew Davies, Principal Programme Manager, TCS Matthew Bunce, Executive Director of Finance
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

The audit, forming part of the 2021/22 Integrated Audit Plan, was undertaken to determine whether appropriate financial reporting / management was in place at the new Velindre Cancer Centre (nVCC) project as it enters the next stages of the Project Master Plan.

Overview

Substantial assurance has been determined in this area.

During the course of the 2021/22 financial year, the Trust secured Welsh Government funding approval for both the nVCC and Enabling Works Outline Business Cases; and for the Enabling Works Full Business Case.

Robust internal financial reporting processes have been maintained, to both the Project and Programme Board.

Expenditure against the approved 2021/22 Capital Resource Limit was effectively managed.

The key matter requiring management attention is as follows:

- The separation of reporting to Welsh Government of the nVCC and Enabling Works projects.

Other recommendations are included within the detail of the report.

Report Classification

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	 2020/21

Assurance summary [1]

Assurance objectives		Assurance
1	Budget & Funding Approvals	Substantial
2	Cost Reporting	Reasonable
3	Forums for Reporting	Substantial

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

Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	The revenue funding position should be reported consistently within the Finance Report.	2	Operation	Low
2.1	Separate Project Progress Reports should be submitted to Welsh Government for the nVCC and Enabling Works projects.	2	Operation	Medium
2.2	Figures reported to Welsh Government should be consistent with those reported internally.	2	Operation	Low

1. Introduction

1.1 This audit forms part of the 2021/22 Integrated Audit Plan and has sought to determine whether appropriate financial management and reporting was in place at the New Velindre Cancer Centre (nVCC) project ('the project') as it enters the next stages of the Project Master Plan.

1.2 The audit covered the period August 2021 to March 2022.

1.3 The key risk considered in the review was that project costs may not be adequately controlled leading to failure to achieve project objectives.

1.4 Noting the ongoing impact of Covid 19, the delivery of the integrated audit plan for 2021/22 included an increased element of remote working.

2. Detailed Audit Findings

Budget & Funding Approvals: Assurance that approved budgets are supported by funding approvals from the Trust / Welsh Government; and assurance that unapproved budgets are clearly defined / reported.

2.1 At the date of fieldwork (March 2022), the approved funding position was as follows:

	nVCC	Enabling Works
2020-21 Capital funding [1]	£2.880m	*Included within nVCC total*
OBC funding (March 2021)	£5.550m	£0.250m
FBC funding (January 2022)	-	£28.1m
Additional funding:		
From nVCC budget (1) [2]	*(£0.350m)*	*£0.350m*
From nVCC budget (2) [3]	*(£1.643m)*	*£1.643m*
Total	**£6.437m**	**£30.343m**

[1]no revenue funding from the Welsh Government has been received in respect of either projects. Revenue expenditure is funded by the Trust.

[2]the transfer of this additional (interim) funding, approved by the Trust Board, was in respect site clearance, site management and security.

[3]the transfer of this additional funding, again approved by Trust Board, was in respect of further site management, security, and legal costs (£1.191m) and adviser technical and design costs (£0.452m). These costs are deemed as 'outside of project scope' by the Welsh Government.

2.2 An outturn capital spend of £5.46m (nVCC: £2.972m; Enabling Works: £2.488m) was reported to the end of 2021/22, in line with the Welsh Government approved Capital Resource Limit of £5.497m.

2.3 Total revenue expenditure, relating specifically to the nVCC project, of £0.109m for 2021/22 has also been reported – funded by the Trust.

2.4 Recognising that external capital funding is now in place, and the 2021/22 Capital Resource Limit was appropriately managed, **substantial assurance** has been determined.

Cost Reporting: Assurance that regular cost and cashflow reporting requirements were adequately defined; that reporting was sufficiently robust and timely to support effective scrutiny; that cost reports clearly outlined assumptions and/or limitations; and that appropriate checkpoint reviews have been undertaken at key junctures to ensure cost assumptions are validated and escalated as required.

2.5 Cost reporting arrangements were reviewed for the period August 2021 to April 2022. As previously reported (***Governance & Financial Reporting: issued April 2021***) monthly finance reports have been prepared by the Assistant Project Director (Commercials & Finance). These are reported to the Project Board and support the bi-monthly Project Progress Report submitted to Welsh Government.

2.6 Following recent requests from Welsh Government, now the Enabling Works FBC has been approved, at the March 2022 submission separate Project Progress Reports had been submitted for the nVCC and EW projects. Previously, a combined report had been submitted (including combined expenditure figures against the approved Capital Resource Limit). At the time of the audit fieldwork, whilst recognising the work done to date to facilitate separate reports, the narrative required updating and project-specific financial data had yet to be incorporated (**MA2**).

2.7 It was also noted that at the January 2022 combined submission, minor discrepancies were observed in the expenditure figures presented compared with those presented within the internal finance report for the same period (**MA2**).

2.8 The internal finance reports include cost information for both the nVCC and Enabling Works projects, with a consolidated report for all projects within the Transforming Cancer Services (TCS) Programme presented to the Programme Delivery Board.

2.9 The format / content of reporting remained unchanged from that reviewed at the previous audit and presented an appropriate level of detail to the Project Board and Programme Delivery Board given the current stage of the projects at the time of review. Reporting included expenditure against the approved Capital Resource

Limit, against approved internal budgets, and with variance analysis presented for each budget area.

2.10 However, on review of the recent finance reports, minor discrepancies were noted in the presentation of revenue funding figures to both Project and Programme Delivery Board (**MA1**).

2.11 Noting the above, **reasonable assurance** has been determined.

Forums for Reporting: Assurance that an appropriate forum has responsibility for receiving and scrutinising cost / cashflow reporting – as defined in terms of reference.

2.12 Governance arrangements in respect of financial reporting remained unchanged from the previous audit.

2.13 For the period under review, monthly financial reporting continued to both the Project and Programme Delivery Boards (see **para 2.11**), with Programme Delivery Board reports also appended to Trust Board papers. Whilst noting the Project Board did not meet in February and March 2022 (due to commitments to the competitive dialogue process), reporting continued to the Programme Delivery Board. Where decisions, with a financial impact, were required to be taken during this period, appropriate approvals were sought, and retrospective reporting undertaken to the Project Board at the April 2022 meeting.

2.14 These arrangements support an appropriate level of scrutiny and decision making with regards the financial position of the project.

2.15 Noting the above, **substantial assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Cost Reporting (Revenue Funding) (Operation)	**Impact**
For the period reviewed (August 2021 to April 2022), finance reports were presented to each Project Board meeting as a standing agenda item; summarising capital and revenue funding and expenditure for both the nVCC and Enabling Works projects. Whilst the reports were otherwise comprehensive and robust, minor discrepancies were noted in the figures presented for revenue funding. For example, the latest report (April 2022) highlighted that revenue funding of £110k has been agreed to date by the Trust (noting no additional Welsh Government revenue funding has been provided); however, the report later (at paragraph 3.6) stated revenue funding totalled £56k for the same period. The latter appears to be a legacy figure left, in error, from earlier reports. Whilst acknowledging this is a minor discrepancy, management have confirmed that £110k is the correct figure.	Potential risk of: • Lack of clarity / confusion to the reader.

Recommendations		**Priority**
1.1	The finance reports should present consistent and up to date information regarding revenue funding.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed. The finance reports will be checked, before presentation, by the Assistant Project Director (Finance & Commercials) to ensure consistency of reported figures and to have no transposition errors.	Completed – June 2022	Assistant Project Director (Finance & Commercials)

Matter Arising 2: Welsh Government Reporting (Operation)	**Impact**
The Welsh Government Project Progress Reports are reported to the Project Board, to enable scrutiny of information presented, and comparison with the finance report. To date, the Trust has submitted a combined Project Progress Report, for both the nVCC and Enabling Works projects (including combined Capital Resource Limit (CRL) and expenditure figures). Following Welsh Government's recent communication of the need for separate reports, noting the Enabling Works project has received FBC approval, the Trust prepared separate reports for the first time in March 2022 However, narrative and financial information had yet to be finalised. It was also noted, when reviewing the last combined return to Welsh Government (January 2022), that there was a minor discrepancy (£25k) between the forecast spend against the 2021/22 CRL of £3.710m (noting these are figures for nVCC & EW combined): • Finance report: £3.706m forecast was reported; and • Project Progress Report: £3.681m forecast was reported	Potential risk of: • Incorrect information / unclear information presented to Welsh Government.

Recommendations		**Priority**
2.1	Narrative and financial information should be finalised for the separate Project Progress Reports (nVCC and EW projects) for the next submission to Welsh Government.	**Medium**
2.2	Figures reported to Welsh Government should align with those reported, internally, in the finance reports, and vice versa.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	Agreed. The WG Project Progress Reports will include all the relevant narrative and financial information relating to the specific project. Separate Project Progress Reports, for May 2022, were submitted for the nVCC and EW Projects.	Completed – June 2022	Assistant Project Director (Finance & Commercials)
2.2	Agreed. As per 1.1, the finance reports will be checked, before presentation, by the Assistant Project Director (Finance & Commercials) to ensure consistency of reported figures and to have no transposition errors.	Completed – June 2022	Assistant Project Director (Finance & Commercials)

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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New Velindre Cancer Centre Development: MIM Procurement

Final Internal Audit Report

June 2022

Velindre University NHS Trust

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

The audit, forming part of the 2021/22 Integrated Audit Plan, was undertaken to determine the adequacy of the procurement process undertaken in receiving the Pre-Qualification Questionnaires (PQQ) to participate in competitive dialogue for the new Velindre Cancer Centre (nVCC).

Overview

Substantial assurance has been determined in this area.

There was an approved Procurement Strategy which set out the timetable for project procurement. Whilst there have been some minor deviations noted to date, it was acknowledged that the project team are managing the current stage of the delivery programme within expected parameters.

The Descriptive Document, as issued to all potential Economic Operators, clearly set out the governance structure to be applied to the project, and expectations for the pre-qualification evaluation process. This, in turn, was supported by six evaluation teams each with a defined responsibility to assess the completeness and compliance of the PQQ responses applicable to their respective areas.

The expectations and requirements of all processes have been followed and in full consultation with the appropriate internal and external parties, culminating into the required reporting for the Welsh Government CAP 2 process.

There were no matters arising included at this report.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance summary [1]

Assurance objectives		Assurance
1	Procurement Strategy	Substantial
2	Governance Structure	Substantial
3	PQQ Evaluation Process	Substantial
4	Document Management	Substantial
5	Declarations of Interest	Substantial

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

1. Introduction

1.1 This audit forms part of the 2021/22 Integrated Audit Plan and has sought to determine whether the adequacy of the procurement process undertaken by the Trust in receiving Pre-Qualification Questionnaires (PQQ) to participate in competitive dialogue for the Design & Build contract at the New Velindre Cancer Centre (nVCC) project ('the project').

1.2 Audit work specific to the preferred bidder will be undertaken as part the 2022/23 Integrated Audit Plan.

1.3 The key risks considered in the review included:

- The procurement exercise had not been sufficiently robust to minimise / mitigate collusion and / or fraud; and
- The procurement exercise had not demonstrated compliance with local / national requirements and value for money had not been demonstrated.

1.4 Noting the ongoing impact of Covid 19, the delivery of the integrated audit plan for 2021/22 included an increased element of remote working.

2. Detailed Audit Findings

Procurement Strategy: Assurance that a Procurement Strategy had been adequately defined and appropriately applied.

2.1 The Procurement Strategy ('the Strategy') relating to the project was approved by the Programme Scrutiny Committee in September 2020.

2.2 Revisions were made, post this date, in relation to the competitive dialogue programme – all of which were considered and approved through the appropriate governance framework for the project. The last update to the Strategy was approved in July 2021.

2.3 The Strategy sets out a 22-month timetable for project procurement – commencing with the informal soft market testing and culminating in the financial close / award of the contract. For each action within the procurement programme, a time period for completion has been defined. For example:

- Pre-qualification / shortlisting of bidders Period of 3 months
- Competitive dialogue stage Period of 7 months
- Bootcamp Period of 1 month
- Preferred bidder stage Period of 8 months

2.4 From the review of supporting documentation, and through the attendance at the Project Board meetings (in an observer role), whilst there has been some deviation

to the expected timetable due to various events, including the withdrawal of one of the potential economic operators and the need for the Trust, in the interests of transparency, to re-advertise the procurement exercise (see ***para 2.18***) it was acknowledged that the project team are managing the programme within expected time parameters.

2.5 Noting the formulation of the approved Procurement Strategy and its appropriate application (to date), **substantial assurance** has been determined.

Governance Structure: Assurance that an appropriate governance structure was in place in respect of the PQQ process and compliance was demonstrated against the same.

2.6 Section 2 of the Descriptive Document (which was issued to all potential Economic Operators) set out the governance and assurance structure for the project. This has been previously reported on, with no issues noted (*2021/22: MIM Governance, issued February 2022, Substantial Assurance; and 2020/21: Governance & Financial Reporting, issued April 2021, Substantial Assurance*).

2.7 The governance structure was further expanded (see ***Table 1***) for the PQQ process with the establishment of evaluation panels to review the submissions from the potential Economic Operators; the output of which was evidenced as reported to Project Board and through the expected governance framework i.e., Programme Delivery Board, Programme Scrutiny Committee and Trust Board.

Table 1

Evaluation Panel	Details of Evaluators
Legal	Legal advisers
Commercial	Financial advisers
Core	Project Director; Assistant Project Director (Commercials & Finance), Senior Project Manager; Director of Cancer Services
Hospital	Specialist Design Advisers; Technical Advisers; Senior Project Manager; Assistant Director of Estates, Environment & Capital Development
Facilities Management	Technical Advisers; Senior Project Manager; Director of Cancer Services; Director of Estates, Environment & Capital Development
Community Benefits	Specialist Environmental Design & Community Benefits Adviser; Environmental Development Officer; Assistant Project Director (Commercials & Finance)

2.8 Post the issue of the respective evaluation reports (see ***PQQ Evaluation Process***), and for the commencement of the competitive dialogue / bootcamp process, the governance structure was further expanded with the following workstreams [the performance of which was outside the scope of this audit – see ***para 1.2***]:

- Financial workstream.
- Legal workstream.
- Community Benefits workstream.
- The Hospital (Design & Construction) workstream.
- Facilities Management workstream; and
- Strategy and Quality Management subgroup.

2.9 Recognising the established governance structure, and evidence of appropriate reporting within the same, **substantial assurance** has been determined.

PQQ Evaluation Process: Assurance that a defined evaluation process was in place for PQQ's in preparation for key stakeholder approval (Trust and Welsh Government).

2.10 The PQQ process is the first stage of the Invitation to Participate in Dialogue (ITPD) whereby an evaluation of the submissions received from potential Economic Operators is undertaken. Three formal submissions were received for the PQQ stage of the procurement exercise.

2.11 The PQQ process was completed on 16 July 2021. This was a slight delay to the original PQQ procurement programme (by a few days). This delay was attributed to an entity within one of the Economic Operator's consortia entering administration post submission of the PQQ, requiring a re-submission and re-evaluation of the same.

2.12 Section 9 of the Descriptive Document determined the pre-qualification evaluation process to be undertaken. Evaluation panels were established with representation from both Trust officers and external advisers (see ***Table 1***).

2.13 The evaluation process undertaken was thorough and in accordance with the defined requirements and timetable (see ***para 2.11 & 2.12***). A number of detailed reports were prepared as part of the evaluation process including:

- PQQ Evaluation Summary Report.
- Workstream Evaluation Reports (total of six); and
- Economic and Financial Standing Report.

2.14 The task for each workstream/evaluation panel was to review the PQQ responses to the questions relevant to their respective area / responsibilities, and to ensure

the response had been prepared in a complete and compliant manner. For each report (except for Legal, where the focus, at this stage, was solely on completeness and compliance; rather than substance of the responses) the allocated officers considered and scored the responses; with a consensus score derived. In all instances, there was minimal variation between the officers scores, therefore recognising the strength of the compliance of the Economic Operators' submissions.

2.15 Whilst some commentary was provided within the Economic & Financial Standing report regarding the gearing and liquidity ratios for some of the service providers within the Economic Operator's consortia, these were not significant enough to impact the 'pass' conclusion.

2.16 Full details of the evaluation process were provided to the Trust Board members to ensure they were fully versed in the process and the outcomes; prior to notification to the Welsh Government as part of the CAP 2 process. The output of which was recommending that all three Economic Operators were invited to the next stage of the procurement i.e., participate in dialogue.

2.17 Following the communication of the ITPD, two of the three Economic Operators indicated to the Trust that they could not proceed further in the process without some risk cover i.e., stipend or equivalent. The application of such was approved by Welsh Government in August 2021; and the terms of the arrangement were shared with the three Economic Operators.

2.18 The introduction of such an arrangement also required an update to be shared with the market recognising it may have changed the decision for those who had originally expressed an interest in the project but had not submitted a response. Accordingly, a transparency notice to this effect was prepared in full consultation with the Trust, Welsh Government, and the Legal Advisers, and shared on Sell2Wales to notify all those who recorded an interest in the project– no further submissions were subsequently received.

2.19 It was also at this point that one Economic Operator withdrew from the procurement process. This was not deemed detrimental as the Scrutiny Committee had previously endorsed the following options regarding the number of bidders it felt would be sufficient to progress the procurement process (and noting the application of option 2 in this instance):

- Option 1: three PQQ responses received, and project undertakes the PQQ evaluation and determine position. Expect to invite three bidders to participate in dialogue.
- Option 2: two PQQ responses received and of high quality. Subject to Welsh Government approval, expect to invite the two bidders to participate in dialogue.

- Option 3: two average or less PQQ response(s). A new contract notice would be issued, and a new procurement process commences.

2.20 Noting the above, the requirements for the defined evaluation process, and deviations where applicable, have been followed and in full consultation with the appropriate internal and external parties. Therefore, **substantial assurance**, has been determined.

Document Management: Assurance that adequate document management has been retained to demonstrate the fair and equitable treatment of all bidders.

2.21 Section 8 of the Descriptive Document set out the rules in respect of the prequalification stage including the use of Sell2Wales and the Bravo e-procurement system. It further stated the management process for requests for clarifications prior to submission of the PQQ; including the cut-off date for responses to be provided to ensure the timetable for progression was maintained.

2.22 In addition to requests for clarifications, the Bravo e-procurement system was also used to post updates to the potential Economic Operators including updates to documents such as the design brief, technical schedules etc; and transparency notices etc. (see ***para 2.18***).

2.23 All documentation relevant to the ITPD was retained on an external e-platform which "*enables organisations working on large capital projects to come together, plan, design and build with seamless information sharing*". This ensured all appropriate parties had access to the same information.

2.24 Access to this e-platform is controlled by the Trust therefore ensuring only bona-fide individuals from the potential Economic Operators, and officers within the Trust, had approved access.

2.25 Noting the above, **substantial assurance** has been determined.

Declarations of Interest: Assurance that appropriate guidance and procedures exist for the declarations of interest and compliance was demonstrated in respect of the same.

2.26 Consideration was given to the requirements in place for declarations of interest for both project team officers, external advisers and the Economic Operators who are invited to participate in competitive dialogue.

2.27 For those project team officers involved, the annual declaration of interest process was confirmed as being extant for this exercise. No issues were noted that would prevent involvement in the procurement process.

2.28 For the Economic Operators, as outlined in the Descriptive Document, a condition of being invited to participate in competitive dialogue, each party was required to complete the form of Confidentiality and Non-Collusion Undertaking. Upon the

Trust's receipt of this document, and in accordance with the defined timetable, the Economic Operators would then be issued with the ITPD.

2.29 The external advisers were also required to complete similar documentation on their appointment.

2.30 The forms were duly received with no issues noted.

2.31 Recognising compliance with expectation for the declarations, **substantial assurance** has been determined.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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New Velindre Cancer Centre Development: Enabling Works Security Contract

Final Advisory Report

June 2022

Velindre University NHS Trust

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

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

Contents

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Report status:	Final
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Fieldwork completion:	3 May 2022
Draft report issued:	13 May 2022
Management response received:	22 June 2022
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Auditors:	Specialist Services Unit
Executive sign-off:	Steve Ham, Chief Executive Officer
Distribution:	David Powell, Project Director TCS Mark Ash, Assistant Project Director (Commercial & Financials) Carl James, Director of Strategic Transformation, Planning, Performance & Estates Matthew Bunce, Executive Director of Finance Mark Young, TCS Senior Project Manager Alex Bowles, TCS Project Manager Barry Williams, Finance Business Partner
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

1. Introduction

1.1 This review forms part of the 2022/23 Integrated Audit Plan and has sought to ensure compliance with the agreed contractual arrangements for security in place at the Northern Meadows site, and associated payments, at the time of the tree clearance works.

1.2 Security arrangements were procured for:

- Advanced works – for the period October 2021 to November 2021: contract value £60k; and
- Tree clearance works – for the period January 2022 to February 2022: contract value £246k.

1.3 At the date of the fieldwork, the total of invoices (£296k) received for the tree clearance works had exceeded the contract value by £50k. Payment had been made to the appointed security firm of £196k with the remaining balance put on hold, pending investigation of the cost variation.

1.4 There were no issues/concerns highlighted by management in relation to the invoices for the advanced works.

2. Executive Summary

2.1 Our review highlighted that the expected procurement process for the appointment and approval of the security firm had been duly applied. Contract documentation, for both appointments, had been signed in a timely manner and in accordance with Trust's defined financial limits.

2.2 However, weaknesses in the contract management process were identified. The key findings from our review are set out in the following table:

- Non application of the defined change process to the base contract, which has resulted in the absence of a formal contract for security arrangements during March 2022 (for which a total of £134k has been invoiced).
- Appointment of additional security cover, to that stipulated in the contract, for which formal approval has not been evidenced.
- Poor control of the financial implications of the additional security cover on the approved budget for the contract.
- Accuracy of the purchase order value to the contract value.

2.3 It is recognised that seasonal constraints, and the wider requirements of the habitat management plan, required the tree clearance works to be completed within a defined timeline to minimise the wider impact on the project programme

(both that of the Enabling Works and the MIM project), in addition to the impact on the pace of progress due to the actions of the project's protestors.

2.4 However, there is an expectation that all contracts, and associated payments are managed in accordance with the Trust's Standing Financial Instructions; with the application of scrutiny where required.

2.5 The detailed findings of this review and points for future consideration are set out within ***sections 3 and 4*** to this report.

3. Detailed Findings

Contracts: Review of the agreed contractual documentation between the Trust and the appointed security firm, and compliance with the same.

3.1 For both security contracts (Advance Works and Tree Clearance Works), the appointment process was through a Single Tender Action (STA) - following an unsuccessful competitive tender process, where no compliant tenders were received.

3.2 The Trust's Standing Financial Instructions require that STA's are reported to the Audit Committee as part of an update on procurement activity. This was only evidenced for one contract award (tree clearance works – reported to the May 2022 Audit Committee).

3.3 The contract documentation in place had been signed by all parties, in accordance with the Trust's Scheme of Reservations Delegations, and in a timely manner.

3.4 The contract (page 19) provides details on the staffing requirements to be provided and the process for variations: "*base contract….with the option to extend week by week, at the request of the client (to be made in writing…) with 7 days advanced notice".*

3.5 This flexibility, afforded by the contract, was evidenced through an authorised change request form, extending the contractual period by a week (to 28 February 2022); in addition to the provision of a further Security Supervisor for the duration of the contract which had been duly approved by Trust management.

3.6 However, through recognition of the programme of works, and review of the invoices received to date, security arrangements continued to be provided throughout March 2022. There was no evidence of any formal variation to the contract documentation and/or formal Trust approval for this period.

Payments: Review of the payments made to date and the associated supporting documentation; and compliance with the procedure for authorisation of payment in accordance with Trust Standing Financial Instructions and authorised delegated limits.

3.7 The security arrangements have been invoiced on a weekly basis. Prior to the receipt of the invoice for payments, the Enabling Works Senior Project Manager

was provided with a summary of the timesheets for the security personnel that have been on site for the relevant week. The hours are approved, applicable hourly rates agreed, and the invoice raised.

3.8 Whilst noting the checks made against the timesheets provided, verification against original site attendance records etc., was not evident. Discussions held with the Enabling Works Senior Project Manager noted that due to the dynamic nature of the work at the site, time could not be afforded to physically confirm / note the number/ skill mix of personnel on site to that included within the respective invoice.

3.9 In accordance with standard accounts payable procedures, the invoice is matched to the approved purchase order to facilitate payment.

3.10 Two purchase orders have been approved for the security contract:

- £60k in relation to the advanced works; and
- £235k in relation to the tree clearance works.

3.11 It was noted that the latter purchase order did not reconcile with the contract value (£246k) – a variance of £11k. An increase to the approved purchase order will also need to be sought to facilitate payment of the invoices relating to March 2022 (see ***para 1.3***).

3.12 Further, noting the changes that had been applied to the required personnel (see ***Change Management***), there was no supporting documentation to confirm the variances in actual site attendance to that determined at the base contract. This, in turn, has made the financial management of the security contract more difficult.

Change Management: Understanding of, and compliance with, the change management procedure relating to the security contract.

3.13 The security personnel requirements as outlined in the contract documentation, including the approved contract variation (see ***para 3.5***) was as follows:

1	Security Manager	Monday to Friday
1	Security Supervisor	*Note: day/weekend attendance requirements not defined in contract. This was an additional role added as part of the contract variation.*
12	Guardsmen	Monday to Friday (Day)
4	Guardsmen	Saturday to Sunday (Day)
6	Guardsmen	Monday to Friday (night)
4	Guardsmen	Saturday to Sunday (night)
2	Patrol vehicles	*Note: this was increased from 1 as part of the contract variation*

3.14 The contract documentation (page 19) states that the standard security requirements "*can be increased at the request of the client, with 7 days advanced notice".*

3.15 The review of the invoices received noted that there was a variation to the personnel requirements in every instance (see ***Appendix A***). However, a formal written request for a change was evidenced in only one instance – for the period 4 February to 7 February (weekend period).

3.16 The change requested was an increase for a minimum of 10 guards, plus two additional for Covid risk / drop out, noting the potential for increased protestor presence as further equipment was brought onto site. The provision invoiced for this period was greater than that requested.

3.17 Validation of the basis for the variation in the required security for the other invoice periods has only recently been sought - as the increased costs became apparent and the invoice payments put on hold. Explanations provided include:

- Increased vigilance following tunnels located at site.
- Increase round site walks and guarding in pairs, ensuring there is not an occupation that would impact on site work, delay or suspend the progress of works; and
- Expensive machinery located at remote areas of the site.

3.18 Some of the explanations cover more than one period, however, there is no consistency in the increase in the personnel applied at the same. For each increase applied, there is a financial impact yet no evidence to confirm this has been subject to appropriate scrutiny, or authorisation, prior to advising the Security Manager to proceed with the change.

Monitoring and Reporting: Review of the performance monitoring and reporting arrangements in operation.

3.19 The review of the contract documentation noted that no formal arrangements for performance monitoring was stipulated.

3.20 A 'ways of working' document was developed at the outset, in consultation with both the Trust and the appointed security contractor, for issue to the security personnel upon their induction to site. This document was further enhanced (February 2022) to address areas of concern raised (see ***para 3.22***).

3.21 No formal meetings were held in relation to the activity of the security contract. Due to the ever-evolving situations at the site, many of the interactions needed to be on a reactive basis i.e., responding to emails.

3.22 A review of some of the email correspondence received was undertaken as a part of this review. These noted performance issues raised in relation to the security provision. Such were received from members of public either via Cardiff Council

or the local Councillors; as well as from the contractor (defining their expectations of the security personnel whilst on site).

3.23 The trail of emails, between the Enabling Works Senior Project Manager and the site's Security Manager, evidenced that appropriate action was taken; as well as stipulating the consequences for any cases of continued non-compliance.

3.24 It is acknowledged that there was no Project Board meeting in February or March, due to the commitments with competitive dialogue workshops. However, there is no evidence of alternative formal reporting to the wider project team regarding performance of the security personnel including changes to the contracted personnel requirements (see ***Change Management***).

3.25 Noting the current tender exercise for security provision for the next stage of the Enabling Works programme, albeit a potentially more static provision given the recent injunction award (prohibiting persons from undertaking direct action within the land), there would be value in completion of a lessons learnt exercise to identify what went well with the management of the security contract and what could be done differently.

4 Recommended Management Action

4.1 The Single Tender Action for the security arrangements on the advanced works should be reported to the Audit Committee.

Management comment:

The Assistant Project Director (Finance & Commercials) will liaise with the Director of Finance to ensure that the STA is reported to the Audit Committee in July 2022.

4.2 Contracts should be in place before duties/works commence. The contract documentation pertaining to the security arrangements for March 2022 should be addressed by all parties.

Management comment:

The Enabling Works Project Manager(s) need to ensure that appropriate approvals are sought, and contracts varied where needed, if activities go beyond a contract end date. The approvals need to be in writing so that contract variations can be actioned. Failure to obtain approvals will be addressed using the normal Trust performance procedure.

4.3 Purchase orders should reconcile with the approved contract sum.

Management comment:

The Assistant Project Director (Finance & Commercials) will ensure that the Project Contracts Team have purchase orders for approved contract sums. The Project Finance Team will reconcile the purchase orders on a monthly basis.

4.4 Board approval is required for the increase to the purchase order value relating to the security provision for the tree clearance works. Prior to this, a full review of variations to contract should be undertaken, in conjunction with the Security Manager, to confirm accuracy of the additional costs incurred.

Management comment:

The Project Finance Team and the Enabling Works Senior Project Manager have completed a review of the contract variations to confirm the accuracy of the additional costs incurred.

A Board report has been prepared to obtain approval for the increase in costs. It has been endorsed for Board approval by the Enabling Works Project Board and it is expected to be presented to the July Trust Board.

4.5 Changes to base contract details should follow a formal change management procedure. All changes should be documented, costed, approved accordingly, and reported to an appropriate forum, to further facilitate appropriate financial management of the approved contract.

Management comment:

The Enabling Works Project Manager(s) need to ensure that appropriate changes to base contract details follow the Project's formal change management procedure. The Project Finance Team will cost any such changes. The approvals of the changes to base contracts will be undertaken in accordance with the Trusts delegated limits process. The changes to base contracts will be reported to the Enabling Works Project Board.

4.6 Management should undertake a 'lessons learned' exercise regarding the requirements/expectations of security provision, noting the current procurement exercise for security resource at the next stage of the Enabling Works programme.

Management comment:

The Assistant Project Director (Finance & Commercials) will undertake a lessons learned exercise with the Enabling Works Project Team in July 2022.

Appendix A: Summary of Invoiced Security Requirements

The following summary has been prepared by the Finance Business Partner, from review of the security personnel hours invoiced.

The significant variances are highlighted in red:

				23.01.2022		30.01.2022		06.02.2022		13.02.2022		20.02.2022		27.02.2022		06.03.2022		13.03.2022		20.03.2022	
				Week	Weekend	Week	Weekend	Week	Weekend	Week	Weekend	Week	Weekend	Week	Weekend	Week	Weekend	Week	Weekend	Week	Weekend
Role	Designation	Base Contract - Average Week	Base Contract - Average Weekend	Week 1		Week 2		Week 3		Week 4		Week 5		Week 6		Week 7		Week 8		Week 9	
Manager	Day	1.00	-	1.00	-	1.00	-	0.80	0.50	1.00	-	1.00	-	1.00	-	1.00	-	1.00	-	1.00	-
Supervisor	Day	1.00	-	-	-	1.00	0.50	1.00	0.50	1.00	1.00	1.00	0.50	1.00	1.00	1.00	0.50	1.00	1.00	1.00	0.50
Gateperson	Day	12.00	4.00	12.40	8.00	13.97	4.00	20.77	14.00	18.00	12.50	18.40	9.00	17.73	10.50	10.80	4.00	12.80	10.00	12.40	4.00
Security	Nights	6.00	4.00	2.40	1.50	5.00	4.00	5.40	3.00	10.20	16.00	9.20	5.50	7.20	4.50	6.20	4.00	7.20	7.50	7.80	1.50
Mobile Patrol	Nights	-	-	0.80	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Vehicle	-	1.00	1.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00

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NHS WALES
Velindre University NHS Trust

Annual Counter Fraud Report
01/04/2021- 31/03/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. INTRODUCTION

This Counter Fraud Annual Report has been written in accordance with Welsh Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS') to provide a written report at least annually to Velindre University NHS Trust on Counter Fraud work undertaken. All NHS organisations, in compliance to their service conditions of their NHS standard contract, must comply with the NHS Counter Fraud Authority's (NHSCFA's) fraud, bribery and corruption standards for providers.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance to the NHSCFA's standards for providers, this annual report will also document and present the following details,

- Days used to deliver counter fraud, bribery and corruption work
- The cost of counter fraud, bribery and corruption work carried out during the year
- Details of any risk based proactive exercises conducted during the year
- The number of information reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made

This report has been complimented throughout the year with detailed progress reports presented to the Audit Committee and additional briefings being presented to the Executive Director of Finance. Following acceptance and approval by the Audit Committee, this Counter Fraud Annual Report is distributed to the NHS Counter Fraud Service (Wales) and is available to the NHSCFA Quality Assurance Team for review if requested.

The NHSCFA is a Special Health Authority charged with identifying, investigating and preventing fraud within the NHS and the wider health groups. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect to the NHSCFA. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care (DHSC). For more information, the NHSCFA website is www.cfa.nhs.uk. For the purposes of this report, the term 'fraud' refers to a range of economic crimes, such as fraud, bribery and corruption or any other illegal acts committed by an individual or group to make a financial or professional gain, or to cause an economic loss.

2. SUMMARY OF COMPLIANCE

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

The LCFS' has demonstrated compliance towards the recognised standards as detailed below.

Compliance is Measured as follows:

Green – fully compliant

Amber – partially compliant

Red – non-compliant

- Accountable Individual and Audit Assurance

  The LCFS' overall governance is held by the Executive Director of Finance. The LCFS' has ensured to notify him of any referrals received and regular updates are provided throughout the investigation process. Additional to this, the LCFS' makes sure to extend this exchange of information to ensure that where appropriate, the senior workforce members are briefed where aspects of a Counter Fraud investigation may overlap with that of a disciplinary concern. During the course of the year regular updates are provided to the DoF, the Counter Fraud Champion and other senior managers where appropriate.

  The LCFS is a member of the Audit Committee and as such provides regular progress reports of Counter Fraud work undertaken throughout the year. All quarterly progress reports have been provided and presented to committee. The Annual Report has now been completed and submitted. The Annual Plan has now been completed in draft form and awaits approval from DoF

and Audit Committee. The Govt Standard Functional return has not yet been completed but the aim is to do so by 31st May 2022. There has been a delay in the reporting of in this end of year period due to the change of management within the counter fraud department.

GREEN

- Counter Fraud Bribery and Corruption Strategy / Policy and Response Plan

The organisation has a Counter Fraud, Bribery and Corruption Policy. This policy is due for review. This review to ensure that it is fully aligned to the NHS CFA strategy. The policy is available to staff via the Intranet and has been promoted during fraud awareness work carried out by the team throughout the year. Further work will be carried out in the year ahead to ascertain if possible to make the relevant documents more visible. The LCFS team this year has ensured to align its counter fraud, bribery and corruption work to the recent changes in NHSCFA counter fraud, bribery and corruption requirements.

GREEN

- Risk Assessment

The LCFS' team have, where appropriate continued to effectively work across the service to share expertise and guidance around fraud proofing, risks and vulnerability. Counter Fraud maintain a direct review and input role in relation to policy which aims to strengthen the wider practices to reducing the risk of fraud through poor policy or governance controls. Throughout the upcoming year this will be strengthened further with a full review into the relevant policies related to Counter Fraud Work. Where local risks are identified, assessment work is been carried out accordingly. During the course of the year work has been undertaken also in relation to Mandate Fraud Risk, Invoice Fraud Risk, Supplier Fraud Risk (this has been informed by a Thematic Assessment exercise implemented by the NHS CFA – the review remains partially complete and will be subject to further review during the upcoming year.) Work has also been carried out in relation to Pre-employment checks involving the use of agency staff. This work is now complete and has been reported earlier via the counter fraud progress reports. Due to the implementation of a new risk management reporting style adopted by the NHS CFA, a delay in training, and the service being stretched for a significant part of the year not all of this work has been recorded in the new format. All new risk work will now align to this methodology and be reported upon the CLUE case management system and locally through the AAC process, and recorded in line with local policy. Relationships and information sharing has continued throughout the year

between LCFS and key contacts in key areas of risk including Workforce and OD, Procurement, and Internal Audit. A review of the joint working protocols in place between LCFS and these departments will take place throughout the year ahead.

AMBER

- Annual Action Plan

An annual action plan has been completed for the year ahead that has been produced in direct alignment to the new Government Standard 13. This document currently awaits agreement and sign off from the DoF and subsequent ratification by the Audit Committee. Progress of the LCFS teams work will be reported periodically at the Audit Committee. Due to the nature of Counter Fraud work the plan remains broad, flexible and subject to change throughout the year as new risks and requirements are identified.

GREEN

- Outcome Based Metrics

Throughout the year the work of the LCFS team has constantly been measured and statistics produced. This has been carried out in the areas of raising awareness, investigation, risk, awareness, joint working, strategic planning, sanctioning, and financial loss and recovery. The service has been successful in documenting direct results. Further work is being implemented in Q1 of the year ahead to routinely collect data in relation to further areas that will assist in being able to directly measure the effectiveness of strategies implemented and work carried out. For example, the effectiveness of a new interactive internal Fraud Enquiry / Reporting tool being implemented, promoted and publicised, will be directly measured against a rise or fall in the amount of contact that is made by staff members. Further monitoring of risk work carried out will be implemented to introduce periodic review in order to assess any savings made.

AMBER

- Reporting Routes

Staff have been made aware throughout the year of the reporting routes available to them. In the last year these included direct contact with the team via email, phone and in person, the use of the online CFA reporting tool, the National Reporting Hotline maintained by Crime stoppers, and an internal reporting form. All instances of fraud reporting have been initially assessed and those that are furthered to formal investigation have been recorded on the case management system (CLUE) and reviewed accordingly. New

reporting methods are being introduced this year as laid out in the annual plan.

GREEN

- Reporting Identified Loss

The CF team has reported all incidents of suspected fraud, bribery using the CLUE management system that was introduced on 9th April 2021. This reporting tool is used to record all investigations, sanctions, recoveries and losses and also has a mechanism to record system weakness and Local Proactive Exercise work. This system has been supervised by CFS Wales and all information has been used to inform progress reporting to Audit Committee and CFS Wales.

GREEN

- Access to trained investigators

At the start of the year the organisation employed three fully trained and accredited investigators that were supported by a full-time administrative support assistant. One of these investigators was off work on sickness leave and remained so throughout the year. The administrative support assistant left in September 2021. The team were joined by a further investigator in January 2022. This team member is at the time of reporting three quarters of the way into an accreditation qualification. This is due to be completed in June 2022. The team have been under staffed for the majority of the year and have provided extra time and been bolstered throughout the year with assistance from the CFS Wales team and members of other NHS Wales teams on an ad hoc basis in order to ensure successful provision of the Counter Fraud Plan for 2021-2022.

GREEN

- Undertake Detection Activity

Where anomalies are identified through counter fraud work e.g. investigations, the CF team strives to carry out detection activity to assess whether there are any weaknesses present. Where this is the case corrective activity is proactively undertaken to mitigate the identified risk. Regular liaison takes place with internal audit in order to understand risks identified by them in order to identify and inform upon Fraud Risk. Data mining has also been undertaken within the context of the NFI database.

The majority of matches have now been closed in relation to this years' exercise with no fraud identified. Liaison with payroll services and accounts receivable for overpayment situations have been prevalent this year as a result of the unprecedented uptake of staff due to the COVID situation. This has resulted in a high volume of overpayment referrals being received by the department. Where necessary formal investigation has taken place and suitable action taken. A new all wales policy in relation to overpayments is being developed by NHSWSSP and NHS Organisations throughout Wales. All actions taken by the CF team in relation to work in this area have been reported accordingly on CLUE inclusive of any recoveries made. Improvement to be made in the upcoming year in carrying out informed detection data mining exercises and subsequent reporting and review to be carried out in line with Cabinet Office supplied methodology.

AMBER

- Access to and Completion of Training

Due to the COVID situation fraud awareness sessions to staff members have been significantly disrupted. However remotely delivered sessions have been created and delivered where possible. The plan for the year ahead is to get back to in room presenting and making sure that Fraud Awareness is mandatory at corporate induction. All wales fraud awareness training has remained available throughout via ESR. A counter fraud newsletter has been published quarterly in order to keep staff appraised. CF team staff have attended all sessions of training provided by CFS Wales and NHS CFA and a number of webinars from NHS CFA have also been undertaken in relation to update training into areas such as risk assessment and CLUE implementation.

GREEN

- Policies and Registers for Gifts and Hospitality and Conflicts of Interest

The organisation has in place policies and registers in compliance with this requirement. The register of Conflicts is managed by the Director of Governance and where appropriate liaison with CF can be sought.

GREEN

3. Allocation of Resources

At 31st March 2022 110 days of Counter Fraud work have been completed against the agreed 110 days in the Counter Fraud Annual Work-Plan for the 2021/22 financial year as shown below. The days have been used investigating allegations of fraud; interviewing witnesses; preparing, delivering and analysing the feedback from the fraud awareness presentations; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; interviewing suspects; and carrying out a risk assessment work including an exercise on pre-employment checks conducted by agencies which supply staff to the organisation, and addressing the areas of risk raised in the CFA Thematic assessment document.

Strategic Requirements 19 Days

(inclusive of corporate governance undertaking, attendance of departmental team at staff training events, report writing, planning and attendance all wales meetings.)

Proactive Work 45 Days

(inclusive of fraud awareness sessions, and publicity work such as newsletters and bulletins, system weakness reviews and reporting, Local Proactive work eg pre-employment Risk Assessment. NHSCFA procurement exercise, and National Fraud Initiative work.)

Reactive Work 46 Days

(inclusive of the investigation of all referrals, preparation of reports for disciplinary processes.)

4. Summary of Costs

Proactive Costs	**£15,753.00**
Reactive Costs	**£11,322.00**
Total Costs	**£ 27,075.00**

5. Breakdown of Investigative work areas

At 1st April 2021 a total of 2 investigations were open and being investigated by the team. One of these has since been transferred to HEIW as it relates to a bursary fraud that is managed by NWSSP and HEIW. (At the time of reporting all NWSSP investigations were reported under Velindre NHS Trust. This has since changed). During the reporting period a further 3 referrals were promoted to investigation. (1) An employee was referred for running a business whilst on sickness leave. The business was identified as cake business that was in existence prior to sick leave. The employee ran in conjunction with her job. She reported sick with work-based stress related illness. No offences and NFA taken. (2) An allegation in relation to abuse of position was made that a senior member of staff had provided free tickets to a charity event to family and friends. The CF fraud enquiry found that there was cause for concern but the evidence available and collected was insufficient to progress the matter to formal criminal prosecution. The matter was referred back to directorate for internal disciplinary remedy. *Ongoing* (3) An allegation was received that a GP had stolen PPE equipment. A full investigation took place and the findings were that no theft had occurred. Equipment had been swapped with another external agency (council) due to sizes etc. Recommendations only in relation to following policy and procedure.

A brief summary of allegations received throughout the year is provided in the table below.

Offence	No. of Referrals	Type
False Representations	1	Student Bursary Fraud (transferred to NWSSP)
Abuse of Position	1	Nepotism
False Representations	1	Running a business whilst on sickness leave

6. Sanctions and Recoveries

During the financial year the team has achieved the following sanctions and recoveries.

Disciplinary Sanctions	**0**
Criminal Sanctions	**0**
Civil Sanctions	**0**
Recoveries	**NA**

In the upcoming year savings attributed to fraud risk identification and remedy will also be recorded.

7. Fraud Awareness

During the period 1st April 2021 – 31st March 2022 a total of 17 awareness session was delivered to 342 staff members across the organisation. The feedback from this was positive.

8. Lines of Reporting

CEO	Steve Ham
Director of Finance	Matthew Bunce
Head of Counter Fraud	Gareth Lavington
LCFS	Nigel Price
LCFS	Emily Thompson
LCFS	Henry Bales

9. Executive Sign Off / Declaration

I declare that the Counter Fraud work carried out on behalf of Velindre University NHS Trust for the year 2021/2022 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard 13). The ratings that have been achieved are reported above and meet that standards set as shown.

Head of Counter Fraud: Gareth Lavington
Executive Director Finance: Matthew Bunce
Date: /2022

NHS WALES
Velindre University NHS Trust

Counter Fraud Progress Report
01/04/2022 - /2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Velindre University NHS Trust from the 1st April 2022 to the 20th June 2022.

The report's format has been adopted in order to update the Audit and Assurance Committee about counter fraud referrals, investigations, activity and operational issues.

At 20th June 2022, 24 days of Counter Fraud work have been completed against the agreed 110 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response and staff awareness; and, carrying out investigative work into fraud related activity.

The breakdown of these days is as follows:

TYPE	Days
Proactive	15
Reactive	9

2. Progress

The Counter Fraud Annual Plan 2022/2023 and the Annual Counter Fraud report 2021/2022 have now both been completed and approved by Executive Director of Finance. The plan has been approved by AAC the report to be submitted to the AAC for review and approval on 19th July 2022.

Staffing

On the 1st April 2022 the new Counter Fraud Manager commenced employment with CAVUHB. This means that the Counter Fraud department now has a team of four personnel. Three are fully accredited (ACFS) the fourth member of the team is a fully qualified investigator joining from a police background and is currently undertaking his ACFS accreditation - the projected time for completion and subsequent nomination to the counter fraud authority is June/July 2022. The new Counter Fraud Manager is a fully accredited LCFS and qualified fraud investigator. This team has the responsibility to provide the Counter Fraud service for five other NHS organisations and this staffing level allows for a maximum provision of 110 days Counter Fraud work per annum to Velindre.

Activity

Infrastructure/Annual Plan

During this reporting period, the main focus has been placed upon developing and getting underway the implementation the Counter Fraud Plan for 2022-2023. This plan has been written and approved at executive level and is now aligned fully to the NHSCFA requirements as stipulated in Government Standard 13. The plan states proposed actions throughout the year. In tandem with any investigation work that is referred and requires action, the main focus of the team in the first quarter of the reporting period (April-July) has been to review and improve the Counter Fraud infrastructure in relation to awareness of fraud in the NHS, awareness of the Counter Fraud Team, addressing any shortcomings in relation to reporting routes and contact for staff members, and identifying the presence and status of relevant policy documents. So far this has led to the following actions been undertaken -

a. The creation and implementation of a dedicated generic email address – the aim is for this to lead an additional reporting route open to staff that will compliment existing routes; will assist in recording activity generated as a result of awareness work; and will double as a dedicated incident reporting

and logging tool which automatically collects data and allows for accurate recording of outcome metrics. ***Complete***

b. The creation of a comprehensive activity database that will assist in maintaining a detailed record of work undertaken with a view to saving resource time in relation to corporate governance. ***Complete***

c. The creation of a new, up to date, interactive and dedicated Counter Fraud enquiry form and a separate Awareness session request form. Accessible by links and QR coding. These are easily available to all staff and aim to provide an additional, more effective, and speedy route to the team that compliments the national reporting line. The enquiry form is provided below (click on following link **Counter Fraud Enquiry Form**) ***Complete***

d. Review of the Counter Fraud Bribery and Corruption Policy – Velindre have a Counter Fraud Bribery and Corruption Policy. This requires review and updating. ***Ongoing***

e. Review of CF digital presence – Counter Fraud have, historically, had very little presence within Velindre digitally. Enquiries and meetings with Comms Department undertaken. Agreed that a bi-monthly newsletter will be completed by the team and forwarded to comms for inclusion in staff messaging that takes place at Velindre. Whilst the newsletter is a useful method of updating staff with all things fraud it acts also as an awareness tool highlighting the presence of the team, the work it does and the easy methods that staff can use to make contact. Further to this all fraud alerts, bulletins to be shared with comms team in a timely manner and distributed accordingly by them throughout Velindre staffing cohorts. Work is underway to develop a fit for purpose Intranet Site that can be accessed by all NHS organisations that a service is provided to. This will be hosted by CAVUHB and when complete will be appropriately signposted within Velindre. This strategy aims to build and re-enforce an anti-fraud culture throughout the organisation. ***On-going***

f. Joint working protocol with Internal Audit agreed with Head of Internal Audit and regular meetings scheduled throughout the year to assist in this protocol ***Complete***

g. Review of Counter Fraud e-Learning arrangements – whilst eLearning available on ESR – it is not a mandatory module at this time and is very

difficult to access Work is underway with the LED team at CAVUHB to develop a modern fit for purpose learning site on the All Wales Learning @ Wales Platform. When complete this will be available to all Velindre staff as an education and awareness tool that will be signposted internally within the organisation ***On-going***

h. Counter Fraud awareness at Corporate Induction now fully integrated. Dates throughout the year have been arranged. ***Complete***
i. Mandate/Invoice fraud risk and awareness discussed with Fraud Champion and DoF. CFA support materials supplied and arrangements underway to provide awareness sessions to relevant staff in this topic. ***On-going***
j. Initial meetings have now been held with Fraud Champion and DoF to gain a better understanding of the bespoke nature of the organisation in order to better understand fraud risk associated to it. Further meetings planned throughout the year. ***On-going***

Alerts/Bulletins

During this reporting period, **three fraud alerts** have been issued:

1. To all relevant staff in relation to mandate fraud (Appendix 1)
2. To all staff in relation to a prevalent scam in relation to Dell Computers. (Appendix 2)
3. To all staff in relation to a possible ESR phishing scam (Appendix 3)

Awareness Sessions

During this reporting period two general fraud awareness sessions has been delivered to Velindre staff.

Further arrangements are underway to deliver sessions to staff in relation to general fraud awareness and mandate fraud.

Newsletters

During the reporting period one newsletter has been produced. (Appendix 4)

Fraud Prevention Notices and IBURN notices

During this reporting period one FPN has been issued by the NHS CFA. This was in relation to the risks associate with Credit Card terminal fraud taking place elsewhere in the NHS. A brief investigation carried out and awaits results from the organisation whether Credit Card Terminals are in use and whether best practice (issued) is being followed. Reported upon CLUE database accordingly.

During this reporting period one IBURN notice has been issued in relation to an Imposter acting as a consultant Doctor providing educational services externally to NHS providers. Enquiries carried out in relation whether services provided to NHS Wales with Acc Payable team at NWSSP - Negative result and recorded upon Clue accordingly.

Referrals/Enquiries

During this reporting period the CAVUHB CF team have received 1 referral via the online enquiry form from Velindre staff. This was in relation to suspicious email activity and information passed to Action Fraud accordingly.

Investigations

At 1st April 2022 there were two (2) investigations open in relation to Velindre. One of the cases has been closed with no further action being taken by the CF team as insufficient evidence to provide a realistic prospect of conviction. This case related to an Abuse of Position in relation to charity work. The case remains open due to an ongoing internal disciplinary process.

The other case has since been transferred to HEIW as it related to a Student Bursary fraud and was wrongly recorded against Velindre UNT.

During this reporting period one referral has been made directly to the team that has been promoted to investigation. This related to a male suspected to be living abroad and using the Velindre Cancer Centre for ongoing treatment. The

male in question is a British citizen but is believed to not be ordinarily resident. Enquiries ongoing.

Other

Nothing to report.

Appendices

Appendix 1

Fraud Alert - Recent Mandate Fraud Risk

Appendix 2

Fraud Alert - Dell Scam Phone Call - V

Appendix 3

Fraud Alert ESR Email.pdf

Appendix 4

Fraud Newsletter May 2022.pdf

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ann Marie Stockdale, Head of Out-Patient, Medical Records and Private Patient Services
PRESENTED BY	Lisa Miller, Head of Operational Services and Delivery Ann Marie Stockdale, Head of Out-Patient, Medical Records and Private Patient Services
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Management Group	06/07/2022	Noted

ACRONYMS	
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

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

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

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Private Patient Team has focused on aged debt dating back to 2016 resulting in a significant reduction in the overall debt position.

2.2 Self paying and top up patients are now required to make payment by bank transfer prior to an appointment/treatment delivery. It is noted that there is a delay from the invoice being raised and the funds being allocated following payment, which impacts the reported debt position.

2.3 The Team have exhausted all reasonable attempts to recover aged debt. A position statement is in the process of being finalised to aid further discussion and agreement in respect of next steps. The statement will be presented to the Private Patient Management Group and the Executive Director of Finance.

2.4 As an audit action, financial key performance indicators have been developed for consideration and agreement. These are as follows:-

Key Performance Indicators (Targets to be agreed)	**31/01/2022**	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**
% Debts Payable by Insurance Companies	95.1%	95.4%	96.0%	95.1%	95.6%
% Debts Not Payable by Insurance Companies	4.9%	4.6%	4.0%	4.9%	4.4%
% Debts aged 30 days or less	33.6%	17.0%	44.5%	0.2%	28.0%
% Debts aged 31-180 days	33.4%	49.7%	25.6%	52.3%	24.2%
% Debts aged 181-365 days	10.8%	13.0%	15.3%	27.0%	23.3%
% Debts aged 1 year +	22.2%	20.2%	14.7%	20.5%	24.5%

Key Performance Indicators (Targets to be agreed)	28/02/2022	31/03/2022	30/04/2022	31/05/2022
Debts recovered in month compared with total debt end of month	7.9%	17.2%	63.3%	20.1%

2.5 The full Report (Appendix 1) demonstrates a significant shift in debt between months particularly by insurance companies. It is noted that insurance companies have 90 days in which to make payment from the invoice date, which is affecting the bottom line. This will be addressed as part of the Contract negotiations

2.6 The present percentage of debts less than 180 days is 52.2%, which when compared to April 2021 of 17%, reflects a highly significant shift towards "recent" rather than "aged" debt, improving the likelihood of receipt and demonstrable benefit of processes embedded. Emphasis of recovery focused on debts aged greater than 180 days to ensure proportion and value do not exceed anticipated levels.

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

2.7 The total value of debt is at an average of £642k per month over the reported period (Jan '22 to May '22), which when compared to the average of April '21 to Sep '21 of £399k, reflects a larger quantum of debt being chargeable to insurance companies.

2.8 The Private Patient Team has been reduced significantly for approximately fifteen months. Following recent recruitment, two staff members will be joining the team returning it to full establishment. There will be a period of training, but it is envisaged that the billing timelines will reduce and will enable more rigorous follow-up with Insurance Companies with a view to improving the time from invoice to payment.

3.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

4.1 The Committee are asked to **REVIEW** and **APPROVE** the financial key performance indicators.

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

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Appendix 1

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

Key Performance Indicators (Targets to be agreed)	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022
% Debts Payable by Insurance Companies	95.1%	95.4%	96.0%	95.1%	95.6%
% Debts Not Payable by Insurance Companies	4.9%	4.6%	4.0%	4.9%	4.4%
% Debts aged 30 days or less	33.6%	17.0%	44.5%	0.2%	28.0%
% Debts aged 31-180 days	33.4%	49.7%	25.6%	52.3%	24.2%
% Debts aged 181-365 days	10.8%	13.0%	15.3%	27.0%	23.3%
% Debts aged 1 year +	22.2%	20.2%	14.7%	20.5%	24.5%

Movement between Months (brackets indicate increase in debts)

Key Performance Indicators (Targets to be agreed)	28/02/2022	31/03/2022	30/04/2022	31/05/2022
Debts recovered in month compared with total debt end of month	7.9%	17.2%	63.3%	20.1%

All debts	31/01/2022	28/02/2022	31/03/2022	30/04/2022	31/05/2022
Within maturity (0-30 days)	194,349	108,522	389,682	932	163,241
31-60 days	44,949	151,954	89,972	141,409	328
61-90 days	40,168	43,327	46,511	61,064	36,376
91-180 days	107,874	121,265	87,415	78,248	104,269
181-365 days	62,635	82,974	133,660	145,049	135,991
1 year +	128,476	128,824	128,579	110,099	142,493
Total	**578,452**	**636,867**	**875,819**	**536,803**	**582,698**
Insured					
Within maturity (0-30 days)	191,500	102,991	380,725	0	163,241
31-60 days	43,477	151,397	85,044	141,409	0
61-90 days	40,018	42,025	46,511	57,174	36,376
91-180 days	100,720	116,223	82,333	77,550	99,891
181-365 days	62,479	82,648	133,334	139,831	130,889
1 year +	111,925	112,273	112,895	94,390	126,653
Total	550,120	607,558	840,842	510,355	557,051
Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)					
Within maturity (0-30 days)	2,849	5,531	8,957	932	0
31-60 days	1,472	557	4,928	0	328
61-90 days	150	1,302	0	3,890	0
91-180 days	7,154	5,042	5,082	698	4,378
181-365 days	156	326	326	5,218	5,102
1 year +	16,551	16,551	15,684	15,709	15,840
Total	28,332	29,309	34,977	26,447	25,648
Self payer					
Within maturity (0-30 days)	0	0	809	0	0
31-60 days	380	0	0	0	0
61-90 days	150	210	0	0	0
91-180 days	260	410	450	360	150
181-365 days	0	170	170	430	470
1 year +	1,098	1,098	231	256	231
Total	1,888	1,888	1,660	1,046	851
Top Up					
Within maturity (0-30 days)	0	5,531	8,148	932	0
31-60 days	338	0	4,928	0	328
61-90 days	0	338	0	3,890	0
91-180 days	6,894	4,632	4,632	338	4,228
181-365 days	156	156	156	4,788	4,632
1 year +	15,453	15,453	15,453	15,453	15,609
Total	22,841	26,110	33,317	25,401	24,797
Overseas					
Within maturity (0-30 days)	2,849	0	0	0	0
31-60 days	754	557	0	0	0
61-90 days	0	754	0	0	0
91-180 days	0	0	0	0	0
181-365 days	0	0	0	0	0
1 year +	0	0	0	0	0
Total	3,603	1,311	0	0	0

All debts	28/02/2022	31/03/2022	30/04/2022	31/05/2022
Within maturity (0-30 days)	85,827	(281,159)	388,750	(162,309)
31-60 days	(107,005)	61,982	(51,437)	141,081
61-90 days	(3,159)	(3,184)	(14,554)	24,688
91-180 days	(13,390)	33,850	9,167	(26,020)
181-365 days	(20,339)	(50,686)	(11,389)	9,058
1 year +	(348)	245	18,480	(32,394)
Total	**(58,415)**	**(238,952)**	**339,017**	**(45,896)**
Insured				
Within maturity (0-30 days)	88,509	(277,733)	380,725	(163,241)
31-60 days	(107,920)	66,353	(56,365)	141,409
61-90 days	(2,007)	(4,486)	(10,664)	20,798
91-180 days	(15,502)	33,890	4,783	(22,340)
181-365 days	(20,169)	(50,686)	(6,497)	8,942
1 year +	(348)	(622)	18,505	(32,263)
Total	(57,437)	(233,285)	330,487	(46,695)
Within maturity (0-30 days)	(2,682)	(3,426)	8,025	932
31-60 days	915	(4,371)	4,928	(328)
61-90 days	(1,152)	1,302	(3,890)	3,890
91-180 days	2,112	(40)	4,384	(3,680)
181-365 days	(170)	0	(4,892)	116
1 year +	0	867	(25)	(131)
Total	(977)	(5,668)	8,530	799
Self payer				
Within maturity (0-30 days)	0	(809)	809	0
31-60 days	380	0	0	0
61-90 days	(60)	210	0	0
91-180 days	(150)	(40)	90	210
181-365 days	(170)	0	(260)	(40)
1 year +	0	867	(25)	25
Total	0	228	614	195
Top Up				
Within maturity (0-30 days)	(5,531)	(2,617)	7,216	932
31-60 days	338	(4,928)	4,928	(328)
61-90 days	(338)	338	(3,890)	3,890
91-180 days	2,262	0	4,294	(3,890)
181-365 days	0	0	(4,632)	156
1 year +	0	0	0	(156)
Total	(3,269)	(7,207)	7,916	604
Overseas				
Within maturity (0-30 days)	2,849	0	0	0
31-60 days	197	557	0	0
61-90 days	(754)	754	0	0
91-180 days	0	0	0	0
181-365 days	0	0	0	0
1 year +	0	0	0	0
Total	2,292	1,311	0	0

AUDIT COMMITTEE

COMMITTEE CYCLE OF BUSINESS 2022/2023

DATE OF MEETING	19/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
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**
None		

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 It is good practice for all Board / Committees to have in place an agreed Cycle of Business for the forthcoming year.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached draft Cycle of Business aims to provide the Committee with the basis on which it will monitor its progress during the year. It also provides clarity to those who contribute to the agenda and sets out expectations for the coming year.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The plan is prepared in line with the structure for the Committee agenda. It will ensure that ongoing agendas are easy to manage and monitor, and provides a structured presentation to enable obvious gaps to be highlighted.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Committee are asked to **note** the contents of the attached Cycle of Business plan for 2022/2023.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Audit Committee Cycle of Business April 2022- May 2023

Item	Frequency	June 2022 Endorsement of Accounts	July 2022	Oct 2022	January 2023	May 2023	June 2023 Endorsement of Accounts
External Audit							
Approval of Annual Outline of Audit Work	Annually	n/a	n/a	n/a	n/a	✓	n/a
Progress Reports	All regular meetings	n/a	✓	✓	✓	✓	n/a
ISA 260 and Accounts Opinion	Annually	✓	n/a	n/a	n/a	n/a	✓
Final Accounts Report/Management Letter	Annually	n/a	n/a	✓	n/a	n/a	n/a
Receipt of Annual Audit Report	Annually	n/a	n/a	n/a	✓	n/a	n/a
Internal Audit							
Approval of Annual Plan	Annually	n/a	n/a	n/a	n/a	✓	n/a
Progress Reports	All regular meetings	n/a	✓	✓	✓	✓	n/a
Receipt of Annual Report	Annually	✓	n/a	n/a	n/a	n/a	✓
Receipt of Individual Reports	All regular meetings	n/a	✓	✓	✓	✓	n/a
Clinical Audit Annual Plan	Annually	n/a	n/a	n/a	n/a	✓	n/a
Clinical Audit Annual Report	Annually	n/a	n/a	✓	n/a	n/a	n/a
Counter Fraud							
Approval of Annual Plan	Annually	n/a	n/a	n/a	n/a	✓	n/a
Progress Report	All regular meetings	n/a	✓	✓	✓	✓	n/a
Receipt of Annual Report	Annually	n/a	✓	n/a	n/a	n/a	n/a
Administration							
Agreement of Committee Cycle of Business	Annually	n/a	✓	n/a	n/a	n/a	n/a
Committee Effectiveness Survey Issued	Annually	n/a	n/a	✓	n/a	n/a	n/a
Committee Effectiveness Survey Report	Annually	n/a	n/a	n/a	✓	n/a	n/a
Production of Audit Committee Annual Report	Annually	n/a	n/a	n/a	✓	n/a	n/a
Review of Audit Committee Terms of Reference	Annually	n/a	n/a	✓	✓	n/a	n/a
Assurance Development and Risk Management Developments							
Review of Standing Orders, SFIs and Scheme of Delegation	Annually	n/a	n/a	n/a	✓	n/a	n/a
Review Trust Risk and Assurance Frameworks *Frequency to be reviewed following embedding of the new frameworks	All regular meetings	n/a	✓	✓	✓	✓	n/a
Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria	Every other meeting	n/a	n/a	✓	n/a	✓	n/a
Losses and Special Payments report	All regular meetings	n/a	✓	✓	✓	✓	n/a
Approval of Governance Statement	Annually	✓	n/a	n/a	n/a	✓	✓
Report of Procurement Activity	All regular meetings	n/a	✓	✓	✓	✓	n/a
To receive audit action plan update	All regular meetings	n/a	✓	✓	✓	✓	n/a
Review of all outstanding audit actions from Internal & External Audit	Annually	n/a	n/a	✓	n/a	n/a	n/a
Legislative & Regulatory Compliance Register	Every other meeting	n/a	✓	n/a	✓	n/a	✓
Clinical Audit Report & Clinical Audit Plan	All regular meetings	n/a	n/a	n/a	✓	✓	✓
The CSQR Programme / medical workforce planning update report	Annually	n/a	✓	n/a	n/a	n/a	n/a
Finance							
Review of Accounting Policies	Annually	✓	n/a	n/a	n/a	n/a	✓
Endorsement of Annual Accounts	Annually	✓	n/a	n/a	n/a	n/a	✓
Receipt of Finance Technical updates	All regular meetings	n/a	✓	✓	✓	✓	n/a
Private Patient Service Financial Controls Review	All regular meetings	n/a	✓	✓	✓	✓	n/a