Public Audit Committee

Thu 12 January 2023, 10:00 - 12:30

Via Microsoft Teams

Agenda

10:00 - 10:00
0 min

1. STANDARD BUSINESS

Led by Martin Veale, Chair of the Audit Committee

1.1. Apologies

Led by Martin Veale, Chair of the Audit Committee

1.2. In Attendance

Led by Martin Veale, Chair of the Audit Committee

1.3. Declarations of Interest

Led by Martin Veale, Chair of the Audit Committee

1.4. Action Log

Led by Martin Veale, Chair of the Audit Committee

1.4.0 Audit Committee Action Log updates following October 2022 Meeting - Updated January 2023.pdf (7 pages)

10:00 - 10:00
0 min

2. CONSENT AGENDA

Led by Martin Veale, Chair of the Audit Committee

2.1. 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 04 October 2022

Led by Martin Veale, Chair of the Audit Committee

2.1.1 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 04 OCTOBER 2022-LF- final amends.pdf (10 pages)

2.1.2. Chairs Urgent Action Report

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

- **Audit Action Tracker Requested Extension Date**
- **Change to the 2022/23 Internal Audit Plan**

2.1.2 Chairs Urgent Action Report_Audit Committee 12 January 2023V3.0.pdf (3 pages)

2.1.3. Velindre Counter Fraud Policy

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

2.1.3a Cover Paper Counter Fraud Bribary Corruption Policy.pdf (4 pages)
2.1.3b Velindre CFBC Policy 27.11.22.pdf (25 pages)

2.1.4. Amendment to Standing Orders – Schedule 3

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

- 2.1.4a Amendment to Standing Orders_Schedule 3.pdf (4 pages)
- 2.1.4b Amendment to Standing Orders Appendix 1_without track changes.pdf (12 pages)
- 2.1.4c Amendment to Standing Orders Appendix 2 - with track changes.pdf (13 pages)

2.2. FOR NOTING

Led by Martin Veale, Chair of the Audit Committee

2.2.1. Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

- 2.2.1 Audit Committee Procurement Report - January 2023 MB Review.pdf (20 pages)

2.2.2. All Wales Audit Committee Chairs AWACC Meeting Highlight Report

Led by Martin Veale, Chair of the Audit Committee

- 2.2.2 AWACCM - Highlight Report - 13.10.2022.pdf (5 pages)

10:00 - 10:00
0 min

3. PRIVATE PATIENT SERVICE REVIEW

Led by Matthew Bunce, Executive Director of Finance

- 3.0.0a Audit Committee Private Patient Report Jan '23.pdf (5 pages)
- 3.0.0b PP Action Plan 28.12.22.pdf (5 pages)

10:00 - 10:00
0 min

4. INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

4.1. Trust Risk Register

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

- 4.1.0a AUDIT COMMITTEE - Trust Risk Register Paper - 12.01.20223 - Vfinal2.pdf (20 pages)
- 4.1.0b Copy of Appendix 1 - RISK-AUDIT- 12.01.2023 - REPORT DATA-final.pdf (8 pages)
- 4.1.0c Appendix 2 - Risk Appetite Statements.pdf (5 pages)

4.2. Trust Assurance Framework

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

- 4.2.0a V05 - TAF Review Paper - JAN 23 - AUDIT COMMITTEE-Final.pdf (7 pages)
- 4.2.0b AUDIT COMMITTEE - V23 TAF DASHBOARD - 10.01.2023.pdf (33 pages)

4.3. Building our Future Together - Governance Assurance & Risk Programme of Work

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

- 4.3.0a GAR PROGRAMME - Audit Com PAPER - Jan 23.pdf (4 pages)
- 4.3.0b APPENDIX 1 - GOV, RISK, TSF TIMEFRAME - EMB SHAPE 19.12.2022 - VO1.pdf (1 pages)
- 4.3.0c APPENDIX 2 -GAR PROJECT OVERVIEW WITH DELIVERABLES- EMB SHAPE - V01.pdf (3 pages)
- 4.3.0d APPENDIX 3 - GAR Steering Group TOR - V02 -EMB SHAPE - 19.12.2022.pdf (5 pages)

4.4. Legislative & Regulatory Compliance Register

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

- 4.4.0a Legislative and Regulatory Compliance Register_January 2023 Audit Committee.pdf (7 pages)
- 4.4.0b MASTER_Legislative Regulatory Compliance Register_ Review December 2022.pdf (9 pages)

4.5. Audit Action Tracker – Overdue and Completed Recommendations

Led by Matthew Bunce, Executive Director of Finance

- 4.5.0a Final Cover Paper - Audit Action Tracker Overdue and Completed Recommendations January 2023 Audit Committee.pdf (14 pages)
- 4.5.0b Audit Action Tracker Overdue and Completed Reccomendations - Audit Committee January 2023.pdf (17 pages)

10:00 - 10:00
0 min

5. EXTERNAL AUDIT

Led by Darren Griffiths (Audit Wales)

5.1. Audit Position Update

Led by Darren Griffiths (Audit Wales)

- 5.1.0a Covering paper AW Audit Committee Update Dec 2022.pdf (2 pages)
- 5.1.0b VUNHST Audit Position Statement 2023 12 Jan.pdf (10 pages)

5.2. Review of VUNHST Quality Governance Arrangements and Management Response

Led by Darren Griffiths (Audit Wales)

- 5.2.0a Covering paper AW Review of Quality Governance Arrangements.pdf (2 pages)
- 5.2.0b VUNHST Review of Quality Governance Arrangements.pdf (32 pages)
- 5.2.0c Management Response.pdf (4 pages)

5.3. Equality Impact Assessments: more than a tick box exercise? and Management Response

Led by Darren Griffiths (Audit Wales)

- 5.3.0a Covering paper AW Equality Impact Assessments.pdf (2 pages)
- 5.3.0b Equality_impact_assessment-english_0.pdf (44 pages)
- 5.3.0c Audit Wales Management Response - EQIA Jan 2023.pdf (2 pages)

5.4. The National Fraud Initiative in Wales 2020-21

Led by Darren Griffiths (Audit Wales)

- 5.4.0a Covering paper AW NFI report.pdf (2 pages)
- 5.4.0b The_National_Fraud_Initiative_in_Wales_2020_21_English_0.pdf (25 pages)
- 5.4.0c NFI 2020 21 management responses.pdf (2 pages)

10:00 - 10:00
0 min

6. INTERNAL AUDIT

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

6.1. 2022/23 Internal Audit Progress Update Report

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

- 6.1.0a VUNHST Audit Committee Progress Update Cover Paper - Jan-23.pdf (3 pages)
- 6.1.0b VUNHST Audit Committee Progress Update - Jan-23.pdf (6 pages)

6.2. Managing Attendance at Work

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

- 6.2.0 VT 2223-05 MAAW - Final Internal Audit Report - Trust issue.pdf (17 pages)

6.3. Patient & Donor Experience

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

6.3.0 VT2223-11 Patient Donor Experience Final IA Report - Trust issue.pdf (17 pages)

6.4. Digital Health & Care Record – Implementation

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

6.4.0 vel -2223-03 dhr final ia report.pdf (12 pages)

6.5. Decarbonisation (Advisory)

Led by Paul Stocker, Internal Audit Manager (NWSSP - Audit and Assurance Services)

6.5.0 Final All-Wales Decarbonisation Velindre.pdf (12 pages)

6.6. Performance Management Framework

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

6.6.0 VT 2223-08 - PMF Final Internal Audit Report.pdf (18 pages)

6.7. nVCC Contract Management Report

Led by Felicity Quance, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)

6.7.0 Velindre nVCC 2223 Contract Management_Final Report_updated for Trust issue.pdf (25 pages)

10:00 - 10:00
0 min

7. COUNTER FRAUD

7.1. Counter Fraud Progress Report Quarter 3

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

7.1.0 VELINDRE Period 3 2022 Progress Report.pdf (8 pages)

10:00 - 10:00
0 min

8. FINANCE

8.1. Private Patient Service Debt Position

Led by Rachel Hennessy, Interim Director of Velindre Cancer Centre

8.1.0a Audit Committee - Aged Debt Private Patient Service Dec 22.pdf (6 pages)
8.1.0b Appendix 1 - Aged Debt Report.pdf (1 pages)

8.2. Receipt of Finance Technical Updates

Led by Claire Bowden, Head of Financial Operations

8.2.0 Technical update January 2023.pdf (3 pages)

8.3. Losses and Special Payments Report (Verbal Update)

Led by Claire Bowden, Head of Financial Operations

10:00 - 10:00
0 min

9. ADMINISTRATION

9.1. Production of Audit Committee Annual Report

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

- 9.1.0a Covering Paper AC Annual Report 2022.pdf (2 pages)
- 9.1.0b Audit Committee Annual Report Jan - Dec 2022 final.pdf (16 pages)

9.2. Review of Audit Committee Terms of Reference

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

- 9.2.0a Review of Audit Committee Terms of Reference Cover Paper.pdf (3 pages)
- 9.2.0b Audit Committee Terms of Refernce.pdf (9 pages)

10:00 - 10:00
0 min

10. HIGHLIGHT REPORT TO THE TRUST BOARD

10:00 - 10:00
0 min

11. MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

10:00 - 10:00
0 min

12. ANY OTHER BUSINESS

By prior approval of the Chair of the Committee

10:00 - 10:00
0 min

13. DATE AND TIME OF THE NEXT MEETING

TBC

10:00 - 10:00
0 min

14. CLOSE

10:00 - 10:00
0 min

15.

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 03 May 2022 Meeting			
05/2022 6.6.0	**Internal Audit Report: DBS Checks** In relation to Management response 2.1.a. (i) DBS Policy target date of September 2022 is too far away. ****ACTION: Matthew Bunce to feedback to Sarah Morley that the Trust should develop it's DBS Local Policy as a matter of priority and consider the points raised in the recommendations/findings.**	**ACTION: Sarah Morley**	**Update DECEMBER 2022:** The draft DBS procedure is Has been shared with TU colleagues and Safeguarding group for comment. This is to be shared with EMB in January 2023 for approval. **Update SEPTEMBER 2022:** The draft DBS procedure is currently with Trade Union colleagues for comment as all documents are developed in Partnership. Comments requested back by 7th October. Two responses received so far. Once this has been collated and amendments made this will be progressed to SLT/SMT for comment and then to EMB for approval. **OPEN** **Update JULY 2022:**	**SM**

			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.	
	Actions from 19 July 2022 Meeting			
07/2022 2.2.1	**Procurement Compliance Report** Andy Butler (AB) has provided MB with an update that a protocol is being developed by NWSSP to give the Trust Audit Committee, through the Director of Finance, early sight of any risk of legal challenges from bidders participating in All Wales Contract tenders**.** **ACTION: Draft protocol to provide Trust Audit Committee with early sight of any risk of legal challenge from bidders participating in All Wales Contract tenders to be included in October 2022 Audit Committee.**	**ACTION: Andy Butler and Matthew Bunce**	**OPEN** **Update DECEMBER 2022:** GJ fed back to MB that he still had concerns and wanted further discussion with NWSSP on this matter. MB raised GJ concerns with AB who agreed to arrange further meeting between LF, MB, GJ, AB and JI. Meeting arranged 08 February 2023 **Update SEPTEMBER 2022:** NWSSP Director of Procurement has shared draft protocol for consideration by the Trust. Meeting arranged 28 September 2022, between	**AB / MB**

			Trust DOF, NWSSP DOF and NWSSP Director of Procurement. The draft protocol was shared outside of Committee with MV and GJ for review.	
07/2022 2.2.1	**Procurement Compliance Report** Initial assessment by the new Head of Procurement is that there are a high volume of Single Tender Actions (STAs) and Single Quotation Actions (SQAs) for which potentially alternative complaint procurement routes may be available. Procurement will commence work to review all available procurement framework agreements to establish whether they can be accessed as an alternative route to market, negating the need for SQA/STA. ****ACTION: Head of Procurement to provide an update and circulate an update ahead of next Audit Committee.**	**ACTION: Helen James**	**OPEN** **Update SEPTEMBER 2022:** Included in the Procurement Compliance Report on agenda. The process to review alternative procurement routes has commenced, but this will take approximately 6 months to complete.	**HJ**
07/2022 5.2.0	**Trust Assurance Framework** ****ACTION: Emma Stephens to discuss with Lauren Fear our requirements for Power BI to support further future development of TAF and share with Steve Wyndham to assess feasibility of what support might be available from Audit Wales Data Analytics Team to take forward as a project.**	**ACTION: Emma Stephens**	**Update JANUARY 2023: CLOSED** BI requirements to support development of the TAF have been shared with Steve Wyndham, Audit Wales. Awaiting confirmation and clarification of what support can be provided by Data Analytics Team within Audit Wales. In addition, discussions have been held with	**ES**

			Head of Digital Delivery to explore any resource that is available internally. There is scope for limited resource to support in next few months, pending completion of Audit Tracker support that is being prioritised. **Update SEPTEMBER 2022:** Scope of BI support requirements currently being assessed in conjunction with Trust Digital Services to assess possible support to be requested from Audit Wales. This will be confirmed before end October 2022.	
	Actions from 04 October 2022 Meeting			
10/2022 2.1.0	**Procurement Compliance Report** ****ACTION: Matthew Bunce to confirm the language and the meaning of the bullet points on Page 2 *The process which NHS Wales bodies entering into contracts* with Welsh Government.**	**ACTION: Matthew Bunce**	**OPEN** **Update JANUARY 2023:** Seeking clarification from Welsh Government colleagues.	**MB**
10/2022 2.1.0	**Procurement Compliance Report** ****ACTION: Alison Hedges to change the text on Page 7 *In addition to this exercise, for non-maintenance/servicing-related requirements, framework agreements are, again, being reviewed to engage with***	**ACTION: Alison Hedges**	**Update OCTOBER 2022: CLOSED.** The wording has been updated on the document and the updated version has been added	**AH**

	preferred suppliers/providers to being reviewed to engage with suppliers/providers appointed to the framework.		and refreshed on the Agenda Bundle.	
10/2022 3.1.0	**Trust Risk Register** ****ACTION: Lauren Fear confirmed that the suite of documents in the July Paper are being set up as a Link to the Main Home Page and when it is live a note will be sent to the Audit Committee with the Link. Lauren Fear will circulate the suite of documents in the July Trust Risk Register Paper outside of Committee.**	**ACTION: Lauren Fear**	**Update JANUARY 2023: CLOSED** **Link** **https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Corporate-Governance---Risk-Management.aspx** Final documents loaded by 12th January.	**LF**
10/2022 3.2.0	**Full Audit Action Tracker Review from Internal & External Audit** ****ACTION: Following discussions the Committee felt there was not sufficient information, specific extension dates and formal requests for extensions, provided on the Audit Action Tracker. Matthew Bunce will feed this information back to each Executive Director and based on the resources and other competing priorities agreed to endeavour to seek realistic requested extension dates for any actions that have passed the agreed implementation date. Full Action Tracker to be circulated with dates in short order in 3 weeks.**	**ACTION: Matthew Bunce**	**Update DECEMBER 2022: CLOSED** The Audit Committee was sent an email 27 October 2022 and was requested to consider the contents of the Audit Action Tracker focusing on the requested extension dates. The Audit Committee was asked to provide out of Committee Approval for the requested extensions. The recommendation was approved and a Chairs Urgent Action Matter Report will be brought to the January 2022 Audit Committee.	**MB**

10/2022 5.2.0	**Staff Wellbeing (Advisory)** ****ACTION: Lauren Fear assured the Committee the question of how information on grievances could be shared with the Independent Members will be picked up with Sarah Morley.**	**ACTION: Lauren Fear**	**OPEN** **Update JANUARY 2023:** Verbal update to be provided.	**LF**
10/2022 5.3.0	**Financial & Service Sustainability** ****ACTION: Page 15, 6.1 Management Response - *Management notes that budget holder and FBP capacity has occasionally been limited* to be changed to *Management accepts that budget holder and FBP capacity has occasionally been limited*.**	**ACTION: Matthew Bunce and Chris Moreton**	**Update DECEMBER 2022: CLOSED** The wording has been changed on the Financial & Service Sustainability Audit Report to read ***Management accepts***. This has also been updated on the Master Audit Action Tracker.	**MB / CM**
10/2022 9.1.0	**Private Patient Service Debt Position** ****ACTION: Lisa Miller responded that no assessments have been completed on recovery in the last 6 months and will action this, working closely with Claire Bowden.**	**ACTION: Lisa Miller**	**OPEN** **Update DECEMBER 2022:** Assessment currently underway which will presented to Director of Finance during quarter 4 of 2022/23.	**LM**
10/2022 9.1.0	**Private Patient Service Debt Position** ****ACTION: Committee members to be provided with a view on how soon we raise an invoice after we are entitled to do so outside of the meeting.**	**ACTION: Lisa Miller**	**Update DECEMBER 2022: CLOSED** All invoicing has to be completed within six months of the activity taking place. This is to ensure all activity is captured (and processed etc) so that invoicing is accurate against the care/treatment delivered.	**LM**

MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
TUESDAY 04 OCTOBER 2022 AT 2:00PM

PRESENT:	
Gareth Jones	Chair and Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Lauren Fear	Director of Corporate Governance & Chief of Staff
Cath O'Brien	Chief Operating Officer
Jacinta Abraham	Executive Medical Director
Chris Moreton	Deputy Director of Finance
Claire Bowden	Head of Financial Operations
Lisa Miller	Director of Operations
Simon Cookson	Director of Audit & Assurance, , NWSSP (Audit and Assurance Services)
Felicity Quance	Senior Audit Manager, NWSSP (Audit and Assurance Services)
Emma Rees	Audit Manager, NWSSP (Audit and Assurance Services)
Rhian Gard	NWSSP (Audit and Assurance Services)
Steve Wyndham	Audit Wales
Darren Griffiths	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
Helen James	Head of Procurement
Alison Hedges	Business Support Officer

1.0.0	**Standard Business** Led by Gareth Jones, Chair, and Independent Member	**Action**
1.1.0	**Apologies** Led by Gareth Jones, Chair, and Independent Member Apologies were received from: • Martin Veale, Independent Member • Steve Ham, Chief Executive Officer • Nigel Price, Local Counter Fraud Specialist • Katrina Febry, Audit Wales	
1.2.0	**In Attendance** Led by Gareth Jones, Chair, and Independent Member Gareth Jones welcomed attendees from Audit Wales and Internal Audit Services to the Audit Committee Meeting.	
1.3.0	**Declarations of Interest** Led by Gareth Jones, Chair, and Independent Member No declarations of interest were declared.	
1.4.0	**Action Log** Led by Gareth Jones, Chair, and Independent Member **05/2022 6.0.0 Internal Audit Report: DBS Checks** The Committee requested this be updated to include a date of when the DBS Policy will be finalised. Matthew Bunce agreed to speak to Sarah Morley to provide a further update to the Action Log outside of the meeting. Include time-period to review the consultation and the various governance it must go through. **07/2022 2.2.1 Procurement Compliance Report – Draft Protocol** The Committee decided this action will be kept open for the time being because online discussions regarding the Protocol haven't been finalised. Once finalised will bring to the Committee for normal governance.	

	07/2022 2.2.1 Procurement Compliance Report – Procurement Framework Agreement Review Helen James confirmed she put a longer term of 6 months but is anticipating will complete before end March 2023. Matthew Bunce noted that there will be products and outputs along the 6 months so could inform its status at various points. The Committee were happy with this approach on the assurances given. **07/2022 5.1.0 Trust Risk Register** Lauren Fear confirmed that a meeting regarding further development time on risk and assurance has been arranged for 09 November 2022 and proposed to close the action. Vicky Morris highlighted the need for a Board decision in terms of supporting risk management and this could then be brought back to Audit Committee regarding on-going development. The Committee agreed this action could be **CLOSED** for Audit Committee recognising it will go to Board and come back to Audit Committee at a future date. **07/2022 5.2.0 Trust Assurance Framework** Steve Wyndham did not recall anyone contacting him regarding support with Power BI. Lauren Fear responded she will check with the Team. **07/2022 6.1.0 Audit Position Update** Gareth Jones flagged this will be discussed at Agenda Item 4.1.0 Audit Position Update and refer back to Statement 'will be undertaken' which is still in the report without clarity around the dates. The Committee were content the item could be **CLOSED** on the Action Log. The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions.	
2.0.0	**CONSENT AGENDA** Led by Gareth Jones, Chair, and Independent Member	
2.1.0	**FOR APPROVAL** Led by Gareth Jones, Chair, and Independent Member	
2.1.1	**Draft Minutes from the Public Audit Committee meeting held on 03 May 2022** Led by Gareth Jones, Chair, and Independent Member • Lauren Fear confirmed a discussion on approach to Reverse Stress Testing will take place in the Session 09 November 2022. • **Item 9.2.0 Private Patient Debt Position – **ACTION: Matthew Bunce and Gareth Jones to have a conversation outside of the meeting regarding process and possible improvements.** The previous Action log reflects conversations took place and a meeting was held with Martin Veale in a different action column, but the need to make sure Minutes and Actions Logs are consistent in future was noted. • Lauren Fear confirmed the Audit Action Tracker had been included in the Trust Board highlight report for escalation. The AUDIT Committee **AGREED** the minutes of the meeting held on the 03 May 2022.	
2.2.1	**Draft Minutes from the Public Part A Audit Committee meeting held on 19 July 2022** Led by Gareth Jones, Chair, and Independent Member The AUDIT Committee **AGREED** the minutes of the meeting held on the 19 July 2022.	
2.2.0	**FOR NOTING** Led by Gareth Jones, Chair, and Independent Member	
2.2.1	**Procurement Compliance Report** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce highlighted the key aspects of the Procurement Compliance Report: • More background regarding what this assurance report is doing for the committee, linking it back to the Standing Orders and Standing Financial Instructions. • Report sets out the compliance and any issues around compliance between June and September 2022.	

	• Added extra section regarding entering contracts following two letters where Welsh Government sought clarity on what notifications had to be provided before entering contracts. There is a table which sets out various delegated limits. • Section on Single Quote and Single Tender applications sets out when they are allowed to be used. The procurement team is working with the Trust to make sure it is fully utilising the available frameworks. • Appendix 1.1 – Provides assurance on Single Tender Actions and Single Quotation Actions that have been entered into in a revised format to make this clearer. • Also added in as agreed the repeat submissions so can see cumulative impact in terms of the contract value. The Committee noted the conflict between Welsh Government Guidance and our Standing Orders on Page 2 and Gareth Jones highlighted the first bullet point in that list 'all NHS Contracts over a million in total to be notified to the Director General prior to tendering for the contract' and took the language to mean that is not at the stage when we are ready to award rather it should be prior to us actually launching the tender for the contract. Matthew Bunce agreed the language in the bullet points wasn't clear and noted the differences in approach for capital projects through a business case process. Gareth Jones confirmed we need to form our own interpretation of those bullet points and then run it past Welsh Government. Matthew Bunce confirmed this is formally part of the standard Standing Order and Standing Financial Instructions schedule across Wales. ****ACTION: Matthew Bunce to confirm the language and the meaning of the bullet points on Page 2 *The process which NHS Wales bodies entering into contracts* with Welsh Government.** Matthew Bunce clarified to the Committee in relation to Page 4 *Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly*. *This* was a standard statement across Wales. Procurement may choose to not sign off but, as Director of Finance, he confirmed he would still review, whilst also talking to procurement to check they are happy that it's a correct procurement process. Chair's urgent and Board approval is also included in this. ****ACTION: Alison Hedges to change the text on Page 7 *In addition to this exercise, for non-maintenance/servicing-related requirements, framework agreements are, again, being reviewed to engage with preferred suppliers/providers appointed to the framework.*** The AUDIT Committee **NOTED** the report subject to the minor amendment.	**MB** **AH**
2.2.2	**Declarations of Interests, Gifts, Sponsorship, Hospitality & Honoria** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The AUDIT Committee NOTED the report.	
	Helen James left the meeting at 2:42PM	
	Agenda item 5.4.0 Research & Development Audit Report was brought forward and discussed at this point in the meeting. See details in section 5.4.0 on the agenda. The Committee **NOTED** the Research & Development Audit Report.	
	Jacinta Abraham left the meeting at 2:45PM	

3.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
3.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear highlighted the key aspects of the Trust Risk Register to the Committee: • The Cover Paper reflects the role of this Committee and the way in which this iteration of the Trust Risk Register has been through both Quality Safety and Performance Committee and Trust Board in September 2022. **Framework Development –** • Following discussion in July the various framework documents, the procedure, the risk appetite strategy, and the Trust Assurance Framework were circulated to members, considered, and approved by the Trust Board in September 2022 and is being published on the Intranet. • Level 3 training for Leadership is complete and Level 2 doing final mop up sessions for those who haven't had this training yet and the ESR module is due to roll out as soon as the Level 2 training is complete. Currently doing work with Shared Services on that. • Welsh Blood Service have completed all migration onto Datix 14 of their Board level reportable risks and are now going through a phased transition of the remainder and all new risks are being loaded on to Datix 14. ****ACTION: Lauren Fear confirmed that the suite of documents in the July Paper are being set up as a Link to the Main Home Page and when it is live a note will be sent to the Audit Committee with the Link. Lauren Fear will circulate the suite of documents in the July Trust Risk Register Paper outside of Committee.** The AUDIT Committee **NOTED** the ongoing development of the Trust's risk framework.	**LF**
3.2.0	**Full Audit Action Tracker Review of Recommendations from Internal & External Audit** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce highlighted the key points of the report to the Committee: • Twice a year the Audit Committee will be reviewing not just Green and Red status actions but also Yellow and Orange status actions. **Internal Audit Reports**: • Since July 2022 further Internal Audit Reports added to tracker, consisting of 12 recommendations, five high, four medium, three low, resulting in 12 actions. • Since July 21 Green, 15 Red, 17 Amber and 11 Yellow status actions. • Table been added to provide overview. Split between High, Medium, Low and N/A to show movement from last Committee. • 64 actions remain outstanding. **External Audit Reports:** • 17 further actions completed since July 2022 Committee. • 29 outstanding actions. • Three reports added since July 2022 Committee, two of which are not new reports and ones that weren't sighted in the tracker, now added for completeness. Vicky Morris commented that the actions needed to be specific, and if the Committee was going to extend the time for performance then it would want to be confident the deadline would be achieved. Gareth Jones noted that he found the tables helpful with different colour coding but felt including Blue closed actions in the total gives a misleading picture. Matthew Bunce agreed next time will keep those there as a memoir but will provide the total without the Blue figure included.	

	The AUDIT Committee: • **NOTED** the contents of the report and the assurance it provides regarding the activities undertaken to address audit recommendations in response to audit report recommendations and associated risks. • **APPROVED** the 21 Internal Audit report actions and 17 External Audit report actions since the July '22 Audit Committee that have been completed (Green Status). The Committee APPROVED that these could be formally Closed (Blue Status). • Were not prepared to approve extensions on the actions that have passed their agreed implementation date (Red Status), until more specific dates and formal requests for extension are provided for consideration. • Decided it was not the role of the Audit Committee to decide what action should be taken for actions not on target for completion (Orange Status) as this was an operational matter for Executives. Requested realistic extension dates be provided for these actions for consideration out of Committee. • **NOTED** the actions that are on target for completion (Yellow Status). ****ACTION: Following discussions the Committee felt there was not sufficient information, specific extension dates and formal requests for extensions, provided on the Audit Action Tracker. Matthew Bunce will feed this information back to each Executive Director and based on the resources and other competing priorities agreed to endeavour to seek realistic requested extension dates for any actions that have passed the agreed implementation date. Full Action Tracker to be circulated with dates in short order in 3 weeks.**	**MB**
	The AUDIT Committee took a break at 3:24 and resumed the meeting at 3:35PM.	
4.0.0	**EXTERNAL AUDIT** Led by Steve Wyndham and Darren Griffiths (Audit Wales)	
	Audit Position Update Led by Steve Wyndham (Audit Wales) Steve Wyndham provided clarity to the Committee on the Charity Accounts Audit timing, confirming this is being scheduled for a December 2022 start with the aim to complete mid-January 2023 prior to the January deadline from the Charity Commission and noted that it would be completed earlier, if possible, however Audit Wales were managing a number of priorities. Gareth Jones questioned if this would give enough time to complete the audit so that obligations are fulfilled to submit that by the end of January 2023. Steve Wyndham replied that he thought this should be the case. Matthew Bunce highlighted the tight timelines in terms of getting approval through the Committee structure before the end of February 2023 and highlighted the need to work closely with Steve Wyndham and his team to make sure any concerns are dealt with quickly and earlier on in the process. Steve Wyndham confirmed that as soon as the draft accounts are available, he will be able to review and consider if there's anything needed to pick up as part of the audit. Matthew Bunce noted due to capacity the draft accounts had not been sent yet and these will be sent to Steve Wyndham as soon as possible. Gareth Jones noted the key is to have regular communication and dialogue with the Trust in terms of progress and asked for clarity on 1st December 2022 date. Steve Wyndham confirmed the start of December for commencement of the audit work. Steve Wyndham raised a point to the Committee which is not included in the paper update, around the audit fee consultation exercise. Steve Wyndham informed the Committee that the consultation is closed - the period ended mid-September - and Audit Wales are now working through comments received and will be providing responses to those bodies and amalgamating those responses into a single document which will be issued to the Senedd Finance Committee who are responsible for approval of the Audit Wales budget and fee scheme. The report will be published in November 2022.	

	Darren Griffiths updated the Committee on the performance audit work: • Review of Quality Governance Arrangements – Trust's comments on the latest draft have been received. Currently working through these aiming to issue the final report over the next couple of weeks which will be ready to be presented to the Audit Committee in the January 2023 meeting. • Structured Assessment - Work is currently underway and again aiming to present the final report to the Audit Committee in January 2023 meeting. Darren Griffiths highlighted to the Committee that Exhibit 3 sets out some of the pan public sector pan NHS Wales reports which have been published with links provided and noted two of the reports are on the agenda for consideration today. The AUDIT Committee **NOTED** the audit position update.	
4.2.0	**Public Sector Readiness for Net Zero Carbon by 2030** Led by Darren Griffiths (Audit Wales) Darren Griffiths led the Committee through the key aspects of the Public Sector for Net Zero Carbon by 2030 items 4.2.0 and 4.2.1 reports: • The reports form part of the long-term program of work on climate change at Audit Wales. • Undertook a baseline review focussed on how the public sector is preparing to achieve Welsh Government collective ambition for a Zero Public Sector by 2030. • Issued a call for evidence and contacted 48 Public Sector bodies to seek evidence. • First report published in July sets out overall conclusion of work, as well as five calls for action of organisations to tackle decarbonisation in the Public Sector. • Second report published in August provides more detail to findings and data from the baseline review. • Five calls for action focus on: Leadership and collective responsibility, clarifying strategic direction and increasing patient changes, and getting to grips with finances understanding the skills gap, and increasing capacity and improving data quality. • No formal recommendations made yet as part of this work. • Have asked public bodies to consider the five calls to action and to prepare a public statement setting out how they intend to respond. As a minimum, would expect to see a paper being presented to Audit Committees setting out the public bodies' response. If they wanted to do a more public statement or press release etc, then within the public body's rights to do so. Lauren Fear highlighted that in terms of Executive ownership this action falls under Carl James and the approach to a public statement should be discussed through Executive Management Board. Gareth Jones commented that it is a challenging objective for all public health bodies and it's not just about infrastructure, it's about everything we do. Funding was a huge challenge also and raised the question how often would this be revisited? Darren Griffith replied he was not sure of the frequency currently because this work is being led by a different team within the organisation however this is the baseline review so probably will be undertaking further studies over the course of the next few years. The AUDIT Committee **NOTED** the report.	
4.2.1	**Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report** Led by Darren Griffiths (Audit Wales) The AUDIT Committee **NOTED** the report.	

5.0.0	**INTERNAL AUDIT** Led by Simon Cookson, Director of Audit & Assurance and Emma Rees, Interim Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)	
5.1.0	**2022/23 Internal Audit Progress Update Report** Led by Simon Cookson, Director of Audit & Assurance (NWSSP - Audit and Assurance Services) Simon Cookson presented the key aspects of the Progress Report to the Committee: • Four final reports, now five as the Financial and Service Sustainability Report shown as in draft, has now been finalised. • Currently one report in draft, three work in progress and a number in planning. • No changes to number of audits planned for the year but will be proposing some changes to own approach to decarbonisation. • One KPI's red currently, management response within the agreed time, work ongoing with Matthew Bunce and Lauren Fear working on this currently. • Starting over next few weeks to think about plan for next year and will pick up on reviews that missed out getting onto this year's plan. • Everything is on track to complete the work during the rest of the year. The AUDIT Committee **NOTED** the report.	
5.2.0	**Staff Wellbeing (Advisory)** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees presented the key aspects of the report to the Committee: • Advisory review looking at effectiveness of wellbeing support and initiatives used by the Trust particularly through and out of the pandemic and to look whether improvements could be made through approaches from other NHS organisations. • Interviewed six different organisations for views. Found in general the Trust is in line with rest of NHS Wales. • Couple of recommendations regarding some improvements could be made to performance metrics, making sure that they truly capture the effectiveness, as well as the use of these initiatives. There were also some points for consideration around other potential wellbeing frameworks such as a King's Fund report. Gareth Jones questioned in the case of staff wellbeing referred as being grievances and that Independent Members don't get any information of any grievances raised by Trust Members or personnel. Vicky Morris responded that the Quality Safety and Performance Committee get sight on the private agenda in terms of formal processes but in terms of raising a grievance did not think data is received. ****ACTION: Lauren Fear assured the Committee the question of how information on grievances could be shared with the Independent Members will be picked up with Sarah Morley.** The AUDIT Committee **NOTED** the report.	**LF**
	Cath O'Brien left the meeting at 4:00pm	
5.3.0	**Financial & Service Sustainability** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees presented the key aspects of the report to the Committee: • Focus for this year is budgetary control and saving plans. • Reasonable assurance rating, with four medium, four low priority recommendations all classed as operating effectiveness.	

	• Needs to be more robustness in how the Trust demonstrates compliance with its Financial Control Procedures. Emma Rees confirmed in relation to the Trust not being able to formally audit areas as anticipated, the original hope for this year's audit was to look at the long-term planning, however due to the latest Covid wave there were elements of scope, particularly around Velindre futures and the revenue streams, which would be instead captured within next year's plan. Matthew Bunce highlighted that the team are currently working through the enabling strategies, for the two main divisions to ensure that the operational impact over the next three years is translated into their financial plans that feed into the overall Trust plan. Vicky Morris had a query in relation to the annual budget approval and the Board's role in agreeing the total income and expenditure. Emma Rees noted that the Standing Orders and Standing Financial Instructions talk about approving the annual financial plan but do not go into specifics on what that means. Matthew Bunce confirmed that going forward, he will explicitly document in the cover paper the part of the Integrated Medium-Term Plan regarding the total income and expenditure of the Trust. Chris Morton highlighted: • The Standing Financial Instructions were reviewed in detail and referenced in the management response specific sections. • The key areas involving responsibilities and delegations in which all Board members, Trust Officers etc, must apply their duties to the satisfaction of the Director of Finance. • In relation to total funding received section 4.2.3 the financial duties each year a financial report is submitted to Trust Board showing the total funding received. Matthew Bunce assured the Committee, acting in accordance with the terms of the Standing Orders and Standing Financial Instructions, he will provide a report throughout the year to the Quality, Safety and Performance Committee, which is then also reported to Trust Board. ****ACTION: Page 15, 6.1 Management Response - *Management <u>notes</u> that budget holder and FBP capacity has occasionally been limited* to be changed to *Management <u>accepts</u> that budget holder and FBP capacity has occasionally been limited*.** The AUDIT Committee **NOTED** the report subject to the changes above.	**MB/ CM**
5.4.0	**Research & Development** Led by Rhian Gard, Principal Auditor (NWSSP - Audit and Assurance Services) Rhian Gard took the Committee through the key aspects of the report: • Rating of Substantial Assurance. • Main goal to seek assurance that there is effective management of Research & Development within the Trust. • Reviewed Policies and Procedures and the Strategy. • Looked at the Governance Framework and found a minor duplication with reporting. • Evidence of good escalation processes working with partners throughout the governance structure. • Looked at the organisational arrangements and found an appropriate level of scrutiny. • Sampled a few projects and the project approval process was well structured and robust. The Committee acknowledged the robust governance processes in place and the importance of having the substantial assurance. This work has many external partners and was an important piece and that it was rewarding to evidence good practice. The AUDIT Committee **NOTED** the report.	
5.5.0	**Enabling Works Integrated Audit Plan 2021/22** Led by Felicity Quance, Senior Audit Manager (NWSSP - Audit and Assurance Services) • nVCC Enabling Works – Final Report Felicity took the Committee through the key aspects of the report:	

	• The report sought to determine the adequacy of the arrangements in place of the project and covered May 2021- June 2022. • Reviewed all the elements set in the Integrated Audit Plan within one piece of work. • Rating of Reasonable Assurance, with five matters arising leading to six individual recommendations. Gareth Jones noted the word of caution in the Executive summary in the final paragraph and it feels like a lot has happened in the Enabling Works project since the date of the report. Felicity Quance noted that she does attend to observe the Project Board Meetings which happen monthly so are often dealing with the issues arising, however this report is at a point in time. Many issues have arisen and are evolving and that could impact on assurance rating for a future report going forward. The AUDIT Committee **NOTED** the report.	
6.0.0	**COUNTER FRAUD**	
8.1.0	**Counter Fraud Progress Report Quarter 2** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington highlighted the key aspects of the report: • Completed 45 days' work of 110. • Team not currently at full staffing level, recruitment underway. • Work for the Trust has been maintained and progress made with regards to the infrastructure of the Counter Fraud Service. • Still work to do with regards to getting dates confirmed for awareness sessions. • Issues in relation to fraud prevention notices, both in relation to cyber enabled mandate fraud, across whole of NHS Wales, not specifically to Velindre. Investigations showed the Trust suffered no attacks and were robust in that area. • Two investigations that were open at the beginning of the period of reporting have since both been closed. The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	
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 Lisa Miller highlighted the key aspects of the report: • There was reduced invoicing capacity during July due to a period of staff training and extra work was put in to catch up in August. • There was an improvement in majority of KPIs being met and improvement of timescales for invoicing and collecting debts. • Introduced a Health Code system for invoicing, which increases the responsibilities on the insurance companies to meet payment deadlines, reduced from 90-30 days. Lisa Miller clarified reduced payments from private companies is a varied practice across different organisations; each contract is individual so the timescale set within that contract is standard to be 30 to 90 days, so this was brought down to the 30-day minimum deadline and been in place since mid-August. Gareth Jones highlighted the outstanding amounts figure from an insurance company owing the amount £159,000 from a year old and queried the recoverability of that and if this has been analysed as some insurers will say they won't pay over a period of outstanding debt? ****ACTION: Lisa Miller responded that no assessments have been completed on recovery in the last 6 months and will action this, working closely with Claire Bowden.** Matthew Bunce noted to the Committee that Liaison Services an external company have held the Trust's data for past 2 years, so as well as picking up on the previous 2 years with the insurance companies he will be asking them to also pick up review some of the more	**LM**

	live debts at the same time. A meeting is arranged for October 2022 to touch base and to start asking them for advice informally initially based on that intelligence. Lisa Miller and Matthew Bunce confirmed an invoice is raised within 30 days from treatment. Gareth Jones queried paragraph 2.4 and if this referred to 30 days from receipt of invoice and wasn't sure whether the days' sales outstanding on the next page is from the time treatment in services was provided up until payment? Claire Bowden clarified as the date of the treatment is unknown the date sales outstanding uses the date the invoice was raised rather than the date of treatment. ****ACTION: Committee members to be provided with a view on how soon we raise an invoice after we are entitled to do so outside of the meeting.** The AUDIT Committee **REVIEWED** and **APPROVED** the financial key performance indicators and **NOTED** the information provided in the report.	**LM**
	Losses and Special Payments Report (Verbal Update) Led by Claire Bowden, Head of Financial Operations Approved one loss in relation to loss of patient's property. Value approved was £1860. The AUDIT Committee **NOTED** the verbal update.	
10.0.0	**HIGHLIGHT REPORT TO THE TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting 24 November 2022. No points for escalation.	
11.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	None.	
12.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
13.0.0	**DATE AND TIME OF NEXT MEETING**	
	12 January 2023, 10:00–12:30 via Microsoft Teams.	
14.0.0	**CLOSE**	
	The meeting CLOSED at 4:32pm	

AUDIT COMMITTEE

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer / Committee Secretariat
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	**CONSIDER** and **RATIFY**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Audit Committee	27/10/2022	APPROVED
Audit Committee	01/12/2022	APPROVED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Velindre University NHS Trust Audit Committee, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Audit Committee. In these circumstances, the Chair and Executive Director of Finance, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Audit Committee - after first consulting with the Chair. Out of Committee approval was sought from the Chair, two Independent Members and an Executive Director. The Executive Director of Finance must ensure that any such action is formally recorded and reported to the next meeting of the Audit Committee for consideration and ratification.

1.2 Chair's action may not be taken where either the Chair or the Executive Director of Finance has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Deputy Chair or the Executive Director acting on behalf of the Executive Director of Finance will take a decision on the urgent matter, as appropriate.

1.3 This report details Chair's Urgent Action taken on the **27 October 2022** and the **01 December 2022.**

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

The items outlined in Appendix 1 have been dealt with by Chairs Urgent Action.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call an Audit meeting and to avoid delays that could affect service delivery and quality.
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 are no specific financial implications related to the activity outlined in this report.

4. RECOMMENDATION

4.1 The Audit Committee is asked to **CONSIDER** and **RATIFY** the Chairs urgent action taken on the **27 October 2022** and the **01 December 2022** as outlined in Appendix **1**.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. Audit Action Tracker – Requested Extension Dates

The Audit Committee were sent an email on the **27 October 2022** on the following basis:

a) The Audit Committee was requested to consider the contents of the Audit Action Tracker focusing on the requested **extension dates** to actions where the target implementation date has passed i.e. Action is not complete (**Red Status**) and Action not on target for completion by agreed date (**Orange Status**).

b) The Audit Committee was asked to provide out of Committee **APPROVAL** for the requested extensions that were provided in the **Requested Extension Date** column.

Due to the urgency of this matter, it could not wait until the January 2023 Audit Committee meeting.

Recommendation Approved:

- Martin Veale, Chair of the Audit Committee, and Independent Member
- Vicky Morris, Independent Member
- Gareth Jones, Independent Member
- Matthew Bunce, Executive Director of Finance

A small number of clarifications /points were raised and subsequently addressed. No objections to approval were received.

2. Change to the 2022/23 Internal Audit Plan

The Audit Committee were sent an email on the **01 December 2022**, inviting the Audit Committee to **APPROVE** the following changes to the Internal Audit Plan for 2022/23:

a) Deferral of Quality & Safety Framework.

b) Information Governance to be undertaken in its place.

Due to the urgency of this matter, it could not wait until the January 2023 Audit Committee meeting.

Recommendation Approved:

- Martin Veale, Chair of the Audit Committee, and Independent Member
- Vicky Morris, Independent Member
- Gareth Jones, Independent Member
- Matthew Bunce, Executive Director of Finance

No objections to approval were received.

AUDIT COMMITTEE

Counter Fraud, Bribery & Corruption Policy and Response Plan

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Gareth Lavington - Head Counter Fraud
PRESENTED BY	Gareth Lavington - Head Counter Fraud
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	03/01/2023	ENDORSED FOR APPROVAL

ACRONYMS	
IIA's	Integrated Impact Assessment's
EQIA	Equality Impact Assessment
LCFS	Local Counter Fraud Specialist
CFS	Counter Fraud Specialist
NHS CFS (Wales)	NHS Counter Fraud Services (Wales)
NHSCFA	NHS Counter Fraud Authority
NHSBSA	NHS Business Services Authority
PACE	Police and Criminal Evidence Act

1. SITUATION/BACKGROUND

1.1 All NHS bodies have a legal obligation to have a provision for Countering Fraud. As a result of this all NHS Health Bodies are required to have in place a suitable and in date Counter Fraud, Bribery and Corruption Policy. This policy is designed to promote an anti-fraud and corruption culture and to ensure that there are appropriate measures in place to deter, detect, prevent and investigate fraud. It aims to eliminate fraud and corruption within Velindre NHS Trust as far as possible. The policy also provides a framework for responding to suspicions of fraud, together with advice and information on fraud, and the implications and outcome of counter fraud investigations. The current policy is out of date and requires amendment.

1.2 This new policy and response plan has been written by the Local Counter Fraud Specialist (LCFS) and is based upon the requirements of the Counter Fraud Provision set out by Government Cabinet Office and the NHS Counter Fraud Authority. It is intended as a guide for all staff on counter fraud work within the NHS.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 This policy document has been reviewed by the Counter Fraud Manager and rewritten in order to bring it up to date and fit for purpose. It is fully compliant with NHS regulations and with the requirements stipulated by the NHS Counter Fraud Authority under the Cabinet Office Government Standard 13.

2.2 The Counter Fraud, Bribery & Corruption Policy and Response Plan relies on the following key legislation and guidance:

- The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of a suspect and the intent to make a gain or cause a loss and replaces the Theft Act 1968 and 1978
- The Bribery Act 2010, abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what had gone before. The Bribery Act 2010 makes it a criminal offence to “give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad”
- Section 83 of the Government of Wales Act 2006, which deals with the discharge of certain counter fraud functions in relation to the health service in Wales
- WHC (2006) 090 ‘The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006’, reinforce the seven principles of public life (The Nolan Principles) and focuses on the three crucial public service

values which must underpin the work of the health service: accountability, probity, and openness.

- All investigations into fraud will be compliant with the Criminal Procedures and Investigations Act 1990 and the Police and Criminal Evidence Act 1984.
- Police and Criminal Evidence Act (PACE). For non-criminal (i.e. civil or disciplinary) proceedings, PACE does not apply, but should nevertheless be regarded as best practice
- All witness statements will be completed in accordance with Section 9 Criminal Justice Act 1967
- VUNHST Disciplinary Policy and Procedure To be followed in any disciplinary action taken by VUNHST towards an employee (including dismissal).
- NHS Counter Fraud Manual provides in-depth details of how sanctions can be applied where fraud and corruption is proven and how redress can be sought.
- Proceeds of Crime Act 2002 (POCA), as basis for seeking redress by issuing a confiscation order of a person's money or a restraining order against assets

2.3 The main changes to the existing Counter Fraud Policy are:

- Section 6.2 Flowcharts to describe VUNHST response when a referral is made to the Counter Fraud service updated and simplified
    - Chart 3 – Gathering evidence removed and replaced with Chart 3 – Disciplinary Process,
    - Chart 4 – Interview Procedure removed., to not include in our public policy how we go about gathering evidence and our interview procedure to avoid giving potential Fraudster's information that gives them an advantage
- Section 2.2 Bribery & Corruption section added
- Section 5.4 NHS Counter Fraud Authority updated removing reference to the NHS Protect (formerly Counter Fraud Security Management Services) as on the 1st November 2017, an independent special health authority was implemented in England - NHS Counter Fraud Authority (NHSCFA) – to replace the previous arrangements which Welsh Ministers entered into with the predecessor organisation of the NHSCFA i.e. NHSBSA/NHS Protect
- Section 9 on Interview Procedure removed
- Appendix 3 removed – NHS Fraud and Corruption Referral Form

2.4 This new policy is submitted **for AUDIT COMMITTEE APPROVAL**.

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	No (Include further detail below)
	The Integrated Impact Assessment is currently being completed and will be shared with EMB once complete. Once the IIAs are complete the policy will be issued for full internal consultation and submission to the EQIA Group for consideration prior to submission to Audit Committee for approval.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal implications may arise as a result of fraud investigations and findings where criminal or civil action is required. This can involve the counter fraud team pursuing matters through the criminal justice system; departmental investigations with the assistance of HR being carried out in line with employment law; the legal and risk team pursuing matters through the civil court; or via the organisational systems in place for making financial recovery.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The implementation of this policy assists in an efficient and successful counter fraud provision. This in turn aims to reduce to an absolute minimum any financial loss to the organisation through fraud

4. RECOMMENDATION

4.1 The Counter Fraud, Bribery & Corruption Policy and Response Plan is **FOR AUDIT COMMITTEE APPROVAL**.

Counter Fraud, Bribery and Corruption Policy and Response Plan

Table of Contents

1. Introduction 3
2. What is Fraud? 4
3. Public Service Values 5
4. Velindre NHS Trust Policy Statement 6
5. Roles and Responsibilities 6
6. The Response Plan 10
7. The Law and its Remedies 19
8. References 222
9. Further Information 23
Appendix 1: NHS Fraud and Corruption: Dos and Don'ts 24

1. Introduction

1.1. One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and means of enforcing the rules against fraud and other illegal acts involving dishonesty or damage to property. For simplicity all such offences are hereafter referred to as “fraud”, except where the context indicates otherwise. This document sets out Velindre NHS Trust’s policy and response plan for detected or suspected fraud.

1.2. It is essential that all staff are aware of, and are able to access up-to-date, accurate Velindre University NHS Trust (VUNHST) policies to ensure they are aware of current approved practices to help reduce risk.

1.3. VUNHST already has procedures in place that reduces the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, documented procedures and a system of internal control and a system of risk assessment. In addition, VUNHST tries to ensure that a risk (and fraud) awareness culture exists throughout the organisation.

1.4. This document is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation.

1.5. The three crucial public service values which must underpin the work of the health service: accountability, probity, and openness. VUNHST is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is therefore committed to the reduction of any fraud occurring within VUNHST, and to the rigorous investigation of any such cases that do occur.

1.6. VUNHST wishes to encourage anyone having reasonable concern that a fraud has or may be occurring to contact the Counter Fraud service. It is VUNHST policy that no employee will suffer in any way as a result of reporting reasonably their concerns.

1.7. The flowcharts in section 6.2 describe VUNHST response when a referral is made to the Counter Fraud service. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions.

1.8. VUNHST has a Service Level Agreement with Cardiff & Vale University Health Board for the provision of the Local Counter Fraud service. The Counter Fraud Manager will report directly to the Director of Finance and will produce an agreed work plan to follow, to fulfil the requirements of the role.

2. What is Fraud?

2.1. Fraud:

The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of a suspect and the intent to make a gain or cause a loss. It includes the following offences that could be committed against the NHS:

- Fraud by false representation (s.2) – dishonestly misrepresenting something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (s.3) – not saying something where there is a legal duty to do so.
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

Areas where fraud may occur include but are not limited to:

- *Travel and expense claims*
- *Petty cash vouchers*
- *Items of Service claims from independent contractors*
- *Time sheets*
- *Fraudulent use of authorised leave*
- *Overpayment of salary/wages*
- *Fraudulent use of VUNHST resources*
- *Working whilst on the sick*
- *Handling of cash*
- *Misappropriation of equipment*

This is covered in more detail at section 7.

2.2. Bribery and Corruption:

"The offering, giving, soliciting of an inducement or reward that may influence the actions taken by a body, its members or officers."

Source: The Code of Audit Practice – Audit Commission

Corruption does not always result in a loss. The corrupt person does not have to benefit directly from their deeds, they may unreasonably use their position to give some advantage to another.

It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

Corruption prosecutions tend to be most commonly brought using specific pieces of legislation dealing with corruption, i.e. under the The Bribery Act 2010.

2.3. Bribery Act 2010

The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011. The Bribery Act 2010 will abolish all existing UK Anti-Bribery Laws and replace them with a suite of new offences markedly different to what has gone before. The Bribery Act 2010 makes it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". It will increase the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine. In addition, the Act introduces a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

3. Public Service Values

Source: WHC (2006) 090 'The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006'.

3.1. The codes reinforce the seven principles of public life (The Nolan Principles) and focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity, and openness.

- Accountability: Everything done by those who work in the NHS in Wales must be able to stand the test of scrutiny by the Welsh Government, public judgments on propriety and professional codes of conduct.
- Probity: There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of the NHS in Wales's duties.
- Openness: There should be sufficient transparency about the NHS in Wales's activities to promote confidence between the NHS body and its staff patients and the public.

4. VUNHST Policy Statement

4.1. VUNHST is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is also committed to the elimination of any fraud within VUNHST, and to the rigorous investigation of any such cases.

4.2. VUNHST wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also VUNHST policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting reasonably held suspicions.

4.3. All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes "reasonably held suspicions" shall mean any suspicions other than those which are raised maliciously and found to be groundless.

5. Roles and Responsibilities

5.1. Executive Director of Finance

The Executive Director of Finance, in conjunction with the Chief Executive, monitors and ensures compliance with the Counter Fraud Directions for the organisation.

The Executive Director of Finance will, depending on the outcome of investigations and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The Executive Director of Finance and Local Counter Fraud Specialist (LCFS) will be responsible for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.

The Executive Director of Finance will inform and consult the Chief Executive in cases where the loss may be above the agreed limit or where the incident may lead to adverse publicity.

If an investigation is deemed to be appropriate, the Executive Director of Finance will delegate to the LCFS, who has responsibility for leading the investigation, whilst retaining overall responsibility himself/herself.

The Executive Director of Finance or the LCFS will consult and take advice from the Director of Workforce and OD, if a member of staff is to be interviewed or disciplined.

The Director of Finance or LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation as part of a disciplinary process.

5.2. Local Counter Fraud Specialist

Local Counter Fraud Specialists (LCFS) are located in each NHS organisation. The Lead LCFS is appointed by the Executive Director of Finance and will be responsible for investigating cases of fraud up to a value of £15,000. All investigations involving more than £15,000 and/or Corruption must be referred to the NHS Counter Fraud Service (Wales) Regional Team. Only individuals who are accredited as Counter Fraud Specialists will be responsible for investigating cases of fraud. The LCFS will be responsible for notifying all cases of fraud to NHS CFS (Wales) in the appropriate manner and via the CLUE Case Management System. The LCFS shall:

- Report to Executive Director of Finance.
- Provide a written report at least annually to VUNHST on counter fraud work within the organisation.
- Be entitled to attend Audit Committee meetings and have a right of access to all Audit Committee members and the Chairman and Chief Officer of VUNHST.
- Undertake, as agreed with VUNHST Executive Director of Finance, proactive work to detect cases of fraud and corruption, particularly where systems weaknesses have been identified. This work shall be carried out so as to complement the detection of potential fraud and/or corruption by auditors in the course of routine audits.

- Proactively seek and report to CFS (Wales) opportunities where details of counter fraud work (involving action on prevention, detection, investigation, sanctions or redress) can be used within presentation or publicity in order to deter fraud and corruption.
- Investigate cases of suspected fraud in accordance with the division of work specified in the Directions as amended and replaced from time to time. Refer to CFS (Wales) all cases appropriate to them.
- Inform CFS (Wales) of all cases of suspected fraud investigated by VUNHST.
- Investigate, report and effect remedy in relation to identified system weaknesses within the organisation that can allow the opportunity for fraud to occur.

5.3. NHS Counter Fraud Service (Wales)

The NHS Counter Fraud Service (CFS) (Wales) will investigate all cases that do not fall within the responsibility of the Local Counter Fraud Specialist.

NHS CFS (Wales) will be responsible for the investigation of cases above £15,000, all corruption cases, and any case at the request of the LCFS, where the CFS (Wales) specialist knowledge and resources could assist with the investigation.

Counter Fraud Service Wales will act as the point of contact for the LCFS in relation to liaison with the Crown Prosecution Service.

5.4. NHS Counter Fraud Authority

On the 1st November 2017, an independent special health authority was implemented in England entitled the NHS Counter Fraud Authority (NHSCFA). This was achieved under amendment from the UK Government Secretary of State for Health.

As a result of this, the previous arrangements which Welsh Ministers entered into with the predecessor organisation of the NHSCFA i.e. NHSBSA/NHS Protect, which was pursuant to section 83 of the Government of Wales Act 2006, which deals with the discharge of certain counter fraud functions in relation to the health service in Wales were reviewed and remained effective with the NHSCFA.

NHSCFA has responsibility for all policy, operational and training matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS.

NHSCFA also provides advice, guidance and risk measurement to NHS Bodies in Wales on all aspects of fraud, bribery and corruption. All instance where fraud is suspected are properly investigated, until their conclusion, by staff who are fully trained and accredited and who are duly nominated by NHSCFA.

5.5. VUNHST Management

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are followed.

They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated LCFS.

Managers must instil and encourage an anti-fraud, and anti-bribery and corruption culture within their team and ensure that information on procedures is made available to all employees. The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported immediately to the lead LCFS. If formal investigation is undertaken by the LCFS/CFS managers have a duty to produce any documents or evidence that is required by the investigation team in a timely manner.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively.

The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees.

6. The Response Plan

6.1. Introduction

The flowcharts in section 6.2 describe VUNHST intended response to reported suspicion of fraud. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions. Each situation is different; therefore, the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

Further details on the processes in the flowchart are provided in section 6.3 (Commentary on Flowchart Items).

6.2. Flowcharts

Chart 1

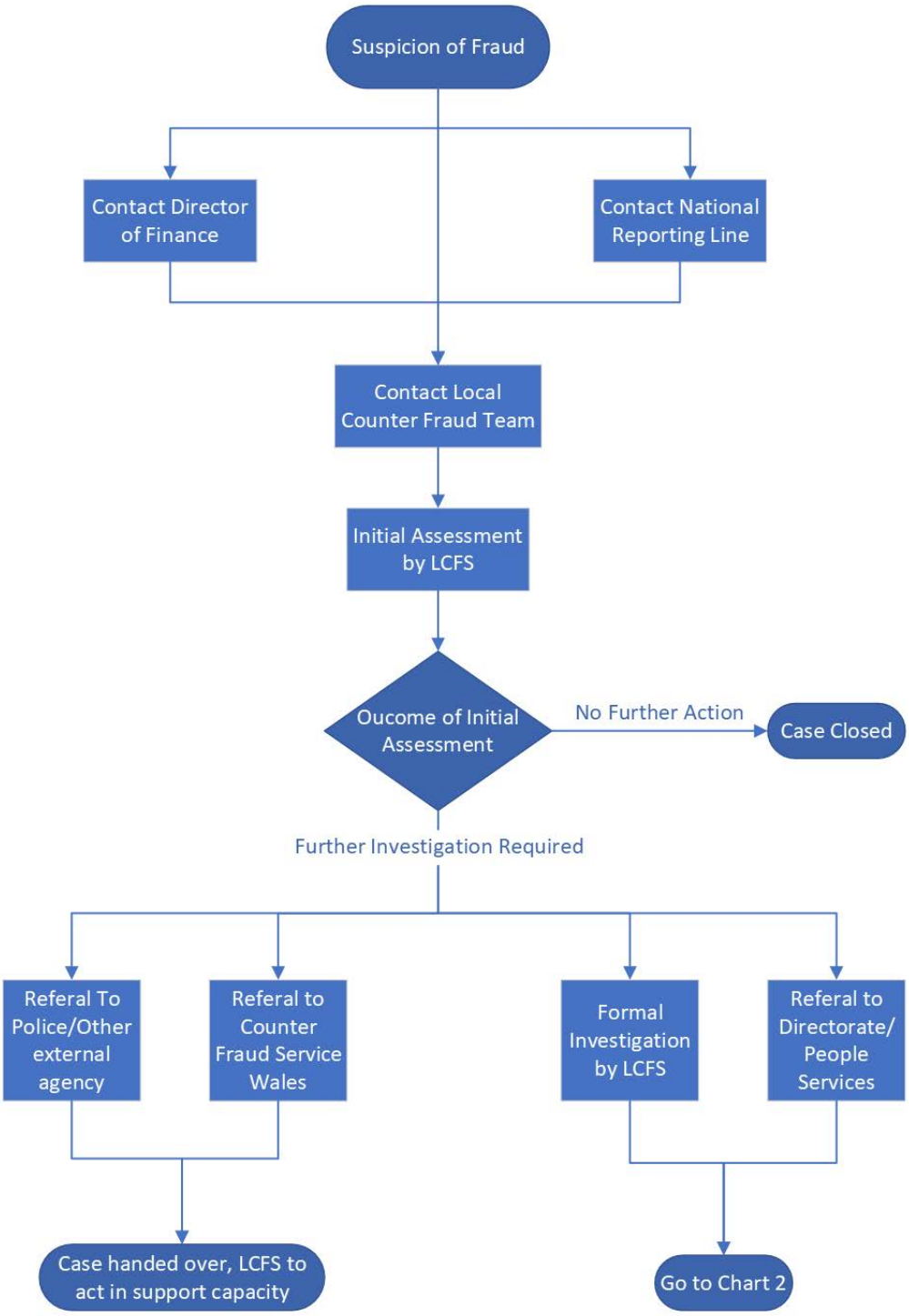


Chart 2 – Local Counter Fraud Investigation

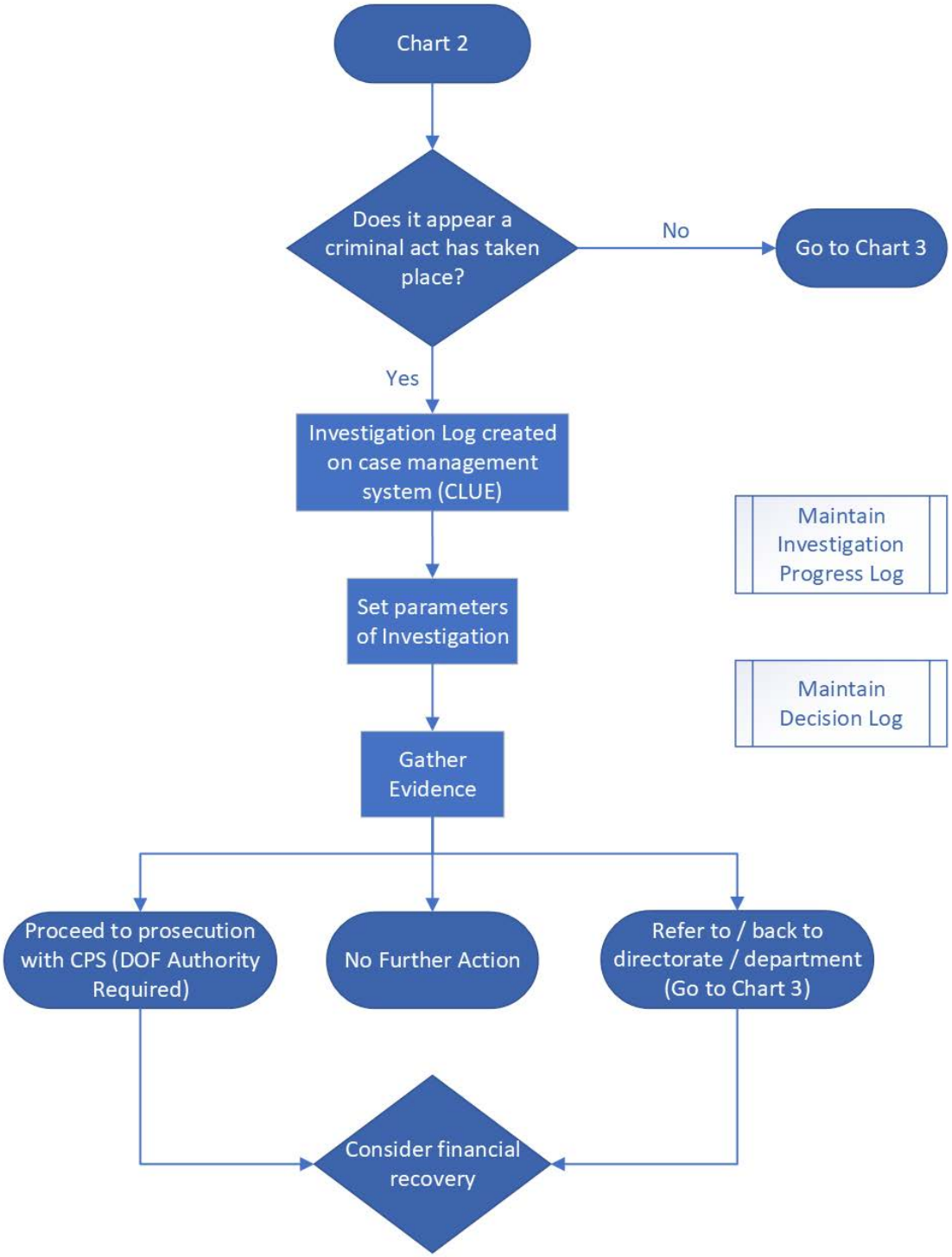
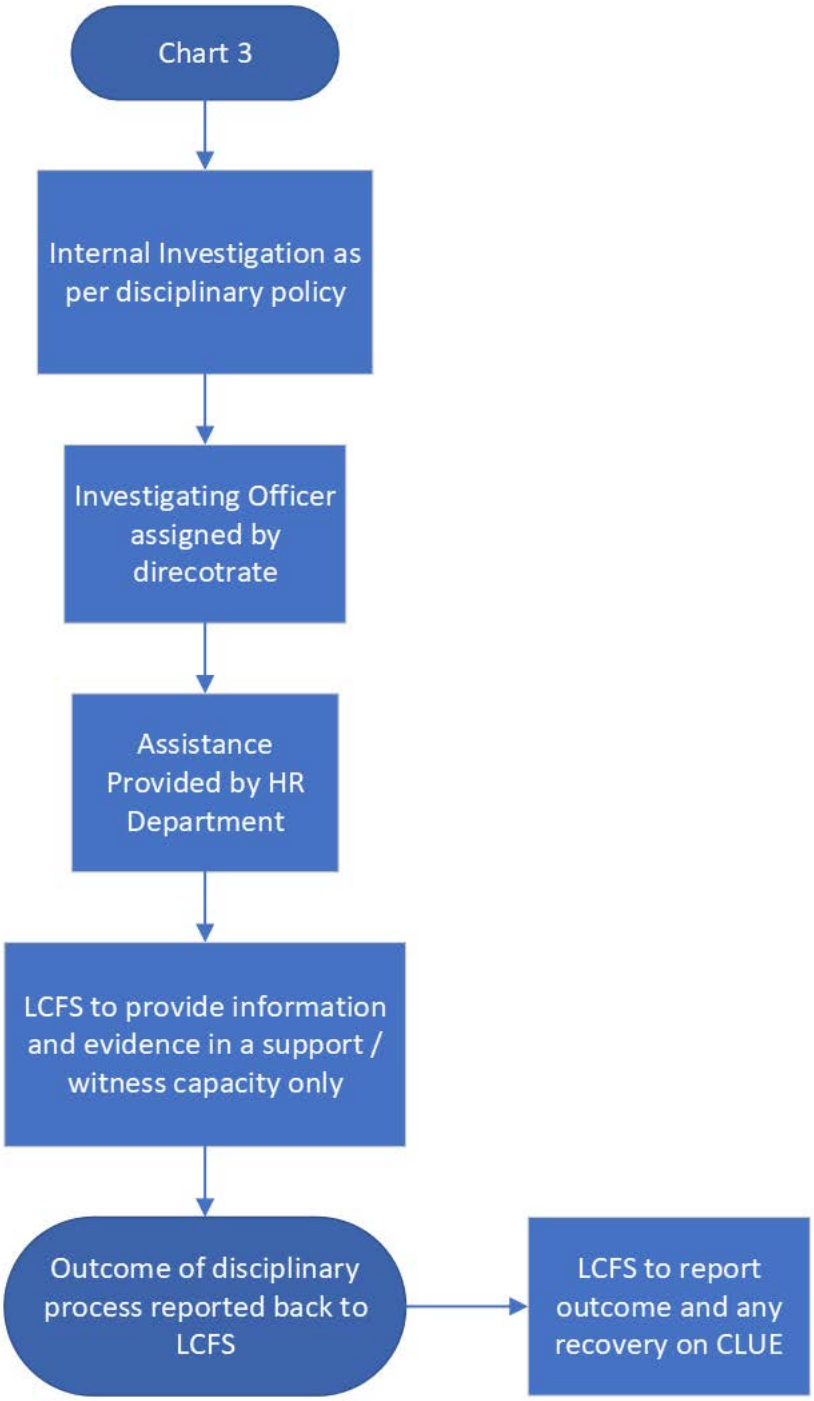


Chart 3 – Disciplinary Process



6.3. Commentary on Flowchart Items

Further explanation of many items is also given elsewhere in this document.

Chart 1 – Suspicion of Fraud

6.3.1. The Local Counter Fraud Specialist (LCFS)

The Lead LCFS will be authorised to treat inquiries confidentially and anonymously if so requested by the individual making the referral.

The LCFS will receive appropriate skill-based training leading to professional accreditation and will be able to respond tactfully and appropriately to concerns raised by staff.

LCFS services are currently provided as part of a Service Level Agreement with Cardiff & Vale University Health Board.

6.3.2. Suspicion of Fraud or Any Irregularities/Anomalies

If any VUNHST employee has any concerns that a fraud has or is taking place, then he/she should discuss any suspicions in the first instance with the Nominated Lead LCFS on 02921 836265.

However, an employee may choose instead to contact the “NHS Fraud & Corruption Reporting Line” on 0800 028 4060.

This contact can be made anonymously.

Time may be of the utmost importance to prevent further loss to VUNHST.

6.3.3. Upon receipt of a referral LCFS will carry out an initial assessment to understand and identify whether there are reasonable grounds to suspect whether criminal offences have been committed. If not, the case will be concluded with no further action taken. Should there be issues of managerial concern evident then LCFS will liaise with appropriate departmental management and Human Resources department.

LCFS will consider and decide whether the case needs to be referred on to other agencies e.g. Police and Counter Fraud Service Wales. If this is

appropriate then LCFS will make the appropriate arrangements. In some instances, a joint investigation may take place.

CHART 2 – Local Counter Fraud Investigation

6.3.4. Progress of investigation

All investigations carried out by the Counter Fraud Department, will be led by an accredited LCFS and will be overseen by the Head of Counter Fraud. All investigations into fraud will be compliant with the Criminal Procedures and Investigations Act 1990 and the Police and Criminal Evidence Act 1984.

The Local Counter Fraud Specialist in charge of the investigation (OIC) will keep a log of events to record the progress of the investigation. This will commence immediately following referral. If a criminal offence is suspected then the referral will be promoted to formal investigation and recorded upon the NHS CFA case management system (CLUE).

6.3.5. Does it appear a Criminal Act Has Taken Place?

In some cases, this question may be asked more than once during an investigation. The answer to the question obviously determines if there is to be a criminal investigation. In practice it may not be obvious if a criminal act has taken place. If a criminal act is believed to have occurred, the matter will be dealt with by the LCFS/CFS (Wales) as appropriate. If other criminal offences are involved e.g. theft, criminal damage, consideration should be given to reporting the matter, after consultation with the LCFS, to the police

6.3.6. Evidence

For the purposes of criminal proceedings, the admissibility of evidence is governed by the Police and Criminal Evidence Act (PACE). For non-criminal (i.e. civil or disciplinary) proceedings, PACE does not apply, but should nevertheless be regarded as best practice.

It is imperative that the collection of evidence must be coordinated if several parties are involved in an investigation, e.g. LCFS and internal audit, police and solicitors. The LCFS will take the lead on this. Evidence gathering requires skill and experience and professional guidance should be sought where necessary. There is a considerable amount of case law concerning the

admissibility of evidence and incorrect procedure can lead to a prosecution collapsing.

6.3.7. Witnesses

If a witness to the event is identified, then they will need to give a written statement. The LCFS will take a chronological record using the witness's own words. (The witness should be prepared to sign the document as a true record) and advised that the statement may be used as evidence should the matter proceed to court. All witness statements will be completed in accordance with Section 9 Criminal Justice Act 1967 and on the witness statement document provided for this purpose. All witnesses will be provided with ongoing guidance and support throughout the process.

6.3.8. Physical Evidence

Upon taking control of any physical evidence, it is very important that a record is made of the time, date, and place it is taken from and by whom, continuity is essential. If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record. It is the responsibility of the LCFS to manage the retrieval, documentation and storage of physical evidence collected during the course of an investigation.

Documentary evidence should be properly recorded, it will need to be numbered and include accurate descriptions of when and where it was obtained and who it was obtained by and from. In criminal actions evidence on or obtained from electronic media needs a document confirming its accuracy.

6.3.9. Interviews

Any interviews carried out with a suspect during the course of a fraud investigation will be carried out only by an accredited LCFS, and will be compliant with the relevant codes and sections of the Police and Criminal Evidence Act 1984.

The subject of the investigation will be written to and advised of the reason for the interview and that he/she is entitled to have a person present at the

interview who can act in a legal capacity (i.e. solicitor), but they are not entitled to have a friend, work colleague and/or union representative present at the interview.

The person being interviewed is also to be informed that whilst their attendance at the interview is voluntary, should they not attend, then the matter may be referred to the police which could then result in their subsequent arrest.

Prior to the start of an interview, the interviewee will be assessed with regard to their wellbeing and a decision will be made whether or not it is appropriate to continue with it. If it is not appropriate, then an alternative date in the future will be sought.

The interview under caution will be tape recorded and once the interview has concluded the interviewee and their legal representative will be provided with a notice informing them of their entitlement to a copy of the recording made. All recordings must be made on a recording device authorised for the purpose.

6.3.10. Investigate Internally

If, after discussion with the LCFS, it appears a criminal act has not taken place, or that the act/s are of a minor nature and it would not be proportionate nor in the public interest to proceed criminally, the next step should be an internal review to determine the facts. The review may recommend various courses of action; instigate an investigation under VUNHST Disciplinary Policy and Procedure; establish what can be done to recover a loss and what may need to be done to improve internal control to prevent the event happening again. Internal disciplinary investigations are the responsibility of the Directorate/Departmental management in conjunction with the workforce and OD department.

6.3.11. Recovering a Loss

The seeking of financial redress or recovery of losses should always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Service (Wales) where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case. Redress allows resources that are lost

to fraud, bribery and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

Where recovering a loss is likely to require a civil action, in the absence of established procedures for this recovery, e.g overpayments policy and debt collection agencies, it will be necessary to seek legal advice. Where external legal advisors are required, due to the possible high cost implications, the investigation manager must ensure that the Executive Director of Finance is consulted. The decision of whether to proceed with any civil action will rest with the Executive Director of Finance.

6.3.12. Court Action, Adverse Publicity and/or Police Involvement

Where the investigation reaches a stage where the case is likely to end up in a criminal prosecution via the criminal justice system, then the LCFS must liaise with the Executive Finance Director. Should the investigation or prosecution be likely to lead to adverse publicity then LCFS should also liaise with VUNHST Communications/Press relations Department. Where a fraud is suspected and the need to use the police to carry out an arrest and/or search, then lead LCFS will make the appropriate arrangements and liaise with the relevant organisation directly. The Executive Director of Finance will be appraised accordingly.

No member of staff should contact members of the press without the authority of the Executive Director of Finance and or the Communications/Press Relations team.

6.3.13. Risk Management

At the conclusion/during the course of an investigation it may become clear that system or process weaknesses or failings have provided the opportunity for fraud or loss to occur. In these circumstances LCFS will conduct a risk assessment into the target area and report accordingly upon any weaknesses identified. The CLUE case management system will be used for this purpose. Any weaknesses and recommendation for remedial action will be reported to the relevant directorate or department. Any risks identified during the course of an investigation will be recorded on the local risk register by departmental management in conjunction with the LCFS. This may give rise to future proactive work such as Local Proactive Exercises that will be conducted by the LCFS to test that remedial actions have been undertaken. Where fraud risk assessment/fraud proofing work is required, departmental management must assist in providing all necessary information requested by the LCFS or Internal Audit in relation to the processes or systems under review.

CHART 3 – Disciplinary Process

6.3.14. Disciplinary Procedure

VUNHST Disciplinary Policy and Procedure has to be followed in any disciplinary action taken by VUNHST towards an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, the results of the investigation (a formal report) and take appropriate action against the employee.

In the event of a disciplinary investigation taking place where a suspicion of fraud exists, then the appointed investigating officer must liaise with the LCFS to agree a way forward. A decision will be made whether the investigations can run concurrently or whether the internal investigation will need to be put on hold until the completion of the criminal investigation or part of it.

In some cases where a fraud is suspected it may be deemed by the Lead LCFS that the matter is of a minor nature, or that it would not pass the relevant evidential or public interest threshold tests, and therefore a formal criminal investigation will not progress. In these instances' the LCFS will keep departmental management and Workforce & Organisational Development department appraised that no further action will be taken. A disciplinary investigation can still take place in these circumstances. If a disciplinary investigation only ensues following the report of a fraud or fraud related offence, the internal investigating officer and HR representative will ensure that the LCFS is kept appraised of the process and any resulting action that takes place. The LCFS will act in support of any disciplinary only investigation in the position of a witness only. Any evidence gathered by the LCFS will be shared with management if it assists with the case.

As per national requirements LCFS will report any outcome on the CLUE case management system.

7. The Law and its Remedies

7.1. Introduction

Section 6 of the NHS Counter Fraud Manual provides in-depth details of how sanctions can be applied where fraud and corruption is proven and how redress can be sought.

To summarise, local action can be taken to recover money by using the administrative procedures of the organisation or civil law. In cases of serious fraud, bribery and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s) and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate. This is known as the triple track approach.

Actions which may be taken when considering seeking redress include:

- no further action
- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under the Proceeds of Crime Act 2002 (POCA)
- recovery sought from ongoing salary payments

In some cases (taking into consideration all the facts of a case), it may be that VUNHST under guidance from the LCFS and with the approval of the Director of Finance, decides that no further recovery action is taken.

Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (Magistrates' Court and Crown Court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

7.2. Proceeds of Crime Act

The NHS Counter Fraud Service (Wales) can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

7.3. Fraud Act 2006

The Fraud Act came into force on 15th January 2007.
The following offences have been repealed:

- **Theft Act 1968**
  - Obtain property by deception (section 15)
  - Obtain money transfer by deception (section 15A)
  - Obtain pecuniary advantage (section 16)
  - Procure execution of valuable security (section 20)

- **Theft Act 1978**
  - Obtain service by deception (section1)
  - Evade liability (section 2)

The new Act simplifies the original deception offences. There is no need to prove that any person was deceived. The Act now outlines three ways to commit fraud:

- Fraud by False Representation (section 2)
- Fraud by Failing to Disclose Information (section 3)
- Fraud by Abuse of a Position (section 4)

Many original 'deception' offences will now be covered by section 2 of the Fraud Act 2006 (false representation) which has three main ingredients:

- Dishonesty
- A false representation (no limitations on how this takes place)
- Intention to commit gain or cause loss

Section 3 covers the offence of fraud by failing to disclose information where there is a legal duty to do so.

Section 4 covers the offence of fraud by abuse of position where the defendant is in a privileged position expected to safeguard (not act against) the financial interests of another person.

Section 6 covers the offence of possession of articles for use in fraud. This extends to possession or control of any article, anywhere and includes electronic data.

Section 7 covers the offence of making or supplying articles for use in fraud. It is designed to capture those who supply personal financial details for use in frauds to be carried out by others; or those who manufacture software programmes for generating credit card numbers.

Section 11 of the Fraud Act – Obtain Services Dishonestly replaces 'obtain services by deception.' This offence requires the actual obtaining of a service and must include a dishonest act or false representation.

The test for dishonesty that is currently relied upon rests in case law and the cases of Ivy v Genting Casino 2017 and *Barton and Booth v R 2020.*

7.4. Corruption

The definition (in the context of the Prevention of Corruption Acts) is the offering, giving, soliciting, or acceptance of an inducement or reward, which may influence the action of any person.

8. References

This policy should be read in conjunction with:

- Standing Orders
- Standing Financial Instructions
- Disciplinary Procedures
- Standards of Business Conduct
- I.T Security Policy
- Public Relations and Communications Strategy
- Whistleblowing Policy
- Dignity at Work Policy
- VUNHST policies relating to:
  - Gifts
  - Hospitality
  - Conflicts of Interest
  - Procurement
  - Capital/PFI Contracts

9. Further Information

Further information and a copy of the fraud policy and response plan may be obtained from the LCFS or VUNHST intranet.

NHS Fraud and Corruption: Dos and Don'ts
A desktop guide for VUNHST

FRAUD is the deliberate or reckless intent to permanently deprive an employer of money or goods through false representation, failing to disclose information or abuse of position.

CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

DO	DO NOT
• **Note your concerns** **Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.**	• **Confront the suspect or convey concerns to anyone other than those authorised, as listed below** **Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.**
• **Retain evidence** **Retain any evidence that may be destroyed, or make a note and advise your LCFS.**	• **Try to investigate, or contact the police directly** **Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.**
• **Report your suspicion** **Confidentiality and anonymity will be respected – delays may lead to further financial loss.**	• **Be afraid of raising your concerns** **The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.**

If you suspect that fraud against the NHS has taken place, you must report it immediately, by:

- directly contacting the Local Counter Fraud Specialist, or
- telephoning the free phone NHS Fraud and Corruption Reporting Line, or
- contacting the Director of Finance.

Do you have concerns about a fraud taking place in the NHS?

If so, any information can be passed to the NHS Fraud and Corruption Reporting Line: **0800 028 40 60**

All calls will be treated in confidence and investigated by professionally trained staff

Your nominated Local Counter Fraud Specialist are:

Gareth Lavington - Head of Counter Fraud – Gareth.Lavington2@wales.nhs.uk– 02921836265

Nigel Price - Local Counter Fraud Specialist – Nigel.Price@wales.nhs.uk – 02921836481

Henry Bales – Local Counter Fraud Specialist – Henry.Bales@nhs.wales.uk – 02921836264

If you would like further information about the NHS Counter Fraud Service, please visit **www.nhscfa.co.uk** **or** **Counter Fraud - Home (sharepoint.com)**

Trust Audit Committee

AMENDMENT TO STANDING ORDERS – SCHEDULE 3

DATE OF MEETING	12th January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science
REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

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

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	26/10/2022	ENDORSED
Quality, Safety & Performance Committee	10/11/2022	ENDORSED

ACRONYMS

SO	Standing Orders

ToR	Terms of Reference

1. SITUATION

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

The purpose of this report is to outline the required changed to the Trust Standing Orders – **Schedule 3,** resulting from the Annual Review of the **Terms of Reference and Operating Arrangements** in respect of the **Quality, Safety & Performance Committee**, (ref. ***Appendix 1 [no track changes] & Appendix 2 [with track changes],*** and is seeking formal **ENDORSEMENT** by the Audit Committee prior to submission to Trust Board.

2. BACKGROUND

The amendments detailed in this report have been agreed via collaborative engagement with the wider Executive Management Team in conjunction with effective oversight and review by the Chair of the Quality, Safety & Performance Committee. The proposed changes have been formally ENDORSED by the Quality, Safety & Performance Committee in November 2022.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Summary of Amendments

The revised Terms of Reference and Operating Arrangements for the Quality, Safety & Performance Committee are set out in ***Appendix 1 & 2,*** with the latter inclusive of track changes for ease of reference and transparency. The proposed amendments include the following key changes summarised below:

Terms of Reference & Operating Arrangements	**Summary of Amendments**
Quality, Safety & Performance Committee	**Section 3:** - Addition of **Duties of Quality and Candour** to the Quality Management System the Trust already has in place.

Terms of Reference & Operating Arrangements	Summary of Amendments
	- Addition of **Integrated Quality & Safety Group** to **Sub Committees,** to provide triangulation and analysis of outcomes of the Quality Management System and Divisional Quality Hubs to the Quality, Safety & Performance Committee. **Section 3 *additional*:** - Highlighted items within the **Delegated Powers and Authority** section are due to be addressed / agreed via further discussion at the November 2022 Quality, Safety and Performance Committee, namely: o Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board; o Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board; o Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015. **Section 4:** - Addition of **Deputy Director of Organisational Development and Workforce** to attendees of the Quality, Safety & Performance Committee. - Amendment of job title of **Quality & Safety Manager** to **Head of Quality, Safety & Assurance**. **Section 6:** - Highlighted items within the **Relationships & Accountability** section are due to be addressed / agreed via further discussion at the November 2022 Quality, Safety and Performance Committee, namely: o **6.4** – The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

Terms of Reference & Operating Arrangements	Summary of Amendments
	o The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Audit Committee is asked to **ENDORSE** for **BOARD APPROVAL** the amendments to the Trust Board Standing Orders – **Schedule 3** as outlined in section **3** of this report, and included in ***Appendix 1 & 2.***

Quality, Safety and Performance Committee

Terms of Reference &

Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2023

1. INTRODUCTION

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

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

2. PURPOSE

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

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

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

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

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

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

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

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

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

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Authority

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

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

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

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

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

Access

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

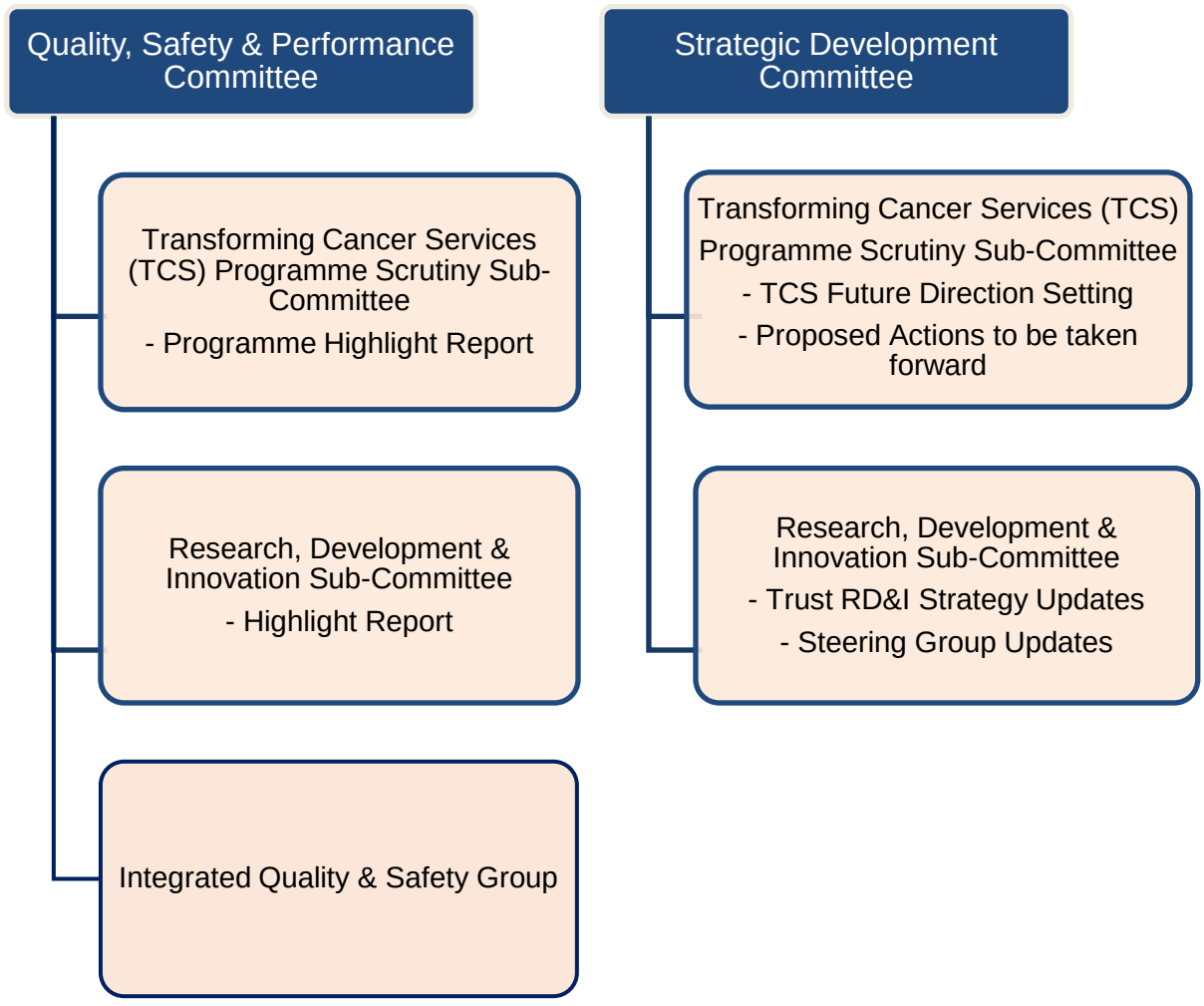
Sub Committees

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

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

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

The sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



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

4. MEMBERSHIP

Members

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

Chair — Independent member of the Board (Non-Executive Director)
One independent member of the Board (Non-Executive Directors)

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

4.2 **Attendees:**

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

4.3 **By invitation**

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

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

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

Member Appointments

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

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

Support to Committee Members

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

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

  Ensure the provision of a programme of development for Committee members as part of the Trust's overall OD programme.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and

accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

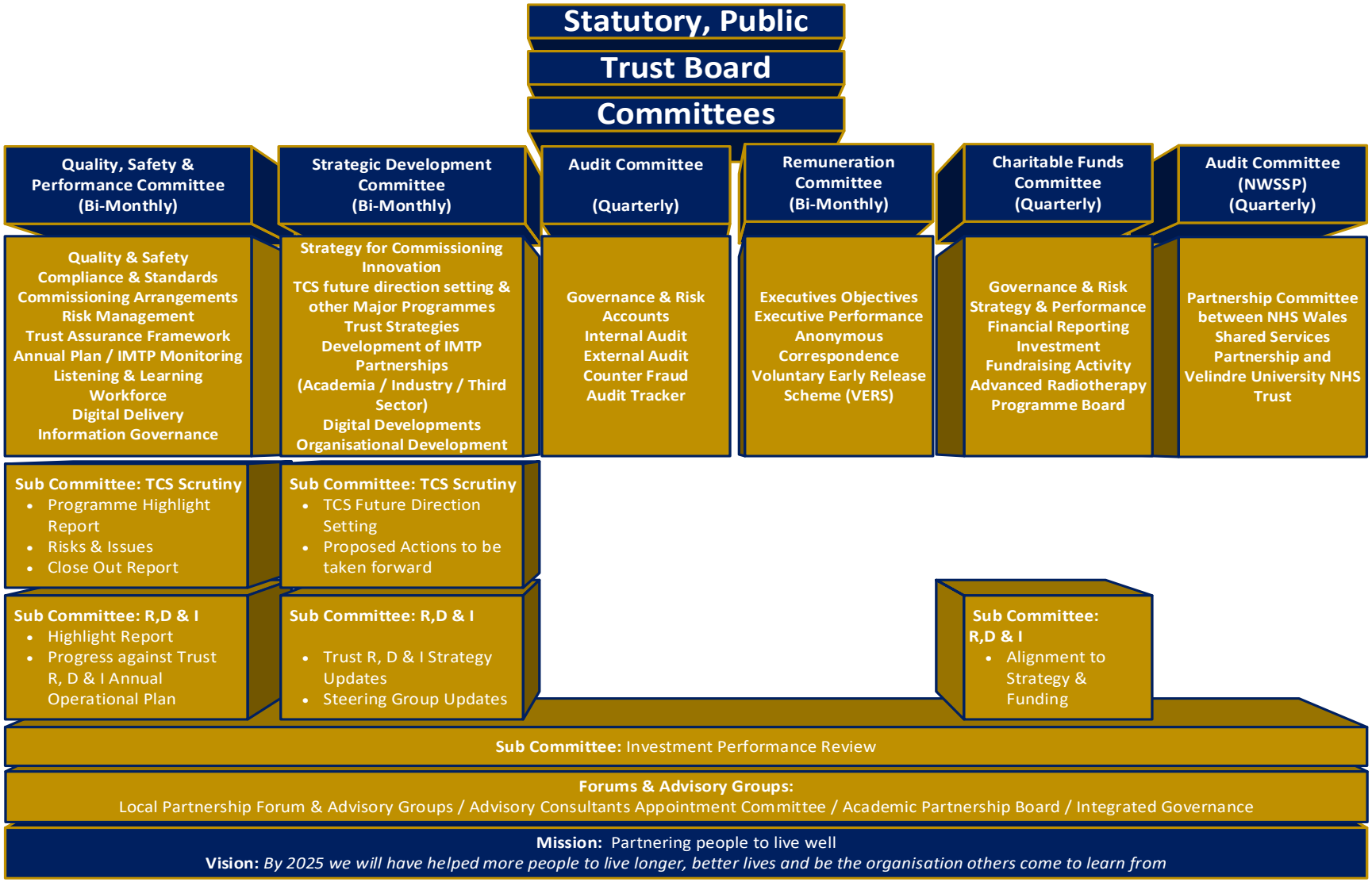
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

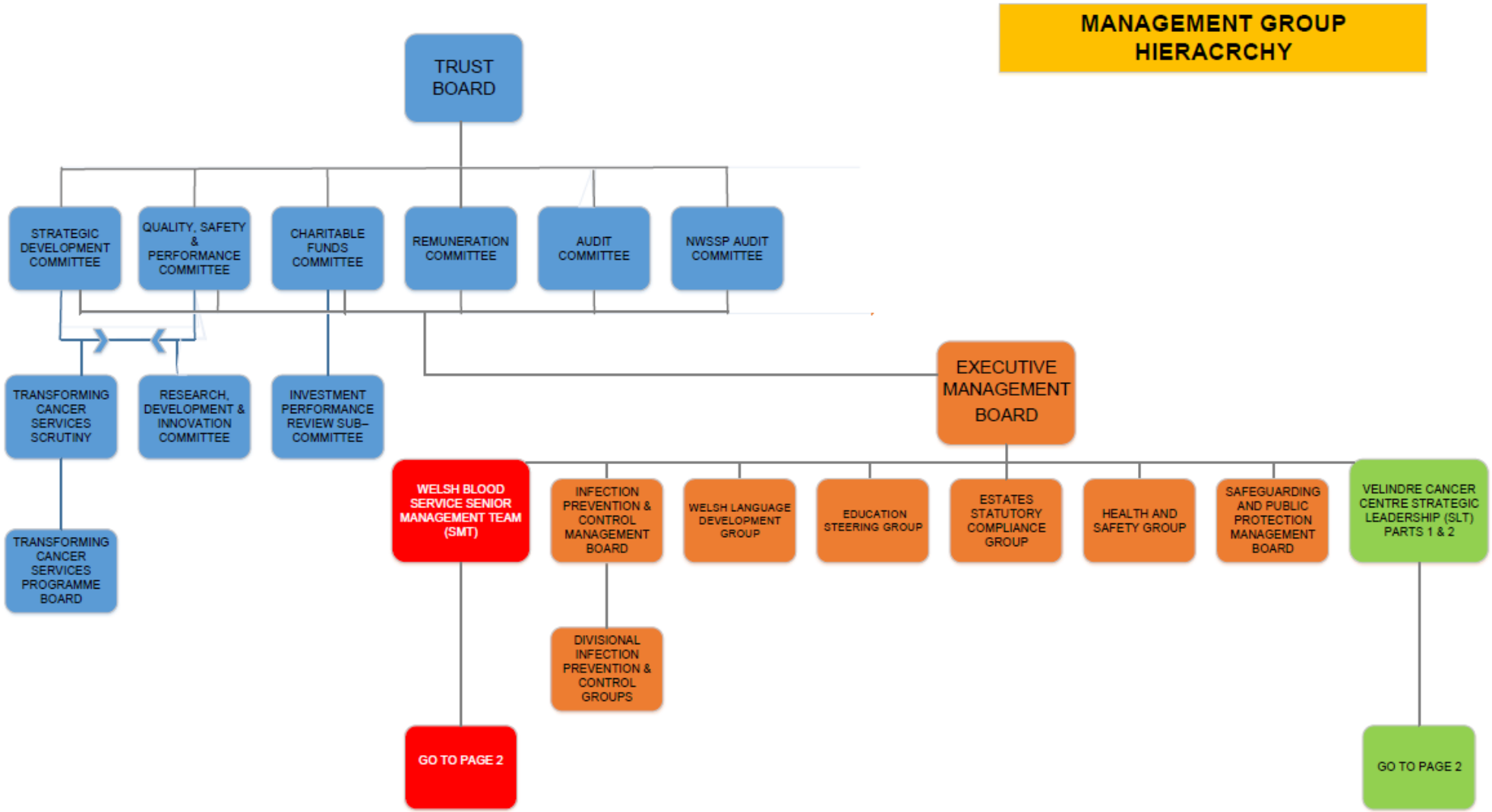
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

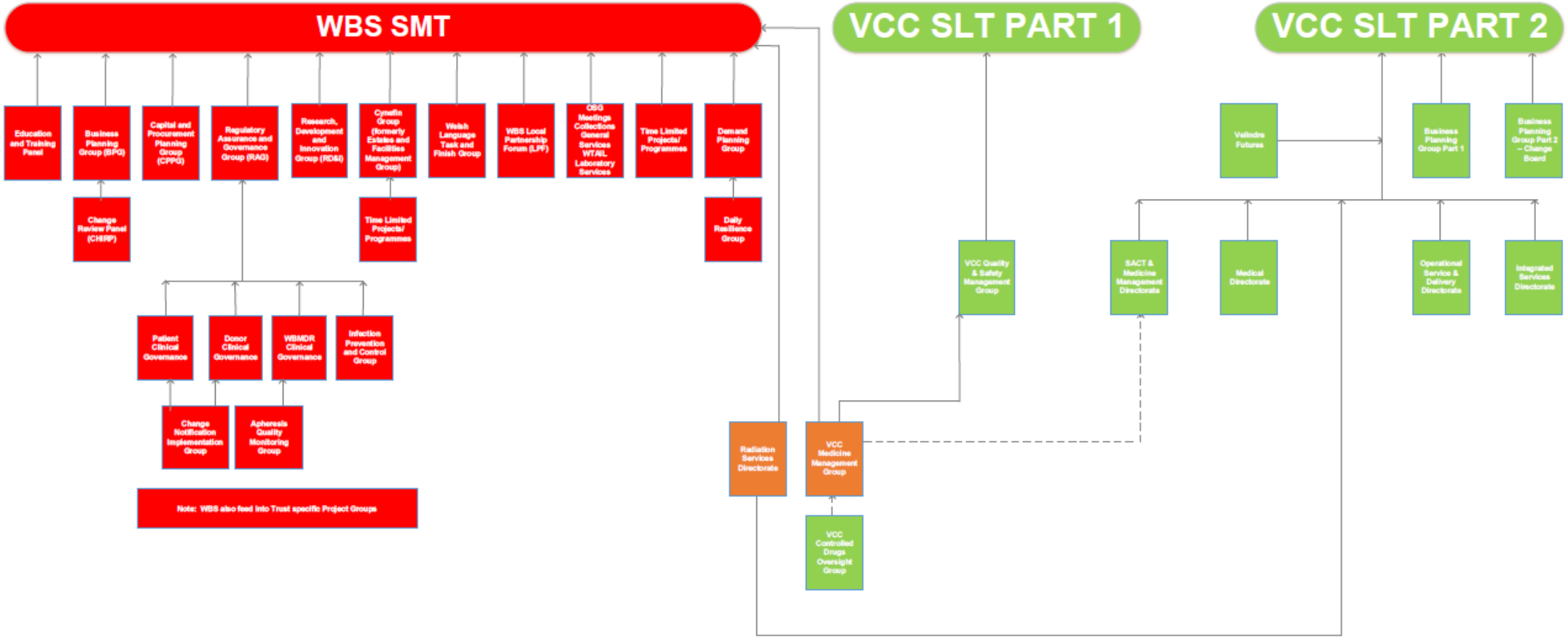
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




WBS SMT
VCC SLT PART 1
VCC SLT PART 2
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cynefin Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
QEG Meetings Collections General Services WT/AL Laboratory Services
Time Limited Projects/ Programmes
Demand Planning Group
Change Review Panel (CHRP)
Time Limited Projects/ Programmes
Daily Resilience Group
Patient Clinical Governance
Donor Clinical Governance
WBMDR Clinical Governance
Infection Prevention and Control Group
Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups
VCC Quality & Safety Management Group
Radiation Services Directorate
VCC Medicine Management Group
VCC Controlled Drugs Oversight Group
Velindre Futures
Business Planning Group Part 1
Business Planning Group Part 2 – Change Board
SACT & Medicine Management Directorate
Medical Directorate
Operational Service & Delivery Directorate
Integrated Services Directorate

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2023

Deleted: 1

Deleted: January 2022

Deleted: October 2022

1. INTRODUCTION

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

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

2. PURPOSE

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

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

Commented [KP(-EP1]: Changed by Sarah Morley

Deleted: of

3. DELEGATED POWERS AND AUTHORITY

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

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

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

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

Formatted: Highlight

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;
- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;
- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.
- Monitor the Trust's sustainability activities and responsibilities;
- Monitor progress against cost improvement programmes;
- Monitor and review performance against the Trust's Assurance Framework.
- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;
- Monitor outcomes / outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;
- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;
- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.
- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;
- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;
- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;
- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

Formatted: Highlight

Formatted: Highlight

Formatted: Font: (Default) Arial, 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 1.27 cm + Indent at: 1.9 cm

Formatted: Font: (Default) Arial, 12 pt

Formatted: Left, Indent: Left: 1.27 cm, Space After: 8 pt, Line spacing: Multiple 1.08 li, No bullets or numbering

Deleted: <#>¶

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

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

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

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

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

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

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

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

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

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

Authority

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

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

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

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

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

Access

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

Sub Committees

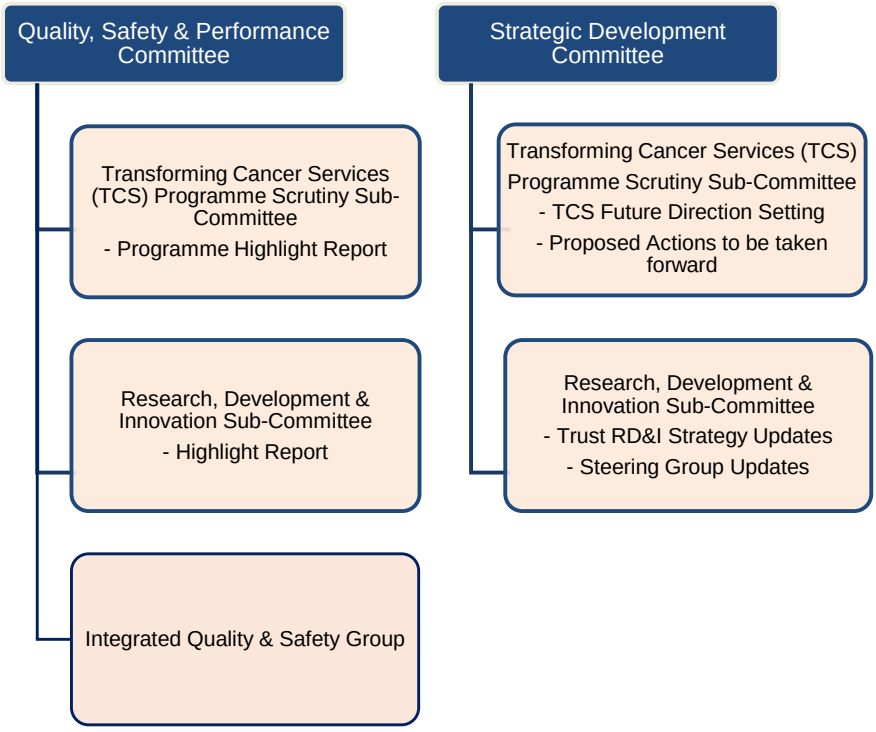
3.5 The Committee has, with approval of the Trust Board, established the:

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

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

The sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:

Deleted: two



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

Deleted: ¶
¶
¶

4. MEMBERSHIP

Members

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

Chair — Independent member of the Board (Non-Executive Director)
One independent member of the Board (Non-Executive Directors)

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

4.2 **Attendees:**

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

Commented [KP(-EP2]: Addition by Sarah Morley
Deleted: t
Deleted: &
Deleted: Manager

4.3 **By invitation**

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

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

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

Member Appointments

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

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

Support to Committee Members

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

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

Ensure the provision of a programme of development for Committee members as part of the Trust's overall OD programme.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

Deleted: Page Break ¶

Formatted: Indent: Left: 1.9 cm, No bullets or numbering

Formatted: List Paragraph, Indent: Left: 1.9 cm, Tab stops: 1.27 cm, Left

Deleted: organisational

Commented [KP(-EP3]: Changes made by Sarah Morley

Deleted: developed by the Executive Director of Organisational Development & Workforce.

Deleted: ¶

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

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

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

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

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

Formatted: Highlight

Deleted:

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

Formatted: Highlight

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;
- Bring to the Board's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

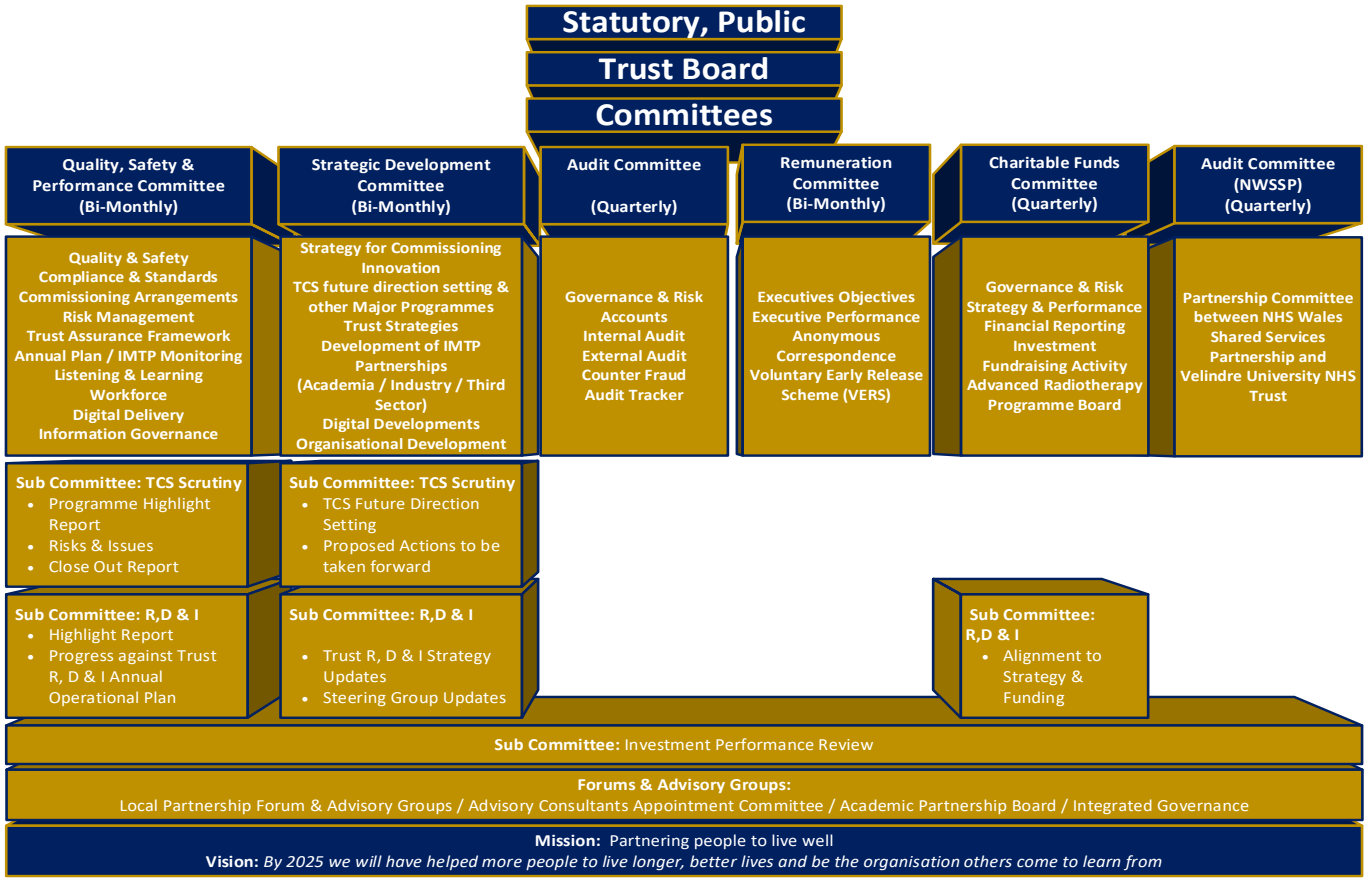
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

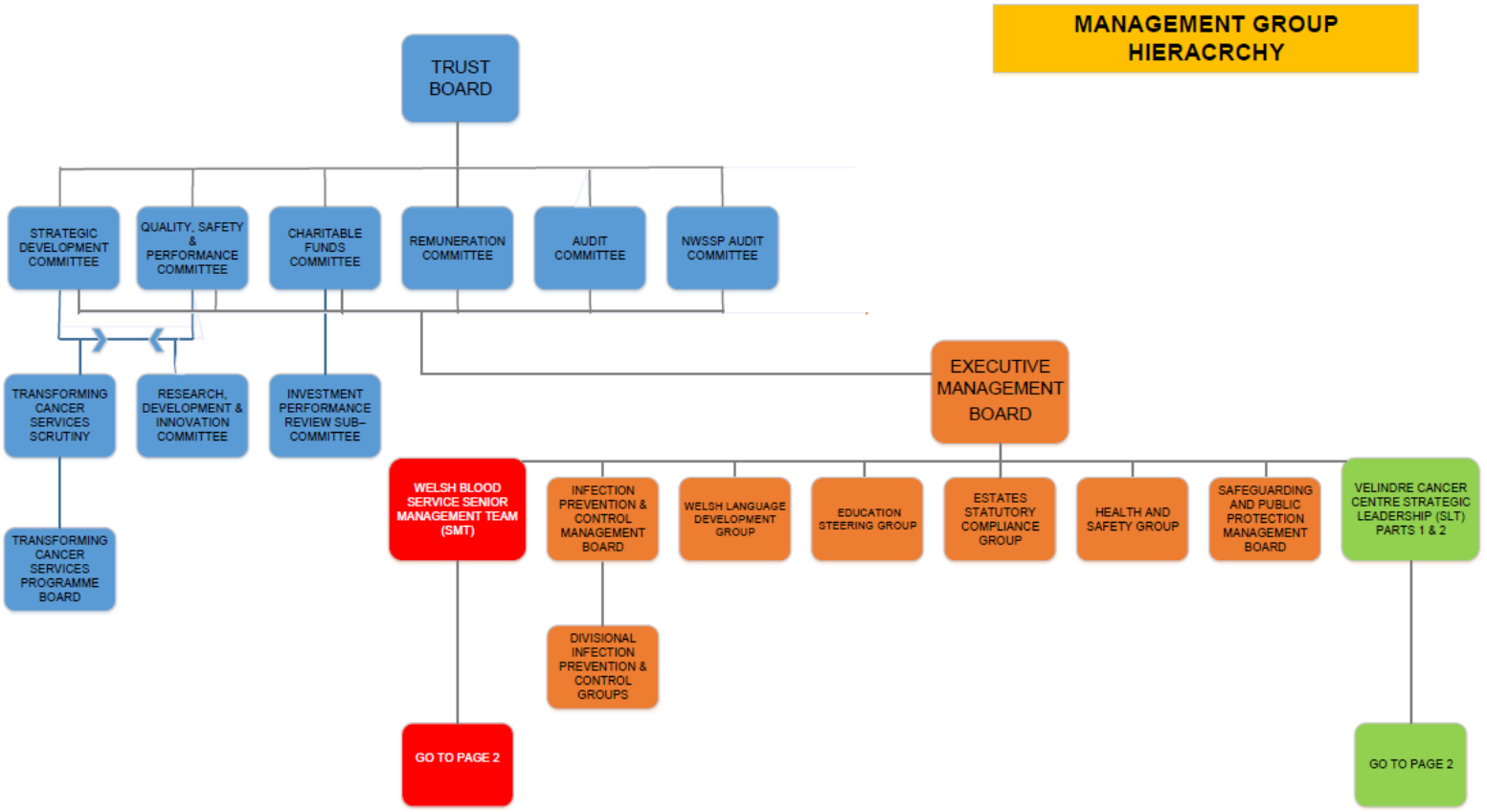
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

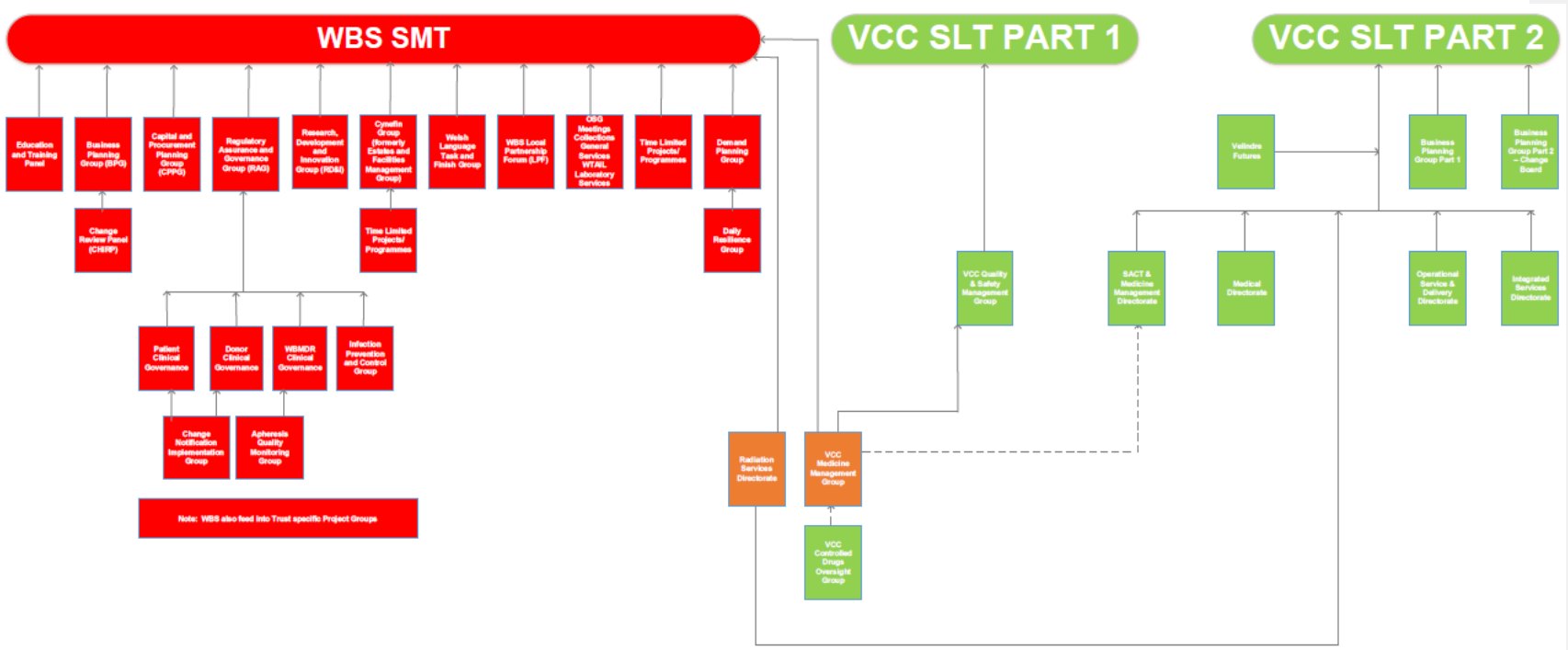
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




WBS SMT
VCC SLT PART 1
VCC SLT PART 2
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cynefin Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
OBG Meetings Collections General Services WTAL Laboratory Services
Time Limited Projects/ Programmes
Demand and Planning Group
Change Review Panel (CHRP)
Time Limited Projects/ Programmes
Daily Resilience Group
Patient Clinical Governance
Donor Clinical Governance
WBMDR Clinical Governance
Infection Prevention and Control Group
Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups
VCC Quality & Safety Management Group
Radiation Services Directorate
VCC Medicine Management Group
VCC Controlled Drugs Oversight Group
Velindre Futures
SACT & Medicine Management Directorate
Medical Directorate
Business Planning Group Part 1
Business Planning Group Part 2 – Change Board
Operational Service & Delivery Directorate
Integrated Services Directorate

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT
12th September 2022 – 2nd December 2022
(Reporting Period)

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
	• VEL – Velindre UNHS Trust • SQA - Single Quotation Actions • STA - Single Tender Action • SO's/SFI's – Standing Orders/Standing Financial Instructions

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 12th September 2022 – 2nd December 2022 and whether in accordance with Standing Financial Instructions (SFIs) Chapter 11 Procurement and Contracting for Goods and Services, Procurement Manual, and the Contract Notification Arrangements, included as Schedule 1 of the SFIs.

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

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

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

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

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

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

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

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

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

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

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

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

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

[1] subject to the existence of suitable suppliers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SFI Reference	SFI Description	Description	Items
11.13	Single Quotation Application or Single Tender Application	Single Quotation Actions	9
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	6
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)	4
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes)	5

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Compliance Assurance

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

Repeat Submissions

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

Non-Compliance

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

All Wales Contracts

Appendix 1.3 summarises the All-Wales Contracts that are in progress by NWSSP for information purposes only. In addition to those presented and noted by NWSSP's Audit Committee, there is an additional list of All-Wales Contracts that are being presented to their next Audit Committee on 24th January.

Legislative Regulatory Compliance Register

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

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

2.2 General Observations Update

SQA/STA Requests

Since the October Committee, the Head of Procurement has undertaken a review of the SQA and STA requests that were submitted and approved from 1st April 2022 to the present date. This update reflects those requested for VCC only, as the WBS element are currently being reviewed by Procurement colleagues based in Betsi Cadwaladr University HB, as they manage the WBS portfolio. For the aforementioned period, 7 SQA's were submitted however, 1 was rejected as there was already an existing contract in place therefore the SQA was unnecessary. Of the remaining 6, they were considered appropriate, approved and are broken down as follows:

3 x professional services – due to the requirement for continuity of the in-depth project knowledge it was essential that the same suppliers were engaged to progress the work. Due to the likelihood of ongoing services being required, it has been acknowledged that a framework agreement should be established to underpin the compliance and governance arrangements.

3 x supply of spare parts, consumables and software upgrades for equipment – Only the Original Equipment Manufacturer (OEM) can supply these products/services therefore, given the potential of the on-going requirement, longer-term arrangements should be pursued and will involve engagement with the respective suppliers. This will be progressed with NWSSP's Maintenance Team in 2023/24.

For the same period, 12 STA's were submitted however, 1 was rejected as there was already an existing contract in place, and another was duplicated. Of the remaining 10, they were approved as follows:

1 x professional services - due to the requirement for continuity of the in-depth project knowledge it was essential that the same supplier was engaged to progress the work. As with the SQA's, it has been acknowledged that the Trust should establish its own framework for services such as these to accommodate the continued use of providers to underpin the compliance and governance arrangements.

5 x supply of spare parts, maintenance and servicing arrangements for equipment. Only the Original Equipment Manufacturer (OEM) can supply these products/services therefore, given the potential of the on-going requirement, longer-term arrangements should be pursued and will involve engagement with the respective suppliers. In conjunction with the SQA's, this will be progressed with NWSSP's Maintenance Team in 2023/24.

1 x management of a charity run/event – the supplier had the Intellectual Property (IP) rights for this event therefore STA was appropriate.

1 x provision of utilities water services – Welsh Water are the sole provider for this utility and a direct award is permitted under the Public Utilities 2016 Regulations.

1 x provision of planning permission – Cardiff Council is the only Organisation that can provide the required planning permission and a direct award is permitted under the Public Contracts Regulations 2015 – Regulation 77, Reserved Contracts for Certain Services.

1 x medical records storage – to provide emergency recovery and storage of water damaged medical records and was appropriate for the short term. Longer term arrangements will be tendered on a collaborative basis for the wider NHS.

Publication of Contract Awards

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

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

For VCC, where requisitions have been received for goods/services over £5k, they have had supporting quotations that were obtained by the respective Divisions/Departments. Of the 1 SQA request received, this was reviewed and, following a quotation exercise, the SQA wasn't necessary. Given the impending end of year pressures, and following the procurement training being provided, there will be a greater emphasis upon reviewing the aggregated expenditure and undertaking a more focused approach in inviting competitive quotations.

2.2 Other Matters of Interest

Trust Board Approvals Process – Update

A training programme has now been drafted and it has been agreed that this will be delivered to the Senior Finance Team in the first instance, with a plan to engage and deliver this training with the various Divisions.

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 – January 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Rachel Hennessy	Velindre Cancer Centre	VCC-SQA-012	01/12/2022 to 31/03/2023	Single Quotation Action	Replacement Scalp Cooling Caps for the Paxman Scalp Cooling System	Paxman Coolers Ltd	£8,960	Sole supplier	Endorsed	Ongoing funding post 1st April to be confirmed. If agreed, Procurement to undertake a formal tender exercise.	First Submission.
Rachel Hennessy	Velindre Cancer Centre	VCC-STA-009	04/10/2022	Single Tender Action	Storage of Patient Records as defined in Section 46 Code of Practice (FOI Act 2000) and NHS Wales Information Management Records Code of Practice 2022.	Harwells Ltd.	£141,805	Emergency/ and Disaster Recovery situation and ongoing service provision. The possible restoration costs have been calculated and approved in the event that once an assessment has been made of the records, the cost for freeze vacuum drying, sanitisation and inspection and specialist cleaning would be £395 per box.	Endorsed	Procurement to undertake a formal collaborative tender exercise in 2023.	Repeat Submission. Previous freezer storage cost is £43,063.04 + VAT including the potential cost = £221,841.65 inc. VAT
Rachel Hennessy	Velindre Cancer Centre	VCC-STA-10	One event in 2023	Single Tender Action	Overseas bike ride to the Rugby World Cup.	White Rock	£82,250	Sole supplier as they own the intellectual property.	Endorsed	Procurement to engage with supplier to consider a longer term arrangement for further events.	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – January 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Rachel Hennessy	New Velindre Cancer Centre	VCC-STA-011	01/09/2022 to 31/08/2023	Single Tender Action	Planning Performance Agreement with Cardiff City Council for planning related matters for the new Velindre Cancer Centre and its enabling works.	Cardiff City Council	£40,000	Sole supplier as the Local Authority.	Endorsed	Compliant procurement route in accordance with PCR 2015 – Regulation 77 Reserved Contracts for Certain Services.	First Submission
Alan Prosser	WBS	WBS-SQA-1016	02/12/2022 to 01/12/2023	Single Quotation Action	Q-Pulse Quality Management System Licence Fee	Ideagen	£9,844	Proprietary Software	Endorsed	Discussion underway regarding tender opportunity	Repeat
Alan Prosser	WBS	WBS-SQA-1017	01/10/2022 to 30/09/2032	Single Quotation Action	Re-creation of sample archive inventory from frozen samples in off-site storage	UK Bio-Stores Ltd	£10,332	Requirement to retain samples at current supplier premises. Transporting these samples offsite would compromise the validity	Endorsed	One off requirement. Samples will be stored for 10 years in line with policy and then destroyed.	First Submission
Alan Prosser	WBS	WBS-SQA-1018	01/10/2022 to 30/09/2023	Single Quotation Action	Digi-Trax HemaTraxCT Software	Digi-Trax	£5,990	Software required to progress the move to FACT-JACIE accreditation and is the only software currently endorsed by ICCBA	Endorsed	Procurement to seek longer term agreement if software is validated	First Submission
Alan Prosser	WBS	WBS-STA-1019	01/10/2022 to 31/03/2023	Single Tender Action	WBMDR International Stem Cell Courier Services	OnTime Courier GmbH	£42,000	Requirement to cover interim period whilst procurement is conducted	Endorsed	Procurement to complete competitive tender process	First Submission
Alan Prosser	WBS	WBS-SQA-1020	One off purchase	Single Quotation Action	WBS Cold Room 06 Replacement	S&G Air Conditioning Contracts	£10,776	Supplier is the current maintenance provider therefore	Endorsed	No further Procurement action required. One off urgent requirement	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – January 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
								has knowledge of the equipment and can support the urgent requirement			
Alan Prosser	WBS	WBS-SQA-1022	01/11/2022 to 31/03/2023	Single Quotation Action	WBMDR Medical Evaluations	Dr Al-Sabah	£10,000	Requirement to cover interim period whilst procurement is conducted. Provider is currently the only clinician who performs the evaluations on behalf of WBMDR	Endorsed	Procurement to complete competitive tender process – Trust Board paper approved	Repeat Submission (Total cost to date £19,740)
Alan Prosser	WBS	WBS-STA-1023	01/11/2022 to 30/04/2023	Single Tender Action	Venue Hire for Blood Collection	Welsh Wound & Innovation Centre	£27,601	Essential for ongoing collection of convalescent plasma	Endorsed	If required post April 2023 a longer term solution may be required	First Submission
Alan Prosser	WBS	WBS-SQA-1024		Single Quotation Action	HIMSS Assessment	HIMSS	£10,063	Requirement to maintain existing arrangement as advised by DHCW	Endorsed	DHCW are co-ordinating a national assessment of requirements to facilitate a national agreement.	First Submission
Alan Prosser	WBS	WBS-STA-1025	01/01/2023 to 30/06/2023	Single Tender Action	Provision of Ultra High Resolution HLA Typing	Histogenetics	£80,000	Requirement to cover interim period whilst procurement is conducted	Endorsed	Procurement to complete competitive tender process – Trust Board paper approved	Repeat Submission (Previous STA £80,000)
Alan Prosser	WBS	SQA/VEL/AB/005 /22-23	09/09/2022 to 08/09/2027	Single Quotation action	Maintenance of Spectra Optia Apheresis Cell Collection Systems	Terumo BCT	£61,187.50	Comprehensive maintenance contract only available from the Original	Endorsed	5 year contract based on an extended equipment lifespan.	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – January 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
								Equipment Manufacturer			
Alan Prosser	WBS	SQA//VEL/AB/006/2022-23	01/09/2022 to 31/08/2025	Single Quotation Action	Maintenance of Biological Irradiator	Rees Professional Services	£22,500	Maintenance contract only available from the Original Equipment Manufacturer	Endorsed	3 year contract agreed to be appropriate	First Submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – January 2023

Appendix 1.2 - Further Matters / Non-Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Rachel Hennessy	Velindre Cancer Centre	VEL-FN-001	31/03/2022 to 30/03/2026	File Note	Maintenance of Revolution CT Scanner	NHS Supply Chain	£262,460	Delay in renewal quote submission. Further negotiation to achieve £6,396 per annum savings when beyond renewal date.	Extended without appropriate authorisation	Procurement Maintenance Team is to engage with service prior to expiry	First time submission
Rachel Hennessy	Velindre Cancer Centre	VEL-FN-003	01/04/2022 to 31/10/2022	File Note	Extended Supply of a Temporary marquee to provide comfort to patients during the COVID-19 Pandemic social distancing	County Marquees Ltd	£18,256	The breach of procedure was due to winter pressure Covid – 19, social distancing in line with Welsh Government Legislation and the requirement to provide suitable covered areas for patient safety waiting. Currently looking at a more substantial fixed modular unit which will reduce overall lease cost.	Competition not sought in accordance with SFI'S	The Marquee was removed in October 2022 and a compliant arrangement has been put in place.	Repeat submission - Last reported in January 2020. Total cost to date - £82,507
David Powell	TCS	VEL-FN-007	13th June 2022 – 22nd July 2022 - £5,902.00 1st August 2022 to 31st March 2023 up to a maximum - £19,749.00	File Note	Provision of equipment related support and advice in relation to nVCC Project's Preferred Bidder Stage activities.	PB Project Management (Wales) Ltd.	£25,651	There was a delay in receiving a quote for the final stage of project, due to the uncertainty of the volume of work that would be required.	Competition not sought in accordance with SFI'S	No further actions.	First time submission
Alan Prosser	WBS	WBS-FN-153	01/05/22 to 30/04/23	File Note	Hootsuite Business Package	Hootsuite Inc	£10,290	Extended without appropriate authorisation due to a contract auto-renewal. This subsequently meant an invoice was received from the provider for payment	Extended without appropriate authorisation	Procurement to seek longer term agreement using a suitable framework	First time submission
Alan Prosser	WBS	WBS-FN-154	One day 18/11/22	File Note	Additional filming day for WBS Recruitment activity	Storm & Shelter	£5,999	Due to staff absence the provider was unable to obtain all the footage required. It was therefore necessary to arrange a further day filming	Extended without appropriate authorisation	Although a file note was completed a Change Contract Notice may have been appropriate if time had allowed	First time submission

.

Velindre University NHS Trust - Audit Committee Report – October 2022

Appendix 1.3 - All Wales Contracts in progress

No.	Contract Title	Doc Type	Total Value	Director of procurement Services (Jonathan Irvine) approval <£750K	Welsh Government approval >£500k	Managing Director (Neil Frow) approval £750k-£1M	Chair Approval (Tracy Myhill) approval £1M+
1.	**Vascular Access Accessories** to purchase Vascular Access Accessories including connectors, filters, administration sets, blood sets, pressure tubing, extension sets including needle free access devices. Contract Dates: 01/08/2022 – 31/07/2026	ratification	£ 14,181,816	13/06/2022	08/07/2022	08/07/2022	13/07/2022
2.	**Walking Aids** covers a wide range of products prescribed to assist with patient mobility, such as walking sticks, four wheeled rollators, elbow crutches, and walking frames. These products are key to the successful day-to-day operation of numerous NHS departments across Wales, such as Physiotherapy and Fracture Clinics. Contract dates 01/11/2022 – 31/10/2026	briefing	£ 2,898,423	14/06/2022	08/07/2022	n/a	n/a
3.	**Framework Agreement for the Provision of Insourcing / Outsourcing Clinical, Surgical and Diagnostic Procedures** affords Health Boards with a compliant and more expedient route to secure such services as it requires. It is worth noting however that it was not designed as a strategic solution to capacity issues within NHS Wales. The use of this agreement therefore was premised on the basis that all other avenues to manage capacity and demand would have been totally exhausted by Health Boards. The scope of the framework covers 21 major clinical, surgical and diagnostic procedures potentially required by Health Boards Contract dates 1st August 2018– 31st March 2023	extension	£ 87,000,000	14/06/2022	20/06/2022	20/06/2022	21/06/2022
4.	**Psychological Support Services** The role of the Professional Support Unit (PSU), Health, Education, and Improvement Wales (HEIW) is to promote and support positive psychology and wellbeing at work for doctors and dentists in training across Wales. Contract dates 01.10.2022 – 30.09.2025 with optional extension to extend to 30.09.2027	briefing	£ 2,796,000	01/07/2022	04/08/2022	n/a	n/a
5.	**Stoma** The Stoma Services project is driven by the need to review the procurement arrangement that is currently in place and strengthen the consistency of service delivery across NHS Wales. The aim of the project is for the service to deliver value to those receiving stoma care services and to build on the existing arrangements by delivering a range of benefits. Contract dates 1st January 2023 – 31st December 2026 (with the option to extend for 2 years)	briefing	£125,000,000 (prescribed items) £17,500,000 (delivery and preparation costs)	08/07/2022	sent to WG 8/7		

6.	**Home Oxygen Service** The contract is for the provision of prescribed oxygen services to patients in their place of residence Contract dates 01/07/23 - 7 Years (with the option to extend for up to 36 months)	briefing	£ 74,451,521	19/07/2022	10/08/2022	n/a	n/a
7.	**Post registration Pharmacy programme** Delivery of a Post-registration Health Professional Education and Training Services to train the future NHS Wales workforce to achieve independent prescribing (IP) status alongside gaining a Royal Pharmaceutical Society (RPS) credential. This will ensure sustainability within the NHS workforce in Wales and to ensure the individual Welsh Health Board's and Trust's Integrated Medium Term Plan workforce requirements are met. Contract dates 7th July 2022 to 01 September 2022; Services commence 1st September 2022 to 31 December 2025 plus option to extend in 12-month tranches up to 31 January 2027.	ratification	£ 2,943,500	12/07/2022	19/07/2022	trust gov applies	trust gov applies
8.	**Polythene Waste Bags and Aprons** To manufacture and supply the NHS in Wales with various polythene waste disposal bags and aprons. Contract dates 01/08/2022 - 30/09/2025, With an option to extend by up to a further 12 months	ratification	£ 6,591,301	19/07/2022	25/07/2022	10/08/2022	18/08/2022
9.	**Provision of Postgraduate Certificate in Critical Care** HEIW) is undertaking a strategic review of commissioned health profession education and training across NHS Wales. HEIW commissions both pre-registration and post-registration qualifications for the NHS Wales workforce. HEIW has identified a requirement to commission critical care education. HEIW is seeking to commission a level 7 60 credit Postgraduate Certificate in Critical Care Contract dates 1st September 2023 to 31st August 2026 with options to extend to 31st August 2028	briefing	£ 1,471,911	20/07/2022	05/08/2022	n/a	n/a
10.	**Medical Locums Managed Services** To provide a managed service to medical workforce managers that includes direct engagement, demand management and recruitment. Contract dates 1st September 2021 - 31st August 2024	extension	£ 2,469,516	20/07/2022	09/08/2022	10/08/2022	18/08/2022
11.	**HCS Lease of Laundry Vehicles** This contract is for the lease and maintenance/repair of 6 vehicles over an initial 3-year period with an option to extend up to 24 months, for use by HCS in relation to Laundry Services. Previously these were procured by legacy organisations, and this contract collates the requirement pan Wales. Contract dates 01/09/2022 – 31/08/2025 with an option to extend for up to a further 24 months.	ratification	£ 630,582	29/07/2022	08/08/2022	10/08/2022	18/08/2022
12.	**AW4189 – Nurses and other Healthcare Professionals Uniforms** The contract is for the supply and delivery of various standard unisex garments to each Health Board and Trust in Wales. All garments are available in sizes XS – 4XL, with the option to choose from two lengths, standard or tall. Contract dates 1st June 2016 - 28th February 2023	extension	£ 4,399,970	22/07/2022	08/08/2022	10/08/2022	18/08/2022
13.	**Framework Agreement for the Provision of Insourcing / Outsourcing Clinical, Surgical and Diagnostic Procedures** The nature of the agreement is such that it affords Health Boards a compliant and more expedient route to secure such services as it requires. It is worth noting however that it was not originally designed as a strategic solution to capacity issues within NHS Wales. Contract dates 1st April 2023 – 31 March 2027 + 4 year extension option	briefing	£ 200,000,000	22/07/2022	18/08/2022	n/a	n/a
14.	**Framework Agreement for Teleradiology Reporting Services: ref SBS/18/SF/JAF/9340**	briefing	£ 646,944	26/07/2022	n/a	n/a	n/a

	A non- committal contract for the provision of Radiology Reporting services was awarded to Everlight on 1st November 2019 and is due to expire on 31st October 2024. This contract is for urgent, backlog and routine reporting of CT, MRI and Plain Film scans and is used by Aneurin Bevan UHB; Cardiff & Vale UHB; Cwm Taf Morgannwg UHB; Hywel Dda UHB; Betsi Cadwalladr UHB; Powys Teaching Health Board; Swansea Bay UHB; and Velindre NHS Trust Contract dates 1st November 2022 – 31st October 2024						
15.	**Lenalidomide** re-tender of Lenalidomide Capsules, which until recently, has been on the Proprietary Drugs contract, which expired on 30th June 2022. The product is available in Capsule form and comes in different strengths ranging from 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg & 25mg (all pack sizes of 21 capsules) Until recently, this product has been covered by a patent and sold under a brand name of Revlimid, by Celgene Ltd. However, we purposely did not tender for this on the new Proprietary Drugs contract, which started on 1st July 2022, as the patent has recently expired and there is now generic competition available in the market. Contract dates 01.11.2022 – 31.01.2024 (with the possibility to extend up to a further 12 months to 31.01.2025)	briefing	£ 3,855,854	15/08/2022	22/08/2022	n/a	n/a
16.	**AW049 student advice service** Contract to manage the student advise service application process by: Receiving online student applications, Requesting evidence to support the student application, Enabling assessment of the application by the service, Providing knowledge management to students. The project scope for the new agreement is to procure an integrated solution for implementation in two phases: Contract dates 01/09/2022 – 4 years initial term, with three further 12-month extension options available (4+1+1+1)	ratification	£ 1,336,500	16/08/2022	sent to WG 16/8		
17.	**Provision of Rating Consultants for 2023 Non-Domestic Rating Revaluation** The provision of rating consultancy services on behalf of the Health Boards, Trusts and Special Authorities within NHS Wales. Where rate rebates are identified the fees charged for this service are paid to the consultant on the basis of a percentage of the rebate (cost avoidance) achieved Contract dates 1st October 2022 to 30th September 2027 with an option to extend on an annual basis at the contracting authorities' discretion up to 30th September 2029	ratification	Nil	22/08/2022	25/08/2022	02/09/2022	
18.	**Meats and Poultry NPS Framework (various)** Bacon and Sausage- NPS Direct Award, Lot 2, Raw, Fresh & Frozen Meat- NPS Direct Award, Lot 2, Poultry; Raw, Cooked Frozen & Chilled- NPS Direct Award, Lot 2, Cooked Meats- NPS Direct Award, Lot 14 Contract dates 01/04/2020 28/02/2022, Extended to 31/03/2023	extension	£ 7,466,943	22/08/2022	n/a NPS Framework	13/09/2022	13/09/2022
19.	**Influenza vaccine season 2023** The contract is for the Seasonal Influenza Vaccine 2023 for the occupational health departments in the Hospitals on an All Wales basis. Contract dates 01/02/2023 – 31/01/2024 (with the possibility to extend up to a further 24 months to 31/01/2026)	briefing	£ 2,651,798	31/08/2022	sent to WG 31/8	n/a	n/a
20.	**Electronic prescribing and scheduling system oncology-haematology** This new agreement is for the continued use of an existing and complex system already in place across Wales. The system functionality provides for the e-prescribing and e-scheduling of Systemic Anti-Cancer Therapy (SACT) essential in delivering treatment to patients.	extension	£ 1,350,321	08/09/2022	original approval applies 19/6/20	13/09/22	13/09/22

	Contract dates 15th January 2020 to 31st October 2022 (option to extend until 31st October 2024 extension of contract until 31st October 2024						
21.	**Wheelchair reconditioning** provision of Wheelchair Reconditioning services to the Artificial Limb and Appliance Service (ALAS) in South Wales (hosted by Cardiff and Vale University Health Board), as part of the All-Wales Posture and Mobility Services (PMS). ALAS, and the associated PMS, is commissioned and funded by the Welsh Health Specialised Services Committee (WHSSC). Contract dates 01/02/2023 – 31/01/2027 option to extend for up to 24 months	briefing	£ 1,131,889	09/09/2022	sent to WG 09/09	n/a	n/a
22.	**Transitional Drugs** This contract is for the tender of some lines which have recently lost their patent exclusivity and therefore have generic competition available. They are therefore transitioning from a Proprietary Drugs (where there is only one originator supplier) to a Generic Drugs arrangement (where there are a number of suppliers available in the market). Contract dates 1st October 2022 to 31st January 2024 (with an option to extend for up to a further period of 12 months to 31st January 2025)	Ratification	£ 2,939,279	12/09/2022	Sent to WG 12/09		

For information, the following is list of contracts to be presented and approved by NWSSP's Audit Committee on 24th January 2023.

No.	Contract Title	Doc Type	Total Value	JI approval <£750K	WG approval >£500k	NF approval £750-£1M	Chair Approval £1M+
1.	Wheelchairs, Associated Parts, and Accessories. Provision of Manual and Powered, Adult and Paediatric Wheelchairs and their associated accessories and consumables Contract: 1st January 2023 – 31st December 2024 +2 Years	ratification	£11,076,944	21/09/2022	26/09/2022	06/10/2022	07/10/2022
2.	Clozapine Indicated for the treatment of schizophrenia (including psychosis in Parkinson's disease) in patients unresponsive to, or intolerant of, conventional antipsychotic drugs. Contract: 01.07.2023 – 30.06.2026 +1	briefing	£1,382,251	17/10/2022	28/10/2022	n/a	n/a
3.	WBS Becs Blood Establishment Computer System (BECS) via its 'ePROGESA' platform and associated modules. This system manages the WBS supply chain activity, including donor engagement, blood collection, manufacturing & testing and component issuing activity. Contract: 1st November 2022 – 31st October 2024 +1.	ratification	£623,278	17/10/2022	02/11/2022	n/a	n/a
4.	Women & child health consumables Framework Supply of Women & Child Health Consumables Contract: 1st December 2022 to 30th November 2025+1	ratification	£2,448,093	19/10/2022	11/11/2022	11/11/2022	11/11/2022
5.	Stoma (prescribed items and delivery/prep costs) Service to deliver value to those receiving stoma care services and to build on the existing arrangements by delivering a range of benefits. Contract 1st January 2023 – 31st December 2026 +2	briefing	£125,000,000 £17,500,000	CS 08/07/22	22/12/2022	n/a	n/a
6.	Contrast Media extension This contract is for all X-Ray Contrast Media purchased by all hospital Pharmacy Departments in Wales for use by radiology departments. Contract 1st November 2019 to 31st October 2023	extension	£12,329,124	25/10/2022	original approval applies 18/9/19	25/10/2022	25/10/2022
7.	Hep C This contract is for the provision of antiviral medicines for the treatment of Hepatitis C (HCV). These medicines are designed to stop the virus from multiplying inside the body and thereby preventing liver damage.	briefing	£13,826,112	27/10/2022	18/11/2022	n/a	n/a

	Contract 01/05/2023 to 30/04/2025 +2						
8.	Nurses Uniforms The contract is for the supply and delivery of various standard unisex garments to each Health Board and Trust in Wales. All garments are available in sizes XS – 4XL, with the option to choose from two lengths, standard or tall. Contract: 1st March 2023 – 28th February 2027+3	briefing	£8,494,396	27/10/2022	sent to WG 27/10	n/a	n/a
9.	Provision of Medical Consumables Commercial Storage Facilities & Distribution Services Safe storage and distribution as required of various medical consumables on behalf of NHS Wales. Contract: 1st December 2021 to 30th November 2023	extension	£1,986,400	02/11/2022	original approval applies 17/11/21	07/11/2022	08/11/2022
10.	Lenalidomide Lenalidomide Capsules, which until recently, has been on the Proprietary Drugs contract, which expired on 30th June 2022. The product is available in Capsule form and comes in different strengths ranging from 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg & 25mg (all pack sizes of 21 capsules) used for the treatment of certain cancers and serious conditions affecting blood cells and bone marrow, namely multiple myeloma, myelodysplastic syndromes and mantle cell and follicular lymphoma Contract: 01/12/2022 to 30/11/2024 +2	ratification	£739,384	10/11/2022	11/11/2022	11/11/2022	n/a
11.	Oral Liquids It consists of all Generic liquids, syrups, solutions, suspensions and powders purchased through hospital Pharmacy Departments. Contract: 01/07/2023 to 30/06/2026 +1	briefing	£10,788,379	25/11/2022	30/11/2022	n/a	n/a
12.	Eating disorder units Eating disorders are a range of complex mental health conditions requiring specialised treatment and support for individuals. Contract: 1st April 2023 to 31st March 2025 +3	briefing	£10,950,000	25/11/2022	20/12/2022	n/a	n/a
13.	Emergency Department Well-being and Home Safe Service Offer support for frail older people and vulnerable adults in emergency departments and to resettle people in their homes with follow-up welfare calls or visits and where necessary to connect them to community services to avoid readmission into the emergency department. Contract: 1st April 2023 – 31st March 2024 +2	briefing	£2,700,417	AS 23/11/22	14/12/2022	n/a	n/a
14.	Primary care workforce intelligence system Procure a single system which brings the Performers List, All Wales Pharmacy Database, and the Primary Care Workforce Reporting System within NWSSP Primary Care services and Employment Services together by April 2024. Contract 1st April 2023 – 3+2	briefing	£960,000	01/12/2022	sent to WG 01/12	n/a	n/a
15.	Human blood derived products Human Blood Derived Products purchased by The Welsh Blood Service. The Welsh Blood Service operate a wholesaling service to All Wales LHB's/Trusts. Due to shortages within this global market, it is necessary to ensure that some of the products i.e. Immunoglobulin's, have all the brands available on contract. This will ensure continuity of supply and will allow the Welsh Blood Service to stock any product ordered through their wholesaling service. Contract: 1st May 2020 to 30th April 2024	extension	£68,946,178	05/12/2022	original approval applies 25/2/20	06/12/2022	12/12/2022
16.	All Wales Ophthalmology Consumables Framework Agreement Ophthalmology Consumables are used in both the Surgical and Outpatient settings of Ophthalmology Departments Contract 1st June 2023 – 31st May 2027	briefing	£22,705,529	08/12/2022	sent to WG 8/12	n/a	n/a
17.	Walking Aids The Contract will cover various walking aid products including crutches, walking frames and walking sticks. Contract: 01/01/23 – 31/12/2026	ratification	£3,672,750	12/12/2022	19/12/2022	21/12/2022	21/12/2022
18.	Biologics Etanercept is licensed for the treatment of adults with moderate to severe rheumatoid arthritis (RA), psoriatic arthritis, non-radiographic axial spondylarthritis and plaque psoriasis. Bevacizumab is licensed for the treatment of several types of cancer. Teriparatide is licensed for the treatment of osteoporosis in post-menopausal women and in men at increased risk of fractures. Adalimumab is licensed for the treatment of moderate to severe rheumatoid arthritis; severe ankylosing spondylitis; Crohn's disease; ulcerative colitis; hidradenitis suppurativa and uveitis. Infliximab is licensed to treat Crohn's disease and rheumatoid arthritis. Rituximab is licensed for the treatment of non-Hodgkin's B-cell lymphomas, chronic lymphocytic leukemia, Wegener's granulomatosis, and microscopic	extension	£53,751,993	15/12/2022	original approval applies 29/4/21	15/12/2022	16/12/2022

	polyangiitis. It is also licensed to treat rheumatoid arthritis in patients who have failed other biologic medications, such as Infliximab or Etanercept Contract: 1st July 2021 to 30th June 2024						
19.	Trastuzumab is approved for the treatment of early-stage breast cancer that is **H**uman **E**pidermal growth factor **R**eceptor **2**-positive (**HER2**+). Trastuzumab is also approved, in combination with chemotherapy for the treatment of HER2+ metastatic cancer of the stomach or gastroesophageal junction in patients who have not received prior treatment for their metastatic disease. This contract is for the supply of medicines to both hospitals and to patients within their own homes. Contract: 1st July 2021 to 30th June 2024	extension	£19,796,274	15/12/2022	original approval applies 29/4/21	15/12/2022	16/12/2022
20.	Remote advice and guidance Provide a tool that can link care providers to expert advice within and across organisational boundaries. Contract: 01/04/23 – 31/03/26+2	ratification	£6,000,000	19/12/2022	21/12/2022	22/12/2022	22/12/2022
21.	Video Consultation VC now forms part of a safe and assured toolkit for patients and clinicians, enabling a flexible approach for clinicians and patients in the delivery of safe and timely care to the people of Wales. Contract: 01/01/2023 -31/12/2023+1	ratification	£3,912,000	20/12/2022	22/12/2022	22/12/2022	23/12/2022
22.	Laryngoscope blades and consumables Contract: 01/06/2023 – 31/05/2027	briefing	£2,223,192	21/12/2022	sent to WG 21/12		

ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING

HIGHLIGHT REPORT

Date of Meeting	**13 October 2022, 09:30**
Chair Name ***Chair Organisation***	Martin Turner Audit Committee Chair Welsh Ambulance Services NHS Trust
Secretariat ***Secretariat Organisation***	Trish Mills, Board Secretary Alex Payne, Corporate Governance Manager Welsh Ambulance Services NHS Trust

Members Present:	
Martin Turner	Welsh Ambulance Services NHS Trust [Chair]
Dyfed Edwards	Public Health Wales
Iwan Jones	Aneurin Bevan University Health Board
Marian Jones	Digital Health and Care Wales
Gill Lewis	Health Education and Improvement Wales
Paul Newman	Hywel Dda University Health Board
Patsy Roseblade	Cwm Taf Morgannwg University Health Board
John Union	Cardiff and Vale University Health Board
Martin Veale	Velindre University NHS Trust
Nuria Zolle	Swansea Bay University Health Board
In Attendance:	
Trish Mills	Board Secretary, Welsh Ambulance Services NHS Trust
Simon Cookson	Internal Auditor, NWSSP [Item 1-2]
Richard Harris	Audit Wales [Item 3]
Dave Thomas	Audit Wales [Item 3-4]
Jonathan Morgan	Observer - Health Education and Improvement Wales
Apologies:	
Medwyn Hughes	Betsi Cadwaladr University Health Board
Alison Lewis	Health Education & Improvement Wales
Stella Parry	Powys Teaching Health Board
Mark Taylor	Powys Teaching Health Board

The following is a summary of the main issues discussed at the meeting

1. Minutes from the 19/05/22 & Outstanding Actions

1.1. The minutes from the meeting held on the 19 May 2022 were agreed as an accurate record. There were no requests for amendments or comments and accepted.

1.2. The actions were reviewed. Action 'AWACC (22) 15' was closed; action 'AWACC (22) 17' will be discussed under work programme arrangements; all other actions were complete.

The following is a summary of the main issues discussed at the meeting

2. Internal Audit Update [Business Development & Analysis Update]

2.1. Simon Cookson delivered a presentation to the group on the audit activity via the new dashboard. The number of reviews and trends across categories and financial years could be observed, in addition to comparison by organisation.

2.2. The following was noted:

- That similar individual organisational presentations will be delivered;
- That is necessary to consider how to use and share the database;
- That user access to the database must be considered;
- The intention is for this information to be used in the 'background';
- That benchmarking the data outside of Wales could be helpful;
- Internal Audit (IA) have approached other IA colleagues to seek such data;
- IA will share the database with Audit Committees, as requested;
- The primary audience is the AWACC and the Board Secretaries Network;
- That it would be helpful for the database to include emergent themes;
- That this database could potentially be subject to misuse.

2.3. IA are content to develop and share the database in whichever way is considered preferable and will take advice from the AWACC. The database is to enable learning; however, it does enable organisational comparison.

2.4. The future approach to IA planning was considered; Simon Cookson stated that this database could be used to inform the future approach in regard to identifying themes which require attention.

2.5. Simon Cookson will socialise the database with other stakeholders, after which the AWACC will decide how to take it forward. Simon will return to the AWACC at its next meeting to follow up this work **[Action].**

3. Audit Wales – External Audit Update

3.1. Dave Thomas and Richard Harris spoke to the group in regard to two matters – the Fee Scheme Consultation and the Work Programme. In regard to the *Fee Scheme Consultation* the following was noted: -

- The Consultation included info regarding the change to audit approach;
- The fee increase is not yet known;
- Plans will be issued in early 2023 which will set out the detail.

3.2. The group discussed resource / workforce challenges within Audit Wales, and the risks that this poses for service delivery. Audit Wales continue to work closely with local finance teams / organisations on this matter;

The following is a summary of the main issues discussed at the meeting

3.3. In regard to the *Work Programme* the following was noted: -

- The wider VfM work programme across all sectors has been shared;
- The structured assessments have been progressed;
- Follow-up to the planned care for orthopaedic services will soon be published;
- Summary of quality governance findings will soon be published;
- There is work on unscheduled care, including review of discharge planning;
- There will be a thematic review of workforce planning.

3.4. Audit Wales would expect to be involved in giving evidence to the Pandemic Inquiry, however they are yet to be invited to do so. There is output from the Test, Trace and Protect report which could be helpful, for example.

4. Work Programme and Operating Arrangements

4.1. The group considered its operation and the business it should receive going forward. The suggestions received for how the group should operate, and the business to receive included: -

- Focus on all-Wales audit activities that affect all bodies, e.g., decarbonisation;
- Focus on all-Wales areas of high-risk activity, e.g., cyber-security;
- Approach to counter-fraud and associated resources to support;
- The socialisation and use of the Internal Audit analysis dashboard;
- Welsh Language Standards compliance – involve the Commissioner;
- The Internal Audit approach / best practice regarding capital projects;
- Related lessons learned from capital projects/programme activity;
- The Gateway review process / compliance;
- All-Wales high-risk compliance requirements, inc. Welsh Language;
- Understanding of the macro-economic environment, in context;
- Partnership working and associated audit management.

4.2. The group agreed to focus on two or three areas at its next meeting, supported by Trish Mills. The preference for its next meeting was for the group to consider counter-fraud and de-carbonsiation;

4.3. Additionally, the group will receive business in relation to the Welsh Language Standards at its next meeting. If this is not practical it will be received at the subsequent meeting;

4.4. Dave Thomas will support the discussion regarding management of capital projects from an individual organisational point of view, as opposed to inclusion for discussion at AWACC;

4.5. Dave Thomas will consider this matter and feedback any useful questions to support Independent Board Members' in governing the management of capital projects to the Chair and Trish Mills **[Action];**

The following is a summary of the main issues discussed at the meeting

4.6. In regard to the macro-economic environment topic, it may be possible for the members to attend meetings of the respective Finance Directors – to better understand the position **[Action];**

4.7. The group agreed the importance of returning to cyber-security as an ongoing audit issue. Trish Mills will support the arrangements for the next meeting and prepare the agenda as discussed.

5. Update from All Wales Board Secretaries Network and Audit Working Group

5.1. Updates from External Audit and Internal Audit: -

- External audit: update on national reviews (climate change; wellbeing audit; unscheduled care work, national quality governance etc);
- Internal audit: Delivered a demonstration of the internal audit analysis tool (discussed by the group earlier).

5.2. Demonstration from the Finance Academy on an interactive awareness tool for the Standing Financial Instructions which has been developed. This tool is very useful for Board Member inductions.

5.3. NHS Executive Governance: -

- The Board Secretaries Network has representation on the Governance and Finance workstream for the development of the NHS Executive;
- The timescales to establish the Executive are very challenging (by the 1 January 2023);
- A PID to consider the complex issues is in development, and the Governance and Finance workstream is working through it;
- Given the interdependencies with the mandate development and functions development workstream, it's too early to provide a substantive update.

5.4. 111 Governance: -

- Received a presentation from Richard Bowan and Nicola Bowen from the 111 Programme Team in light of the proposed transition of the 111 Programme Board to Goal 2 delivery group;
- The Board Secretaries Network have raised various agreements that require updating with Richard Bowan, and in particular Rani Malleson from Aneurin Bevan as host, is leading this work.

5.5. Conflicts of Interest: -

- Cardiff and Vale are piloting to target doctors' declarations;
- Reviewing ESR functionality and ability to generate Power BI dashboards;
- Considering Civica to support managing declarations of interest.

The following is a summary of the main issues discussed at the meeting

5.6. Covid-19 Inquiry: -

- Discussions around preparedness for Module three core participant status;
- Core participant applications likely required in a three-week period;
- The Network will discuss further the principle of whether this is done individually or collaboratively;

6. Any Other Business

6.1. At Trish Mills' request, the group considered how best to record and disseminate its discussions. It was asked that Trish investigate whether production of a highlight report rather than minutes is accepted practice, but it was agreed that this would be acceptable for the record of this meeting **[Action].**

7. Next meeting:

7.1. The date for the next meeting is to be agreed; Trish to consider options **[Action].**

AUDIT COMMITTEE

Private Patient Service Improvements

DATE OF MEETING	12th January 2023
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 AND APPROVAL

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

COMMITTEE OR GROUP	DATE	OUTCOME
Private Patient Improvement Group	22/12/2022	Approved content
EMB	03/01/2022	Endorsed

ACRONYMS

VUNHST	Velindre University NHS Trust
EMB	Executive Management Board

VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is for the Audit Committee to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting held during December 2022.
- **APPROVE** the amended Private Patient Improvement Plan
- **NOTE** the commencement of Liaison Financial Services external expert support for the areas identified in the improvement plan

2. BACKGROUND

The Private Patient Improvement Group was established to enhance the governance and functioning of the Trusts Private Patient Service in response to the recommendations in the external review undertaken.

3. REPORTING COMMITTEES

It had previously been approved by the Board that the Private Patient Improvement Plan actions would be allocated and reported to three Board Committees for oversight and assurance. This would create duplication of work and prevent oversight of the 'whole improvement'. It was therefore proposed that the financial and commercial improvements will be reported to the Audit Committee by the Executive Director of Finance and the improvement plan as a whole and delivery via the Improvement Group will be reported to the Quality, Safety & Performance Committee by the Executive Director Nursing, AHP & Health Science.

4. PRIVATE PATIENT IMPROVEMENT HIGHLIGHT REPORT

The following are highlights from the Private Patient Improvement Group meetings held during November and December meetings 2022:

ALERT / ESCALATE	There are no items to alert or escalate
ADVISE	• Whilst the plan was to appoint an NHS Private Patient Service Critical Friend to provide specialist support to the Group to date it has not been possible to find another NHS organisation willing to provide that support. In the absence of Critical Friend support it is proposed Liaison Financial Services who the Trust commissioned to provide private patient support to assist with delivery of improvement actions also provide the Critical Friend role • The original Improvement Plan developed from the external review recommendations that had been approved by the Audit Committee has been reviewed and redrafted to reflect realistic deliverable actions and timescales. At each meeting of the private patient improvement group the actions within the plan are reviewed and progress updated. The plan was approved by the Improvement Group, Velindre SLT and the EMB and has been **ENDORSED** by the Quality, Safety & Performance Committee and is attached in ***Appendix 1*** for Audit Committee **ENDORSEMENT**. • It was identified that in order to deliver a number of the required outputs by the end of March 2023 external specialist support would be required. This support was procured by the Executive Director of Finance. • The External Private Patient experts Liaison Financials commenced supporting the Trust from the 3rd December 2022. • The elements of the Improvement Plan that were for delivery by Liaison have been reviewed and they confirmed that all actions assigned to them could be delivered within the identified timescale with the exception of one. Improvement action 17: 'Renegotiate the contracts with insurers' was identified as for completion by the 31st March 2023. Liaison have advised that all the preparatory work would be completed by March 2023, but more time is required for the re-negotiation of the contracts and that a more achievable timescale for this is the 30th June 2023. • The Commercial & Financial actions being progressed are: ➢ Renegotiate the contracts with insurers – ***Liaison commenced review of current contracts. Target completion date of 31/03/2023 will remain for the preparation work of reviewing current contracts, tariffs and ensuring Trust billing is up to date.***

	➢ Develop new professional fee arrangements which provide consistency across disciplines ➢ Develop a private patient tariff for both self-pay and insured private patients ssetting fees at commercial levels – **Liaison *work has commenced to review the current fees and cost of services which will then be compared to market intelligence around fees for cancer services in other NHS Private Patient services*** ➢ Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure. ➢ Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act. ➢ Increase private income through exploiting opportunities to expand the clinical scope of the private patient service. ➢ Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report - ***PPMG agreed that current Trust systems appropriate to capture information.*** ➢ Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk. ➢ Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service. ➢ Retrospective review of last 2 years insurer income to identify if Trust can recover additional income for services provided – ***Liaison commenced work reviewing income and patient data provided by Trust***
ASSURE	• Monthly meetings established of the improvement group with terms of reference approved that clearly articulates the task and finish nature of the group, the required attendee and their roles/responsibilities • A Project Manager and admin support is being provided to the private patient project • The aged debt profile and risk have been reduced significantly which is reflected in regular reporting to the Audit Committee. • Good progress has been made on the operational actions which includes a review and update of Standard Operating Procedures, a review of pre-authorisation and invoicing processes. • Clear demarcation between the Improvement and Delivery Groups.
INFORM	There were no matters to Inform
APPENDICES	***1. Private Patient Improvement Plan***

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Organisational learning identified through external report - significantly enhanced governance of the Private Patient service required
RELATED HEALTHCARE STANDARD	Safe Care
	All other Standards are also relevant
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There are adverse legal implications if there is insufficient governance in relation to Private Patient service
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Significant financial implications in respect of current service provision as identified in external report

6. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting held during November and December 2022
- **APPROVE** the amended Private Patient Improvement Plan and **AGREE** to oversee the implementation of the financial and commercial improvements
- **NOTE** the commencement of Liaison Financial Services external expert support for the areas identified in the improvement plan

Improvement Plan - Private Patient Service

Date Updated: 22/12/2023

Ref No.	Status	Date	Recommendation/ Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
STRATEGIC BUSINESS MANAGEMENT									
PP1	**IN PROGRESS**	28.01.22	Review and update Private Patient Service Specification	Quality, Safety & Performance	21/11/22 - Draft Policy circulated to Improvement Group members on 12th and 19th November 2022. Awaiting feedback. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	Head of Operational Services and Delivery	30/06/2022	31/03/2023	
PP16	**IN PROGRESS**	28.01.22	Develop marketing plan/commercial strategy	Quality, Safety & Performance	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	COB/MB / External Provider	31/07/2022	31/03/2023	
PP3	**IN PROGRESS**	28.01.22	Integrate business planning into Trust IMTP process	Quality, Safety & Performance	The service management group feeds into the wider Operational Services and Delivery Directorate where such business planning takes place. This feeds into the IMTP process. Content for 2023/24 IMTP will be based on outcome of strategy discussions and direction.	AMS	31/07/2022	N/A	Agreed private patient strategy will feed into Trust IMTP proess which conlcudes at end of March
PP19	**IN PROGRESS**	28.01.22	Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Quality, Safety & Performance	Links to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	30/09/2022	31/03/2023	
PP5	**IN PROGRESS**	28.01.22	Develop/procure and implement patient management and information system	Quality, Safety & Performance	Electronic patient record in place. The Digital Health and Care Record will be implemented across the Private Patient Service. Standard reports agreed with the Business Intelligence Team.	AMS	31/07/2022	N/A	
PP26	**IN PROGRESS**	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital	Quality, Safety & Performance	This will follow the agreement of a Strategy.			31/03/2023	
PP8	**IN PROGRESS**	28.01.22	Produce job planning guidance to define NHS and private patient work within Consultant job plans	Quality, Safety & Performance	National template used which is incorporated into job planning discussions.	EGE/NH	30/04/2022	N/A	
PP9	**IN PROGRESS**	28.01.22	Implement changes to the existing clinical governance arrangements which provide assurance that private patient work is subject, as a minimum, to the same scrutiny and level of service for NHS patients.	Quality, Safety & Performance	Common systems, policies and procedures used for NHS and private patients to collect clinical information, risks, incidents, complaints and claims. Patients can be idenfied by certain fields.These are monitored at a monthly management group. Information is included in indivdiaul apprasials as part of the standard process.	JA	30/04/2022	N/A	

Improvement Plan - Private Patient Service

Date Updated: 22/12/2023

Ref No.	Status	Date	Recommendation/ Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
PP10	**IN PROGRESS**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Quality, Safety & Performance	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action.	EGE/AMS	30/06/2022	31/12/2022	
PP12	**IN PROGRESS**	28.01.22	Introduce private patient contract/agreement to be signed by all staff undertaking PP practice.	Quality, Safety & Performance	Process in place for Consultants who undertake private practice	EGE/AMS	31/07/2022	N/A	
PP13	**IN PROGRESS**	28.01.22	Ensure rolling programme in place to ensure workforce agreements are reviewed in a timely manner	Quality, Safety & Performance	Cycle of business in place for the service and under development for management group.	AMS	30/04/2022	N/A	
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	Audit Committee	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022. **21/12/2022 - Target date revised to reflect discusions with Liaison Services who are supporting the renegotiation. A target of 31/03/2023 will remain for the preparation work of reviewing current contracts, tarrifs and ensuring Trust billing is up to date. DPIA's will be completed.**	COB/MB / External Provider	30/09/2022	30/06/2023	
PP18	**IN PROGRESS**	28.01.22	Develop a new process to produce estimates with prescribed verbiage which ensures that the Trust complies with the Unfair Trading Practices Act.	Audit Committee	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/05/2022	31/03/2023	
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023	
MEDICAL GOVERNANCE									
PP7	**IN PROGRESS**	28.01.22	Evaluate and review all clinical professionals undertaking private practice, and privilege rights, as well as appropriate indemnity insurance.	Quality, Safety & Performance	Discussions underway with regard to process requriements.	Clinical Director	30/04/2022	30/09/2022	

Improvement Plan - Private Patient Service

Date Updated: 22/12/2023

Ref No.	Status	Date	Recommendation/ Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
PP8	NOT STARTED	28.01.22	Establish Clinical Advisory Committee	Quality, Safety & Performance	Private Patient Consultant Engagement Meeting took place on the 14th December 2022 and the establishment of a Clinical Advisory Committee was discussed. Terms of Reference to be shared and Clinical Lead (who will Chair the COmmittee) to be appointed.	Clinical Director	30/04/2022	31/03/2023	
COMMERCIAL									
PP21	IN PROGRESS	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	Audit Committee	21/11/2022 - Refer to narrative in PP17. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023	
PP22	IN PROGRESS	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	Audit Committee	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023	
PP23	CLOSED	28.01.22	Update the Undertaking to Pay form to include all the necessary legal and GDPR rules	Audit Committee	Form up-dated, which included input from the Information Governance Manager. Completed 23.06.21.	AMS	30/09/2022	N/A	
PP25	IN PROGRESS	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Audit Committee	Cost estimates provided for those that self pay. Work progressing for private patients and insurance companies. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023	
PP27	IN PROGRESS	28.01.22	Increase private income through exploiting opportunities to expand the clinical scope of the private patient service.	Audit Committee	increased income by ensuring all activity is billed in line with process. Now charging for some element of care previously not charged for. Currently discussing expansion of radiology service. Any significant changes are closely linked to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	Clinical Lead	31/07/2022	31/03/2023	
PP28	CLOSED	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	REPEAT PP20	External provider	31/07/2022	N/A	

Improvement Plan - Private Patient Service

Date Updated: 22/12/2023

Ref No.	Status	Date	Recommendation/ Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
OPERATIONAL									
PP30	**CLOSED**	28.01.22	Develop training plan for PP staff	Quality, Safety & Performance	Training plans in place for all staff members. There has been a delay in securing the services of an external specialist provider therefore this has not been progressed.	AMS	31/07/2022	N/A	
PP31	**CLOSED**	28.01.22	Integrate Medical Secretary into Health Records department	Quality, Safety & Performance	The Medical Secretary has been integrated in to the Medical Records Department, specifically in terms of attending monthly meetings and inclusion in regular and adhoc communications/up-dates. The ability to physically co-locate as has been delayed due to space limitations in light of covid restrictions.	TB	28/02/2022	N/A	
PP10	**OPEN**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Quality, Safety & Performance	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action. 21/11/2022 - Refer to narrative in PP1.	EGE/AMS	30/06/2022	31/03/2023	
PP14	**IN PROGRESS**	28.01.22	Review management structure and reporting arrangements	Quality, Safety & Performance	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	COB / External Provider	30/04/2022	31/03/2023	
PP15	**IN PROGRESS**	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	Quality, Safety & Performance	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	COB / External Provider	30/04/2022	31/03/2023	

Improvement Plan - Private Patient Service

Date Updated: 22/12/2023

Ref No.	Status	Date	Recommendation/ Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
PP37	**OPEN**	28.01.22	Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report.	Audit Committee	The CANISC Patient Administration System is the primarily solution for this information. Therefore an additional system is not required. Three standard reports have been established:- Report 1 - General overview of private patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Patient KPI report (activity and phlebo) established (to be reviewed and signed off) Requirements provided to provide a single report that captures all activity at a patient level (which can be filter, including attendance month, year, department, activity type etc). This is dependent upon BI resources and prioritisation. BI resource currently focussed on implementation of DHCR. Dedicated finance resource required to produce monthly report for Senior Leadership Team. WPAS has now been deployed. There is ongoing work to ensure SOPs etc are aligned to ensure PPs are correctly recorded in the system to support ongoing activity reporting. **22/12/22 - Issues with the change in patient infomation systems are currently being worked through.**	WJ	30/05/2022	31/03/2023	PPMG agreed that current systems appropriate to capture information.
PP41	**OPEN**	28.01.22	Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk.	Audit Committee	No update provided	DO	30/05/2022	N/A	
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Audit Committee	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	PW	31/07/2022	31/03/2023	

AUDIT COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	12.01.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
BOARD DEVELOPMENT DISCUSSION ON RISK APPETITE	**08.11.22**	**Discussed**
EMB RUN	**03.02.23**	**Discussed**

Acronyms

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

1. BACKGROUND

The purpose of this report is to:

- Share the current extract of risk registers to allow the Audit Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.
- Summarise the final phase in implementing the Risk Framework.
- Inform of the approach to the refresh of the Trust's risk appetite.

2. ASSESSMENT OF MATTERS FOR CONSIDERATION

Key points for the Audit Committee:

1. Work has taken place on VCC risk, including information to manage risk. The work undertaken is reflected in the data cut included in this paper. Work continues with the VCC SLT to move forward the work around risk.
2. Following discussion at EMB a review of risks recorded for the Welsh Blood Service was carried out, the amended risk record can be seen in 2.2.3 of the risk register.
3. Executive Management Board have endorsed the conclusions of risk appetite refresh for Trust Board approval in January, if further endorsed in January Audit Committee. This matter is dealt with first in 2.1 below.

2.1 Risk Appetite Refresh

Two matters to conclude on:

1. Agree refresh level of risk appetite for each risk category
2. Agree refresh of escalation levels according to risk appetite levels into governance layers of the Trust.

2.1.1 Level of Risk Appetite for Each Risk Category

Domain	Current Risk Appetite Level	Proposed refreshed level- following Board development discussion (Highlighted changes in yellow)
Quality	2 – Cautious	2 – Cautious
Safety	1 – Minimal	1 – Minimal
Compliance	2 – Cautious	2 – Cautious
Research and development	3 - Open	3 - Open
Reputation	2 – Cautious	2 – Cautious
Performance and service sustainability	2 – Cautious	2 – Cautious
Financial sustainability	2 - Cautious	2 - Cautious
Workforce	**2 - Cautious**	**3 - Open**
Partnerships & innovation	4 - Seek	4 - Seek
Information Governance	2 – Cautious *Working approach – to be agreed in Trust Board in Jan 2023	2 – Cautious
Enviromental	**2 – Cautious** ***Working approach – to be agreed in Trust Board in Jan 2023**	**3 - Open**

The discussion at Board Development for both workforce and environment was given the scale of the organisation's and wider industry challenges in these respects

that an Open level to Board risk appetite is most appropriate to meet these challenges.

Following the agreement of the levels, the updated statements for those with any change, in addition to IG and Environmental to be agreed by Executive Lead and included in the Trust Board papers. All Executive Leads to confirm wording for current statements also – change will be required to reflect Duty and Quality for instance.

2.1.2 Escalation Levels According to Risk Appetite Levels into Governance Layers of the Trust

Risk Appetite Levels	Escalation level to Trust Board if risk at level Score below – according to the 5x5 matrix	Proposed refreshed level- following Board development discussion (Highlighted changes in yellow)
0 – Avoid	9	9
1 – Minimal	12	12
2 – Cautious	12	15
3 – Open	12	15
4 – Seek	15	16
5 – Mature	15	16

There was a suggestion that for levels 2 and 3, these should also be level 16. However the consensus was as above. This could then be refreshed for 2023/24, based on a further year of maturity of the risk framework.

2.1.3 Risk Appetite Next Steps in Engagement and Embedding

- Policy agreed and all in clear in one place for staff on intranet and external stakeholders on intranet
- Part of level 2 training already included the concept and importance of risk appetite. This cohort will also receive specific regular risk briefings – including on Risk Appetite refresh outcome
- Update to Divisional Leadership Teams and the Extended Leadership Team on Risk Appetite refresh outcome
- Embedded into new cover paper format in risk section to encourage active consideration
- All challenging each other in strategic decision making to active and relevant

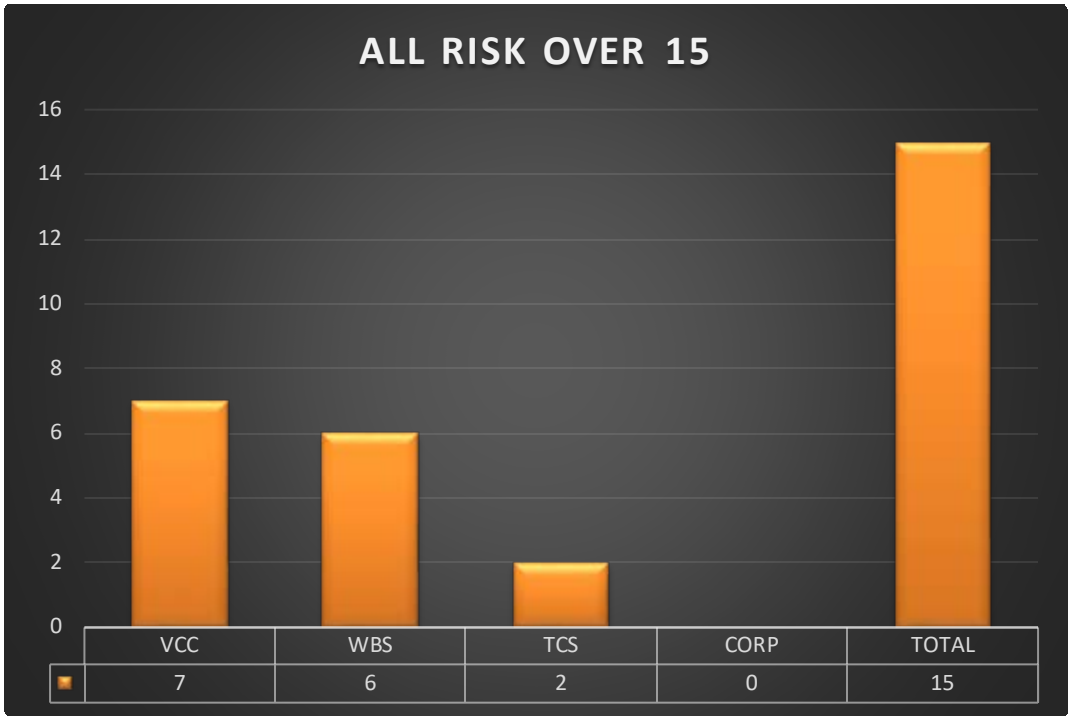
2.2 Trust Risk Register

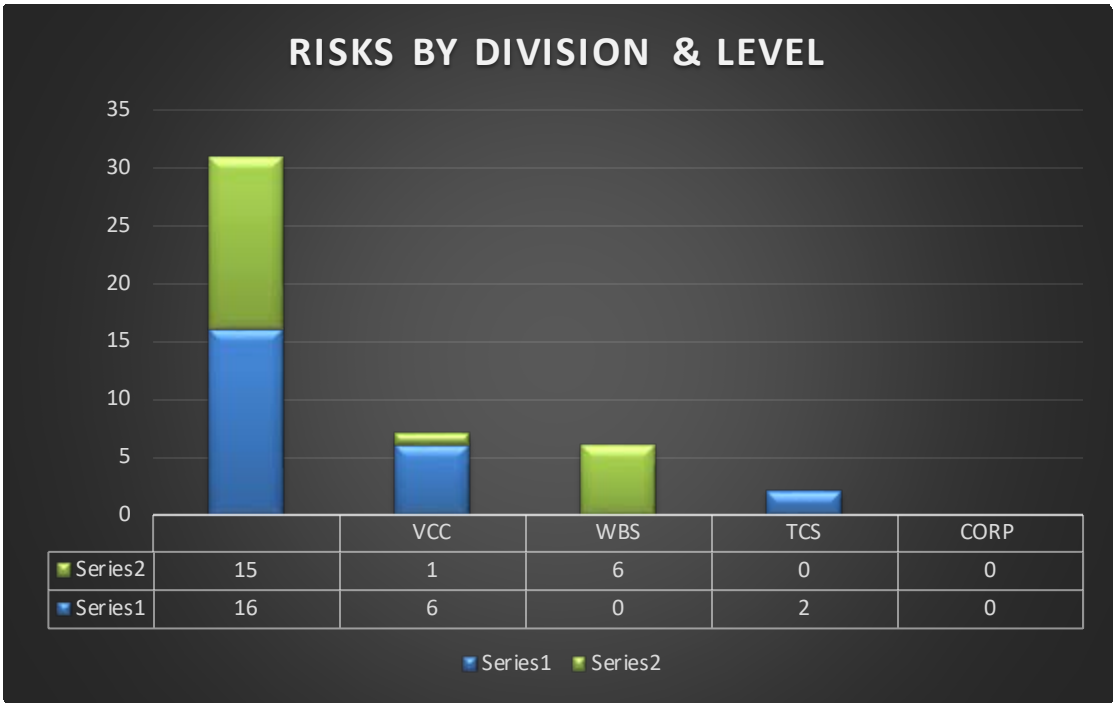
2.2.1 Total Risks

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

2.2.2 Risks by Level

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


ALL RISK OVER 15
16
14
12
10
8
6
4
2
0
VCC
WBS
TCS
CORP
TOTAL
7
6
2
0
15


RISKS BY DIVISION & LEVEL
35
30
25
20
15
10
5
0
VCC
WBS
TCS
CORP
Series2
15
1
6
0
0
Series1
16
6
0
2
0
Series1
Series2

2.2.3 **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, date risk opened on Datix, amount of days risk open and title of the risk.

Of the 15 risks recorded there are 7 risks for Velindre Cancer Centre, 6 risks for Welsh Blood service, 2 risks for Transforming Cancer Services and no risks over 15 for the Corporate function.

Risks level 16

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

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Review date	Length of time risk open
2769	There is a risk to quality /complaints /audit /GxP as a result of limited access to FoxPro expertise and use of outdated systems, leading to increased risk of incorrect test results and clinical advice.	Quality	26/10/2022	New Risk	Welsh Blood Service	vDOS emulation to allow running of applications on latest version of Windows. Where possible, seek to ensure integration with 3rd party systems and services can be supported as part of future procurements. Patient results are verified prior to issue.	(This refers to line reference number 1.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders' requests.	16	14/04/2023	72

2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Accepted	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	14/04/2023	71
2775	There is a risk to quality/complaints/audit/GxP as a result othe use of outdated, legacy systems, leading increased risk of incorrect results and clinical advice	Quality	27/10/2022	New Risk	Welsh Blood Service	Working group to manage prioritisation of a 'back-log' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource.Patient results are verified prior to use.	(This refers to line reference number 3.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. There is a resulting increased risk of data entry/transcription errors leading to incorrect test results and clinical advice, potentially impacting patient safety. As there are increased manual, and resource heavy workarounds, staff morale may be reduced and there is a potential that staff may not be able to be released to focus on service-enhancing projects.There is an increased reliance on specialist staff and therefore, an increased pressure on workforcce.	16	14/04/2023	71

2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Accepted	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	14/04/2023	71
2779	There is a risk to financial sustainability as a result of ongoing use of obsolete/end of life systems, leading to requirement of increased staffing resource.	Financial Sustainability	27/10/2022	New Risk	Welsh Blood Service	None identified	(This refers to line reference number 12.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. There is increased staffing resource required due to ongoing use of obsolete/end of life systems	16	14/04/2023	71
2800	Newly discovered services at Asda	Performance and Service Sustainability	02/11/2022	Accepted	Transforming Cancer Services	1. Secure site investigation from Welsh Water	There is a risk that the high-pressure water main at Asda, which have recently been discovered, will need to be moved, which may lead to a delay of several months to Asda's works.	16	16/01/2023	65

2689	There is a risk to performance and service sustainability as a result of limited access to FoxPro expertise, leading to IT system failures and inability to provide one or more WHAIS services.	Performance and Service Sustainability	01/09/2022	New Risk	Welsh Blood Service	Business continuity using 3rd party (high cost) agency resource. Potential to transfer some operational responsibilities to NHSBT and/or other 3rd parties.	WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to provide one or more WTAIL services, if unable to respond to urgent IT incidents or system failures and inability to develop existing WTAIL IT systems due to lack of availability of appropriate FoxPro expertise within Digital Services team.	16	14/04/2023	127
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Accepted	Transforming Cancer Services	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	22/12/2022	119

2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	05/11/2021	Accepted	Velindre Cancer Centre	No current controls - emails come in daily (including over the weekend) from within Velindre and outside (AOS teams, HB teams, primary care teams).An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. Task and finish group to be established with key staff members in attendance.	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	30/11/2022	427

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

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Review date	Length of time risk open
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	Safety	14/09/2020	Accepted	Velindre Cancer Centre	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk assessment due to the anticipated shortage of appropriate candidates.	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN)	15	30/12/2022	844

							vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches.			

							However, this negatively impacts on other essential core duties.			
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce and OD	28/07/2022	Accepted	Velindre Cancer Centre	Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. AOS sessions have been put into consultant job plans going forward.	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	15	31/01/2023	162
2433	DHCR037(R) - There is a risk that patient records will be incomplete, caused by data held in Canisc not being migrated to DHCR while interfaces are switched off during the dry run period. The impact will be the inability access up to date information.	Performance and Service Sustainability	09/06/2021	Accepted	Velindre Cancer Centre	Although treatment data will not update over go-live weekend, radiotherapy would have up to date record on paper & in Aria/ Mosaiq. Treatment helpline/ on call staff to be made aware of this.Radiation Services will only be treating emergency patients over the go-live weekend.Action point to be recorded on go-live weekend plan to ensure treatment helpline/ on call staff aware of this issue	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.DHCR037(R) - Risk that RT treatment will not update over go-live weekend. Patient record will not be fully complete - may affect advice given	15	30/12/2022	576

2630	Digital Health & Care Record DHCR062(R) - There is a risk that patients will still be live in Canisc at the end of the 12-week dual running period, caused by an increased number of patient treatment delays/suspensions. There will be a negative impact on service capacity with the additional need to manually migrate IRMER forms that are nearly complete or fully complete. This may further negatively impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	12/08/2022	Accepted	Velindre Cancer Centre	Working group has been established to consider all options and discuss potential measures and mitigations. An impact assessment and project plan is being written, requiring further review. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period. This would require a significant increase in resource.	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirement, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	15	30/12/2022	147

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences.This may impact on the quality of care due to a reduction in resilience and development of the service	Performance and Service Sustainability	09/02/2022	Accepted	Velindre Cancer Centre	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas.A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required.There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabbaticals etc. affecting staffing levels day to day.""There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interrupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	17/01/2022	331
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	Performance and Service Sustainability	10/06/2022	Accepted	Velindre Cancer Centre	Due to the change in the content of the training position to include acute oncology, VCC has be unsuccessful in securing trainees. this is leading to significant gaps in the training rota. There is a national shortage for these roles	Due to not recruiting through the national training programme, we are out to advert to fill the gaps by recruiting speciality doctors in their place. Where we are unable to cover gaps, we are temporarily providing support via oncology. this is a short term solutions as there is an impact on the ability to cover rota within the cancer centre. Where necessary the consultant will act down to cover the specialist registrar gap.	15	30/06/2023	210

3. Development of Risk Framework

3.1 Three levels of training to be delivered:

- All staff Level - training covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input from which all staff in the organisation have access to in order to raise a risk. This training will be delivered via online learning on ESR. This training is in the later stages of the process with Shared Services and is anticipated to be live on the online learning portal by the end of February 2023.
- Management level – covering the Policy and Corporate Management Level Procedure and second form on Datix 14, which requires scoring, articulation of controls, setting actions and assigning ownership. It is following this step that a risk is confirmed onto the risk register. The Manager level then has the on-going responsibility for the overall management of that risk. Level 2 training has been completed. Additional sessions will be run for all divisions for those who have not yet accessed level 2 training.
- Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. Training has been completed for Board members and Executive Management Board members, including Divisional leadership.

3.3 The review of risk appetite was discussed with the Board in the development session on 8th November 2022. Risk appetite discussions commenced taking account of approaches in other organisations for reference. Discussions were around the risk appetite level of 15 for the Trust. Additionally, an exercise regarding reverse stress testing was considered with a scenario around special measures being agreed upon as appropriate to test, ensuring appropriate approaches are taken for both the Welsh Blood Service and The Velindre Cancer Service. This work will be continued with progress updates being provided in the March 2023 reporting cycle.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If risks aren't managed / mitigated it could have financial implications.

4. RECOMMENDATIONS

The Audit Committee is asked to:

- **ENDORSE** the revised Risk Appetite levels, following initial discussions at the Board Development session on 8th November 2022, for Trust Board approval in January.
- **NOTE** the risks level 16 and 15 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Review date	Length of time risk open
2769	There is a risk to quality/complaints/audit/GxP as a result of limited access to FoxPro expertise and use of outdated systems, leading to increased risk of incorrect test results and clinical advice.	Quality	26/10/2022	New risk	Welsh Blood Service	vDOS emulation to allow running of applications on latest version of Windows. Where possible, seek to ensure integration with 3rd party systems and services can be supported as part of future procurements. Patient results are verified prior to issue.	(This refers to line reference number 1.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders' requests.	16	14/04/2023	76

2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Accepted	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	14/04/2023	75
2775	There is a risk to quality/complaints/audit/GxP as a result othe use of outdated, legacy systems, leading increased risk of incorrect results and clinical advice	Quality	27/10/2022	New risk	Welsh Blood Service	Working group to manage prioritisation of a 'back-log' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to use.	(This refers to line reference number 3.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. There is a resulting increased risk of data entry/transcription errors leading to incorrect test results and clinical advice, potentially impacting patient safety. As there are increased manual, and resource heavy workarounds, staff morale may be reduced and there is a potential that staff may not be able to be released to focus on service-enhancing projects. There is an increased reliance on specialist staff and therefore, an increased pressure on workforcce.	16	14/04/2023	75

2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Accepted	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	14/04/2023	75
2779	There is a risk to financial sustainability as a result of ongoing use of obsolete/end of life systems, leading to requirement of increased staffing resource.	Financial Sustainability	27/10/2022	New risk	Welsh Blood Service	None identified	(This refers to line reference number 12.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. There is increased staffing resource required due to ongoing use of obsolete/end of life systems	16	14/04/2023	75
2800	Newly discovered services at Asda	Performance and Service Sustainability	02/11/2022	Accepted	Transforming Cancer Services	1. Secure site investigation from Welsh Water	There is a risk that the high-pressure water main at Asda, which have recently been discovered, will need to be moved, which may lead to a delay of several months to Asda's works.	16	16/01/2023	69

2689	There is a risk to performance and service sustainability as a result of limited access to FoxPro expertise, leading to IT system failures and inability to provide one or more WHAIS services.	Performance and Service Sustainability	01/09/2022	New risk	Welsh Blood Service	Business continuity using 3rd party (high cost) agency resource. Potential to transfer some operational responsibilities to NHSBT and/or other 3rd parties.	WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to provide one or more WTAIL services, if unable to respond to urgent IT incidents or system failures and inability to develop existing WTAIL IT systems due to lack of availability of appropriate FoxPro expertise within Digital Services team.	16	14/04/2023	131
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Accepted	Transforming Cancer Services	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	22/12/2022	123

2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	Safety	14/09/2020	Accepted	Velindre Cancer Centre	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MRE advice on, and review of	15	30/12/2022	848
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce and OD	28/07/2022	Accepted	Velindre Cancer Centre	Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. AOS sessions have been put into consultant job plans going forward.	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	15	31/01/2023	166

2433	DHCR037(R) - There is a risk that patient records will be incomplete, caused by data held in Canisc not being migrated to DHCR while interfaces are switched off during the dry run period. The impact will be the inability access up to date information.	Performance and Service Sustainability	09/06/2021	Accepted	Velindre Cancer Centre	Although treatment data will not update over go-live weekend, radiotherapy would have up to date record on paper & in Aria/ Mosaiq. Treatment helpline/ on call staff to be made aware of this. Radiation Services will only be treating emergency patients over the go-live weekend. Action point to be recorded on go-live weekend plan to ensure treatment helpline/ on call staff aware of this issue	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR037(R) - Risk that RT treatment will not update over go-live weekend. Patient record will not be fully complete - may affect advice given	15	30/12/2022	580
2630	Digital Health & Care Record DHCR062(R) - There is a risk that patients will still be live in Canisc at the end of the 12-week dual running period, caused by an increased number of patient treatment delays/suspensions. There will be a negative impact on service capacity with the additional need to manually migrate IRMER forms that are nearly complete or fully complete. This may further negatively impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	12/08/2022	Accepted	Velindre Cancer Centre	Working group has been established to consider all options and discuss potential measures and mitigations. An impact assessment and project plan is being written, requiring further review. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period. This would require a significant increase in resource.	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirement, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	15	30/12/2022	151

2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	05/11/2021	Accepted	Velindre Cancer Centre	No current controls - emails come in daily (including over the weekend) from within Velindre and outside (AOS teams, HB teams, primary care teams). An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. Task and finish group to be established with key staff members in attendance.	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	30/11/2022	431
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	Performance and Service Sustainability	10/06/2022	Accepted	Velindre Cancer Centre	Due to the change in the content of the training position to include acute oncology, VCC has be unsuccessful in securing trainees. this is leading to significant gaps in the training rota. There is a national shortage for these roles	Due to not recruiting through the national training programme, we are out to advert to fill the gaps by recruiting speciality doctors in their place. Where we are unable to cover gaps, we are temporarily providing support via oncology. this is a short term solutions as there is an impact on the ability to cover rota within the cancer centre. Where necessary the consultant will act down to cover the specialist registrar gap.	15	30.06.2023	214

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	Performance and Service Sustainability	09/02/2022	Accepted	Velindre Cancer Centre	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	17/01/2022	335

RISK APPETITE SCORING MATRIX

AGREED BY THE BOARD AS PART OF THE AGREED 2020 FRAMEWORK THAT RISK APPETITE MATRIX SCORING WOULD BE REVIEWED FOR 2020 FOLLOWING THE GOOD GOVERNANCE INSTITUTE (GGI) AS EITHER **AVOID, MINIMAL, CAUTIOUS, OPEN, SEEK** OR **MATURE** RISK APPETITE.

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain / Risk Category	Risk Appetite (GGI Level)
1	Quality The provision of high-quality services is of the utmost importance for Velindre University NHS Trust. The Trust acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a 'LOW' appetite for risks which my compromise the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact quality, could have catastrophic consequences for our patients.	2 - Cautious
2	Safety Velindre University NHS Trust hold patient, donor and staff safety in the highest regard. We have a 'NONE – LOW' appetite for risks which may compromise safety, however recognising that individual risk tolerance may on some occasions go above this if it is in the best interests of patients to accept some risk in order to achieve the best outcomes from individual patient care, treatment and therapeutic goals. We accept this and support our staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk. N.B., Key to keeping patients, donors and staff safe is the condition of the estate. We are committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and do not represent a health and safety risk.	1 - Minimal

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain/Risk Category	Risk Appetite (GGI Level)
3	Compliance We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.	2 – Cautious
4	Research and development We have a HIGH risk appetite for Clinical Innovation that does not compromise quality of care and patient safety / the Trust has a HIGH appetite for risks associated with innovation, research and development in order to take forward our vision in relation to the new treatments, developments of new models of care and improvements in clinical practice that support the delivery of our person centred values and approach. The Trust will only take risks when it has the capacity to manage them and is confident that there will be no adverse impact on the safety and quality of the services provided.	3 – Open
5	Reputation The Trust will maintain high standards of conduct, ethics and professionalism at all times. We have a LOW risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	2 – Cautious

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain/Risk Category	Risk Appetite (GGI Level)
6	Performance and service sustainability We have a LOW- MODERATE risk appetite for risks which may affect our performance and service sustainability. And are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19) which may result in lower performance levels and unsustainable service delivery for a short period of time.	2 – Cautious
7	Financial sustainability Velindre University NHS Trust is entrusted with public funds and must remain financially viable while safeguarding the public purse. The Trust has no appetite for accepting or pursuing risks that would leave the organisation open to fraud or breaches of Standing Financial Instruction. We strive to deliver our services within the budgets our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care according to a LOW- MODERATE risk appetite. We will ensure that all such financial responses deliver optimal value for money.	2 – Cautious

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain/Risk Category	Risk Appetite (GGI Level)
8	Workforce Velindre University NHS Trust is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. We have a MODERATE risk appetite for decisions taken in relation to workforce but given the recognised workforce shortages we may tolerate a HIGH level of risk on some occasions to support patients. N.B., We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our Trust Values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.	2 – Cautious
9	Partnerships The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We therefore have a HIGH risk appetite for partnerships which may support and benefit the patients in our care. For example, the Trust has a high appetite for risks associated with innovation and partnership with industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the Trust will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.	4 - Seek

AUDIT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	12/01/2023

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**
Strategic Development Committee	**08.12.2023**	**Discussed**

ACRONYMS			
VCC	Velindre Cancer Centre	SMT	Senior Management Team
WBS	Welsh Blood Service	ELT	Extended Leadership Team
SLT	Senior Leadership Team		

1. SITUATION / BACKGROUND

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

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at ***Appendix 1,*** which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.
- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework across the organisation, since the last meeting of the Audit Committee.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Trust Assurance Framework Strategic Risks – Next Steps

As previously reported to the Audit Committee, the following next steps are currently underway:

- Links to Risk Register, Performance Framework and Quality Framework
- Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.
- Mapping Trust Assurance Framework to Committee governance cycle.
- Embedded into mechanisms of cycles of business and agenda setting.
- Link to Audit tracker, including actions and progress to complete, linked to assurance levels.

Further development work, as discussed the Trust Board Development meeting in November:

- Further work as Executive Management Board, Senior Leadership Team/Senior Management Team and Extended Leadership Team to develop articulation of strategic risks, aligned to the Integrated Medium Term Plan (IMTP) process. Agreed will plan for Trust Board approval, following endorsement by Strategic Development Committee in March.
- It was agreed that two reverse stress testing exercises be undertaken utilising a tailored approach aligned to each of the core service divisions, i.e. Welsh Blood Service and Velindre Cancer Service. These will be planned for February 2023 and the outcomes reported through the March reporting cycle.

2.2 Trust Assurance Framework Dashboard

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

- Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since November 2022.

- To also note that in the November 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					
			APR	MAY	JUN	JUL	SEP	NOV
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**						

- **Actions on specific strategic risks**

  - **TAF 01: Demand and Capacity**
    - **Residual Risk Score –** 12. This remains unchanged since the previous review and there is no specific evident trend emerging in the data.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
    - **Sources of Assurance –** There have been no changes to

the sources of assurance.
- **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

- **TAF 02: Partnership Working and Stakeholder Engagement**
  - **Residual Risk Score –** 8.This remains unchanged since the previous review. The residual risk has decreased from 12 to 8 since September 2022.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes to the sources of assurance.
  - **Action Plan for Gaps Identified –** There have been additional actions included since the last review.

- **TAF 03: Workforce Planning**
  - **Residual Risk Score –** 12. The residual risk increased from 9 to 12 in the September 2022 governance reporting cycle and has remained at this level since that time.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

- **TAF 04: Organisational Design**
  - **Residual Risk Score –** 9. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan has been further developed to include the Trust Values Project, which will fulfil a wider brief under the Organisation Design Approach, this work has included engagement work with Board members in the first round of engagement. Additionally, work continues with further programmes being added to the portfolio to ensure this work meets objectives.

- **TAF 05: Organisational Culture**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness –** A thorough review of the levels of control effectiveness has been carried out resulting in an overall Control Effectiveness rate of Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the

sources of assurance since the previous review

- **Action Plan for Gaps Identified –** The action plan is progressing on target.

- **TAF 06: Quality and Safety**

  The description of the risk has been amended during this review, now detailed as:

  'Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the 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. These are not currently in place and 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.'

  - **Residual Risk Score –** 15. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE), unchanged since the last review.
  - **Sources of Assurance –** Gaps in controls and assurance have been amended following review;
    - Following approval of the Quality and Safety Framework approved in July 2022, implementation commenced.
    - Quality and Safety Operational Group Planning meeting held, inaugural meeting arranged in October 2022.

    An additional gap in assurance has been identified:
    - The current mapped meeting reporting structure does not cover floor to board at divisional level.
  - **Action Plan for Gaps Identified –** Amendments have been made to the action plan to address the gaps identified and target dates reviewed.

- **TAF 07: Digital Transformation**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE) despite a shift in some key control ratings individually.
  - **Sources of Assurance –** Amendments and additions to the lines of defence have taken place as part of the review; specifically cyber assurance controls being in place and digital transformation guided by an agreed digital architecture have been added. Gaps in controls have also been highlighted around the development of a digital architecture, appropriate external standards for benchmarking being agreed and the establishment of a digital programme.
  - **Action Plan for Gaps Identified –** Three additional actions have been

added to the action plan:

1. Create the Trust Digital Reference Architecture
2. Review the scope/scale/need for a Digital Programme
3. Confirmation on the SIRO/Cyber Security roles and responsibilities

- **TAF 08: Trust Financial Investment**
  - **Residual Risk Score –** 12. The residual risk decreased from 16 to 12 in the July 2022 governance reporting cycle and has remained at this level since that time.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** The reviewed sources of assurance have resulted in some additions:
    1. Key objectives of investment framework and relationship to contract performance and value identified.
    2. Investment framework to be articulated and agreed by Divisions and Executive Team.
    3. Investment framework to be applied within IMTP process.
  - **Action Plan for Gaps Identified –** There has been extensive review of the action plan resulting in the addition of new actions being added, detail below the main actions can be seen in Appendix 1:
    1. Review of contracting model for impact of COVID related measures.
    2. Establish Trust Investment Prioritisation Framework

- **TAF 09: Future Direction of Travel**
  - **Residual Risk Score –** 8. 12. The residual risk decreased from 12 to 8 in the November 2022 governance reporting cycle and has remained at this level since that time.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE).
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review.
  - **Action Plan for Gaps Identified –** Dates have been added to the action plan where possible. There remain some dates awaiting dependent on committee outcomes.

- **TAF10: Governance**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review with no trend emerging since March 2022. However, this is anticipated to decrease in line with the development and implementation of the Governance, Assurance and Risk Programme of work across the Trust.
  - **Overall Level of Control Effectiveness –** This remains as 'Effective' (E).
  - **Sources of Assurance –** No amendments have been made nor additions since the last review.
  - **Action Plan for Gaps Identified –** A formal programme of work for Governance, Assurance and Risk has been developed reporting into the wider Organisational Development programme for the Trust, this

encompasses 20 key projects underpinning the further development and operationalisation of the Trust Assurance Framework. Key aspects are summarised in Appendix 1.

3. 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.

4. RECOMMENDATION

The Audit 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 section 2.

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

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	Sep-22	1 - Outstanding for quality, safety and experience											
NEXT REVIEW	Oct-22	RISK DOMAIN						Performance and Sustainability					
EXECUTIVE LEAD	Cath O'Brien	**RISK SCORE (See definitions tab)**											
		INHERENT RISK			**RESIDUAL RISK**						**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**				**Likelihood**	**Impact**	**TOTAL**
		4	4	**16**	3	4	**12**				2	4	**8**

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventativ**	**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

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

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-23
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	Contact has been made with HBs and work has been done on data sets and will continue to be reviewed in regular VCS/HB meetings	Complete
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

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.											
LAST REVIEW	Nov-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations											
NEXT REVIEW	Jan-22				RISK DOMAIN			Partnership					
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**											
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**					
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**			
		3	4	**12**	2	4	**8**	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		

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
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

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	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	RISK DOMAIN Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	4	3	12	2	3	6

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

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	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	Hybrid 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

TAF DASHBOARD

WORKFORCE PLANNING

Action Plan		Owner	Progress Update	Due Date
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 a range of 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	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Nov-22	**RISK DOMAIN** **Performance and Service Sustainability**
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	4	**12**	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

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness 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
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

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
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
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 Organisational 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	takeholder 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. The scope of the programme and governance arrangements will be developed and agreed in November, during which the timelines associated with the main elements will be determined. Further programmes have been added to the portfolio to ensure this work meets its objectives.	Nov-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 have taken place with Board members as first round of engagement activity. This will be followed by wider engagement across the Trust.	Dec-22

TAF DASHBOARD ORGANISATIONAL CULTURE

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Nov-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jan-22	**RISK DOMAIN** **Performance and Service Sustainability**
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**
	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**
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x			E	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			E	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	PE	Executive Management Board review/ patient and donor feedback	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x		E	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			PE	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			PE	Executive Management Board review / staff feedback	IA	Internal Audt Review	PA	Audit Wales/HIW	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	Not possible to fully determine whether the activities the Trust is undertaking are delivering the desired strategic outcomes at a Board level i.e. many of the outcomes for cancer and blood services are population based and the Trust currently does not get this information
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented (new quality metrics not sufficiently developed and/or utilised)	Inability to fully determine whether the services are maximising performance to deliver the desired outputs/outcomes at a service/Trust level
Not all supporting strategies approved by the Board e.g. Clinical and Scientifc strategy	Not yet able to d

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)	Apr-23

Develop clinical and scientific strategy	Jacinta Abraham	Jaz Abrahams/Nicola Williams/Carl James will be jointly responsible. Initial scoping meetings commenced and resourcing being indentifed prior to commencing work	2023 (comple tion
Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022). Additional cycle agreed to test PMF (october board edevelopment session) - target date for live PMF Dec 22 / Jan 23 Cycle. PMF being trialed currently and will Go Live in April 2023 (using February 2022 data/cycle)	Apr-23

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the 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. These are not currently in place and 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	Oct-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

		RISK SCORE (See definitions tab)								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
EXECUTIVE LEAD	Nicola Willams	**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							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE	Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE	15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
							EMB	IA			Professional bodies	Not Assessed
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE	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 approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inagural meeting arranged in October 2022.	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 statutory guidance 12 week consulation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	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 current mapped meeting reporting structure does not cover floor to board at divisional level
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 full 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	Framework finalised and approved by Board in July 2022	COMPLETE

TAF DASHBOARD

QUALITY AND SAFETY

1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Alan Prosser Paul Wilkins	Corporate OCP completed and recruitment 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	Oct-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Implementation plan developed and approved	Mar-23
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inagural meeting planned for October 2022	Oct-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Investigation training provided to officers within corporate quality & safety team and both divisions	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. Consultations planned for Autumn 2022.	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. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Jan-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.	COMPLETE

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	Oct-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Nov-22	**RISK DOMAIN** Performance and Service Sustainability
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	3	**9**

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	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			E
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
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
Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

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			NE	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			E	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	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	PA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			NE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed

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	PA	Wales Audit Office	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	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	PA
C13	Cyber assurance controls in place	Chief Digital officer		X		PE	Review via Divisional SMT / SLT. Cyber Security eLearning (Stat. & Mand.) Board Development Sessions.	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office. WG/CRU as competent authority for NIS	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital officer	X	X		PE	Digital Programme established. Architectural Review Board	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c1,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.
Digital architecture needs to be developed to guide digital transformation activities.	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.
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.	Confirmation on SIRO / Chief Digital Officer responsibilities for cyber assurance alongside Information Governance.
Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	CDO started on 1st July as anticipated, key controls in the TAF reviewed and can be presented at a future SDC. Paper on Digital Programme on Strategic Development Committee agenda 14th December 2022 for initial consideration	Nov-22
1.2	Create the Trust Digital Reference Architecture to support C14 and	Chief Digital	New Action	Jan-23
1.3	Review the scope/scale/need for a Digital Programme to provide	Chief Digital	New Action	Jan-23
1.4	Confirmation of the SIRO/Cyber Security roles and responsibilities	Chief Digital officer	AGREED ROLES AND RESPONSIBILITIES	CLOSED

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	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Nov-22	**Goal 2**	**RISK DOMAIN**	**Financial Sustainability**

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

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	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

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
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**					

TRUST FINANCIAL INVESTMENT RISK

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.**	**Dec-22**
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Dec-22
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Dec-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.**	**Dec-22**
	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed

TRUST FINANCIAL INVESTMENT RISK

	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing, due November	Dec-22
1.3	**Establish Trust Investment Prioritisation Framework**	**Matthew Bunce**	**Initial proposals prepared, Executive discussions to shape and take forward**	**Dec-22**

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	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Nov-22	Goal 2			RISK DOMAIN		Research and Development				
EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)									
		INHERENT RISK			RESIDUAL RISK			TARGET RISK			
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	
		3	4	12	2	4	8	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	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			E	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

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	New PMF not yet in place with revised measures to track delivery of Trust strategy
Limited commercial expertise (capacity) within the Trust	Local commissioning/regional commissioning processes unchanged with no new ways of measuring effectiveness
Robust commissioning arrangements across Wales	

Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppo	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	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)
1.4	development of clinical and scientific strategy	Jacinta Abraham		tbc
1.5	Development of KPIs and PMF to track strategy delivery	Carl James	Draft KPIs developed and PMF being plioted	Dec 22/January 23 Board reporting cycle
1.5	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	Oct-22	1 - Outstanding for quality, safety and experience									
NEXT REVIEW	Nov-22	**Goal 1**			**RISK DOMAIN**		**Compliance and Regulatory**				
EXECUTIVE LEAD	Lauren Fear	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	2	4	**8**	

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

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

TAF DASHBOARD

GOVERNANCE

											Audit Wales Review of Quality Governance Arrangements	
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
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.	Lauren Fear	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	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete
Develop and iplement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	This will be picked up in the overall Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work	Dec-23
Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	Project TAF1.0 within the Governance, Assurance and Risk (GAR) programme of work is underway to align frameworks with the Trust Assurance Framework. The Risk Framework is currently being mapped.	Mar-23
Refresh of Trust Assurance Framework risks	Lauren Fear	Project TAF 2.0 withint he GAR Programme has started, risks are reveiwed on a monthly basis and reported through governance routes accordingly	Dec-23
Revised reporting mechanism to be developed	Lauren Fear	Project TAF 3.0 withint he GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams, led by Execs	Mar-23
Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	Work is ongoing mapping the Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	Mar-23

AUDIT COMMITTEE

Governance, Assurance and Risk Programmes of Work

DATE OF MEETING	12th January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	19.12.22	DISCUSSED/ REVIEWED

ACRONYMS

GAR	Governance, Assurance and Risk
BOFT	Building our Future Together

1. SITUATION/BACKGROUND

1.1 The Governance, Assurance and Risk (GAR) Programme of work sits within the Building our Future Together (BOFT) Programme, which is an organisational design programme designed to ensure that we are organised appropriately to support delivery of the Trust's 2032 strategy, which has the safety and quality of care for our patients and donors as its golden thread.

1.2 The Governance, Assurance and Risk programme has been developed to focus the work within the governance remit for the Trust. The programme pulls together three main areas of work; Governance, Assurance and Risk. There are a total of twenty projects within the programme of work; ten governance projects, six risk projects and four assurance projects. The Governance, Assurance and Risk programme will ensure accountability and ownership is in the right place, supported by effective structures, in addition the programme of work will improve our effectiveness and efficiency.

1.3 The programme takes into account all outstanding Audit Wales and Internal Audit actions open in the Audit Tracker.

1.4 A Governance, Assurance and Risk Programmes of Work Steering Committee has been established with a mechanism by which to inform and support the decision making authority through the existing governance structures and/ or at an existing delegated authority levels for the individuals involved. In addition, the steering group can propose recommended actions into existing governance structures, playing a role of a focused task and finish group.

1.4 The Building our Future Together is a three year development programme. The Governance, Assurance and Risk programme looks to progress within one year, the date parameters for the steering committee are aligned with the programme of work timeline.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Given the Audit Committee role in oversight of the governance, risk and assurance frameworks for the Trust, it is important for the Committee to discuss the proposed development programme.

2.2 There is also a link to the Trust Board self-assessment as part of the annual Governance statement. The outline proposal at this stage is that completion of the deliverables set out would set the path from maturity level 4 to maturity level 5 by April 2024. This is not for formal discussion at this stage however the proposed link is important to outline to the Committee for any initial views.

2.3 The Audit Committee are therefore asked to:

2.4 Review the Governance, Assurance and Risk Programmes of Work (appendix 1) considering the deliverables attached to the programmes (appendix 2).

2.5 Timeframe for the programmes of work of one year to be considered as part of the three year organisational development Building our Future Together programme (appendix 1)

2.6 Terms of Reference for Governance, Assurance and Risk Programmes of Work Steering Committee (appendix 3) to be noted to support the work going forward and to provide governance assurance.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Audit Committee are asked to:

- **DISCUSS** the programmes of work (appendix 1) and deliverables (appendix 2) of the Governance, Assurance and Risk Programmes of Work.
- **DISCUSS** the timeline of the Governance, Assurance and Risk Programmes of Work, alongside the three year Building Our Future Together organisational change project (appendix 1).
- **NOTE** the Terms of Reference for Governance, Assurance and Risk Programmes of Work Steering Committee.

REF	TITLE	2022				2023											
		PHASE 1				PHASE 2			PHASE 3			PHASE 4			PHASE 5		
		QUARTER 3				QUARTER 4			QUARTER 1			QUARTER 2			QUARTER 3		
		SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
GOV1.0	STRUCTURE																
GOV2.0	PROCESS AND TEMPLATES																
GOV3.0	COMPLANCE AND CORE PROCESS																
GOV4.0	GOVERNANCE TRAINING AND DEVELOPMENT																
GOV5.0	BOARD DECISION MAKING																
GOV6.0	DELEGATION FRAMEWORK																
GOV7.0	ASSURANCE THROUGH GOVERNANCE DEVELOPMENT																
GOV8.0	HOSTING ORGANISATIONS EFFECTIVE GOVERNANCE ARRANGEMENTS																
GOV9.0	INNOVATION																
GOV10.0	BOARD COMMITTEE EFFECTIVENESS																
RISK1.0	RISK POLICY AND CORPORATE PROCEDURE																
RISK2.0	REFRESH RISK APPETITE																
RISK3.0	RISK REPORTING THROUGH GOVERNANCE																
RISK4.0	ESTABLISHMENT OF RISK MANAGEMENT ASSURANCE GOVERNANCE																
RISK5.0	QUALITY OF INFORMATION ON DATIX																
RISK6.0	RISK TRAINING																
TAF1.0	ALIGNMENT OF FRAMEWORKS																
TAF2.0	REFRESH OF TRUST ASSURANCE FRAMEWORK RISKS																
TAF3.0	REVISED REPORTING MECHANISM																
TAF4.0	MAPPING OF TAF THROUGH GOVERNANCE CYCLE																

PROJECT REFERENCE	PROJECT TITLE	PROJECT TIMEFRAME	PROJECT OBJETIVE	PROJECT DELIVERABLES
GOV1.0	**Structure**	Work has started in phase 1 and will continue into phase 2, Q3 and Q4 2022/23	Deliver on actions from both Internal Audit's reviews of Governance, risk and assurance audits and Structured Assessments and Quality Governance audits from Audit Wales. Implement ways of working for Corporate Governance layer and link into Trust wide Governance.	1. Clear view of all internal and external audit actions to enable timely and effective implementation. 2. Key Performance Indicators established to assess and monitor benefits realisation of new committee structure. 3. Subcommittee reporting lines will be confirmed through review of agenda and cycle of business to ensure not duplication or gaps in reporting. 4. Building Our Future Together ways of working implementation including the development of joint EMB/Divisional Leadership Team working to ensure. 5. Set of clear principles and guidance around organisational Governance. 6. Compare outputs of divisional map of meeting reporting structures with an established view of what reporting is required to corporate layer. 7. Clear alignment of reporting timelines and requirements into Corporate Governance layer. 8. Agreed programme of work with Faculty of Medical Leadership Management organisational layer
GOV2.0	**Process and Templates**	Work has started in phase 1 and will continue in Q3 2022/23	Establish more effective and consistent reporting.	1. A standard approach and process to agenda format and structure across the Trust Board/Committee and divisional meeting arrangements e.g. use of consent agenda, categories for 'noting', 'discussion and review', 'endorsement' and 'approval'. 2. Core governance subjects included across the divisional meeting arrangements. 3. A consistent format and house style for minutes across Trust Board, Committee and Divisional meetings. 4. A consistent format and process for action logs across Trust Board, Committee and Divisional meetings. 5. All aspects of the Terms of Reference will be captured in the cycle of business across divisions, Committees and Trust Board. 6. Ownership and accountability across all levels of the Trust. 7. Divisional senior meetings have clear cycles of business. 8. A consistent format to the structure of paper templates across Trust Board and Committees with clear guidance for completion. 9. Corporate Governance manual will be reviewed and refreshed to include full suite of revised and new Corporate Governance documentation.
GOV3.0	**Compliance and Core Process**	Work will commence in phase 2, Q4 2022/23	Clear and effective accountabilities.	1. Training needs analysis for updated Corporate Governance Manual. 2. Embedded consistent use of Board and Committee process flow chart planning tool. 3. Embedded compliance tracking dashboard.
GOV4.0	**Governance Training and Development**	Work will start in phase 1, Q3 and continue through phases 2 and	Supporting the development of Board members, Governance Team and those in wider Governance related roles with their accountabilities through training and development.	1. Everyone in scope will be trained in report writing. 2. Training sessions for chairs and meeting support of all groups identified on the Governance map.

		3, Q4 2022/23 and Q1 2023/24		3. Refreshed Corporate Governance induction training video. 4. Development programme agendas to take into account all matters in updated Good Governance Guide. 5. Annual report from each Independent Member Champion role. 6. Independent Members will participate in two 15 Step Challenge events per year. 7. Relevant members will complete minute training. 8. Developed training programme for new members and refresher training for existing team members.
GOV5.0	**Board Decision Making**	Work will start in phase 1, Q3 and continue through phases 2 and 3, Q4 2022/23 and Q1 2023/24	Further enhance effective governance when making decisions.	1. Relevant chapters of the Good Governance Guide updated to reflect additions since last publication. 2. KPIs to assess and monitor effectiveness of Executive level governance, including assessment of how the paper template is used.
GOV6.0	**Delegation Framework**	Work will commence in phase 1, Q3 2022/23	Design and implementation of appropriate lines of accountability and responsibility for both financial and non-financial delegation frameworks.	1. Matrix to support decision making governance route; SLT/SMT, EMB, Trust Board. 2. Terms of Reference for Trust Board, Committees and Divisional senior team meetings reviewed and refreshed.
GOV7.0	**Assurance Through Governance Development**	Work will commence in phase 1, Q3 2022/23	TBC (working with Gillian Hooper)	1. Scope of work detailed in Engagement letter from Gillian Hooper will be delivered.
GOV8.0	**Hosted Organisations Effective Governance Arrangements**	Work will commence in phase 1, Q3 2022/23	Assurance, oversight and delivery of effective governance arrangements.	1. Refreshed hosted agreements.
GOV9.0	**Innovation**	Work will commence in phase 3, Q1 2023/24	Develop and promote a Trust learning culture for governance, risk and assurance.	1. The product of BOFT approach principles will be shared with peers for learning. 2. Implementation of scope of work detailed in engagement letter shared with peers.
GOV10.0	**Board and Committee Effectiveness**	Work will commence in phase 1, Q3 2022/23	Successfully progress from level four to level five Board maturity effectiveness.	1. Examples of best practice identified, learning undertaken and insight fed back into the organisation. 2. Programme of review in place with feedback shared following reviews
RISK1.0	**Risk Policy and Corporate Procedure**	Work is underway and will continued through phase 1, Q3 2022/23	Develop and embed a Trust Risk Policy and corporate procedure throughout the Trust.	1. Risk policy and procedure will be live on intranet site for all staff to access.
RISK2.0	**Refresh Risk Appetite**	Work will commence in phase 1, Q3 and continue into phase 2, Q4 2022/23	Refresh and recalibrate the risk appetite for the Trust.	1. Refreshed risk appetite approved by the Trust Board and communicated through all governance layers.
RISK3.0	**Risk Reporting Through Governance**	Work will commence in phase 1, Q3 and continue into phase 2, Q4 2022/23	Embed quality and consistent reporting on risk throughout the Trust.	1. Consistent report style and governance pathway for risk register through Senior Leadership Teams, EMB, Committees and Trust Board
RISK4.0	**Establishment of Risk Management Assurance Governance**	Work will commence in phase 1, Q3 2022/23	Establish the Trust Risk Assurance Group to support a culture of risk management assurance across the Trust.	1. Terms of Reference established for the group. 2. Regular meetings established. 3. Clear set of principles around risk management culture.

RISK5.0	**Quality Information on Datix**	Work will commence in phase 1, Q3 2022/23	Develop and embed new Datix module and ensure quality data is stored and maintained on Datix for all risks in the Trust.	1. All Trust risks will be held on the Datix system. 2. Guidance and support available to ensure quality data is stored and maintained on Datix.
RISK6.0	**Risk Training**	Work has commenced and will be completed by the end of phase 1, Q3 2022/23	Ensure everyone in the Trust receives the appropriate level of risk training.	1. Training delivered to all staff and Board members in the Trust, at the appropriate level. With a clear training pathway for new starters and refresher training on a 2 yearly cycle.
TAF1.0	**Alignment of Frameworks**	Work will commence in phase 2, Q4 2022/23	Align key frameworks with the Trust Assurance Framework.	1. Alignment with Risk Management Framework. 2. Alignment with Quality and Safety Management Framework 3. Alignment with Performance Management Framework.
TAF2.0	**Refresh of Trust Assurance Framework Risks**	Work will commence in phase 2, Q4 2022/23	Refresh and recalibrate strategic risks.	1. Refreshed strategic risks aligned with the refresh of the Trust risk appetite.
TAF3.0	**Revised Reporting Mechanism**	Work has commenced and will continue through phases 1 and 2, Q3 and Q4 2022/23	Embed the use of digital systems to semi-automate the Trust Assurance Framework	1. Semi-automated system in place to aid monthly review cycle for the Trust Assurance Framework. 2. Implementation of new automated dashboard to report and monitor progress against the Trust principle risks.
TAF4.0	**Mapping the Trust Assurance Framework Through Governance Cycle**	Work will commence in phase 2, Q4 2022/23	Embed the Trust Assurance Framework into the governance cycle of committees and Trust Board	1. Relevant committees will include the Trust Assurance Framework regularly and in line with the cycle of business.

Building Our Future Together

Governance, Risk and Assurance Programmes of Work

Steering Committee

Terms of Reference & Operating Arrangements

Developed:	September 2022
Approved:	
Next Review Due:	

1. Building Our Future Together Context

1.1 Building our Future Together is an organisational design programme designed to:

- ensure that we are organised appropriately to support delivery of the Trust's 2032 strategy, which has the safety and quality of care for our patients and donors as its golden thread
- provide a way of working and shape to the organisation which enables us to maintain focus
- ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future
- draw together our organisational developments with a common sense of purpose
- improve our effectiveness, efficiency and value based approach
- develop the mechanisms which enable us to prioritise where and when we focus our efforts
- provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition
- support realistic, authentic and compassionate leadership

2. Decision Making

2.1 The Steering Group does not have a delegated authority from the Trust for decision making. Instead, it is a mechanism by which to inform and support the decision making authority through the existing governance structures and/ or at an existing delegated authority levels for the individuals involved.

However, there are particular topics on which the Steering Group can propose recommended actions into existing governance structures, where it can play a role of a focused task and finish group to explore topics.

The membership of the Steering Group is focused and therefore is not designed to replace appropriate engagement of internal and external stakeholders on any part of the scope of the programme of works.

3. Scope

3.1 20 Projects – detailed in Appendix 1

3.2 The date parameters for the committee will be one year, aligned to the programme of work timeline.

3.3 Validation and testing will be factored into the committee function throughout the programme of work.

4. Membership

4.1

Senior Responsible Officer (Committee Chair)	Lauren Fear	Director Corporate Governance & Chief of Staff
Indepentent Member Lead	Gareth Jones	Independent Member
Executive Director Lead	Nicola Williams	Executive Director of Nursin AHPs and Health Science
Divisional Leads	Cath O'Brien	Chief Operating Officer Divisional Directors Senior Manager/Senior Leadership Leads
Governance and Assurance	Emma Stephens	Head of Corporate Governance
Project Support	Mel Findlay	Business Support Officer

4.2 Members will take a task and finish approach, helping to drive forward work within the programme, which will then feed into the established governance mechanisms.

5. Reporting Arrangements

5.1 The Steering Group will report into the overall Building our Future Together governance structure, which in turn reports into Executive Management Board – Shape.

6. What the Steering Group Does

6.1 Recommend scope into BOFT/EMB governance arrangements for approval.

6.2 Set each phase of work on a quarterly basis.

6.3 Task & finish group on specific topics to make recommendations through the work programme.

6.4 Oversight of successful delivery and sustainable practice – with further formal assurance taking place in appropriate part of Trust Governance and Accountability Framework, as laid out in the Trust Accountability Report

7. Meeting Frequency

7.1 Meetings will take place every two months.

8. Applicability of Standing Orders to Committee Business.

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee.

PROJECT REFERENCE	PROJECT TITLE	PROJECT TIMEFRAME	PROJECT OBJETIVE
GOV1.0	**Structure**	Work has started in phase 1 and will continue into phase 2, Q3 and Q4 2022/23	Deliver on actions from both Internal Audit's reviews of Governance, risk and assurance audits and Structured Assessments and Quality Governance audits from Audit Wales. Implement ways of working for Corporate Governance layer and link into Trust wide Governance.
GOV2.0	**Process and Templates**	Work has started in phase 1 and will continue in Q3 2022/23	Establish more effective and consistent reporting.
GOV3.0	**Compliance and Core Process**	Work will commence in phase 2, Q4 2022/23	Clear and effective accountabilities.
GOV4.0	**Governance Training and Development**	Work will start in phase 1, Q3 and continue through phases 2 and 3, Q4 2022/23 and Q1 2023/24	Supporting the development of Board members, Governance Team and those in wider Governance related roles with their accountabilities through training and development.
GOV5.0	**Board Decision Making**	Work will start in phase 1, Q3 and continue through phases 2 and 3, Q4 2022/23 and Q1 2023/24	Further enhance effective governance when making decisions.
GOV6.0	**Delegation Framework**	Work will commence in phase 1, Q3 2022/23	Design and implementation of appropriate lines of accountability and responsibility for both financial and non-financial delegation frameworks.
GOV7.0	**Assurance Through Governance Development**	Work will commence in phase 1, Q3 2022/23	TBC (working with Gillian Hooper)
GOV8.0	**Hosted Organisations Effective Governance Arrangements**	Work will commence in phase 1, Q3 2022/23	Assurance, oversight and delivery of effective governance arrangements.
GOV9.0	**Innovation**	Work will commence in phase 3, Q1 2023/24	Develop and promote a Trust learning culture for governance, risk and assurance.
GOV10.0	**Board and Committee Effectiveness**	Work will commence in phase 1, Q3 2022/23	Successfully progress from level four to level five Board maturity effectiveness.
RISK1.0	**Risk Policy and Corporate Procedure**	Work is underway and will continued through phase 1, Q3 2022/23	Develop and embed a Trust Risk Policy and corporate procedure throughout the Trust.
RISK2.0	**Refresh Risk Appetite**	Work will commence in phase 1, Q3 and continue into phase 2, Q4 2022/23	Refresh and recalibrate the risk appetite for the Trust.
RISK3.0	**Risk Reporting Through Governance**	Work will commence in phase 1, Q3 and continue into phase 2, Q4 2022/23	Embed quality and consistent reporting on risk throughout the Trust.
RISK4.0	**Establishment of Risk Management Assurance Governance**	Work will commence in phase 1, Q3 2022/23	Establish the Trust Risk Assurance Group to support a culture of risk management assurance across the Trust.
RISK5.0	**Quality Information on Datix**	Work will commence in phase 1, Q3 2022/23	Develop and embed new Datix module and ensure quality data is stored and maintained on Datix for all risks in the Trust.
RISK6.0	**Risk Training**	Work has commenced and will be completed by the end of phase 1, Q3 2022/23	Ensure everyone in the Trust receives the appropriate level of risk training.
TAF1.0	**Alignment of Frameworks**	Work will commence in phase 2, Q4 2022/23	Align key frameworks with the Trust Assurance Framework.
TAF2.0	**Refresh of Trust Assurance Framework Risks**	Work will commence in phase 2, Q4 2022/23	Refresh and recalibrate strategic risks.
TAF3.0	**Revised Reporting Mechanism**	Work has commenced and will continue through phases 1 and 2, Q3 and Q4 2022/23	Embed the use of digital systems to semi-automate the Trust Assurance Framework
TAF4.0	**Mapping the Trust Assurance Framework Through Governance Cycle**	Work will commence in phase 2, Q4 2022/23	Embed the Trust Assurance Framework into the governance cycle of committees and Trust Board

AUDIT COMMITTEE

LEGISLATIVE AND REGULATORY COMPLIANCE REGISTER

DATE OF MEETING	12/01/2023

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	
CDM 2015	Construction Design & Management Regulations 2015
HSE	Health and Safety Executive
HTM	Health Technical Memorandum
ICO	Information Commissioner's Office
IG	Information Governance
ISO	International Organisation for Standardisation
MHRA	Medicines and Healthcare products Regulatory Agency
NIS	Network and Information Systems
NWSSP	NHS Wales Shared Services Partnership
PCR	Public Contract Regulations

QSPC	Quality, Safety and Performance Committee
SFI	Standing Financial Instructions
SIRO	Senior Information Responsible Officer
UKAS	United Kingdom Accreditation Service
VfM	Value for Money
VUNHST	Velindre University NHS Trust
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 since the previous update reported to the July 2022 Audit Committee 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 across the Trust.

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, 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 Cyber Information Security & Resilience Legislative and Regulatory requirements are captured via the Information Governance entries held on the register.

2.4 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 'ad 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 since the previous update reported to the July 2022 Audit Committee, 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: Estates, Environment & Capital

Construction Design & Management Regulations 2015 (CDM 2015) (ref. – Row 7) - These are not currently subject to an independent routine inspection programme, however, it is recommended by Trust officers that we conduct an internal audit programme as standard good practice. In roads have been made over the last few months to improve the Trust position with respect to compliance. The Estates department have completed works supported by external consultants to update a suite of standard operating procedures to ensure project delivery complies with CDM 2015. The Control of Contractors Policy has been updated and approved on the 10 November 2022 by the Quality, Safety and Performance Committee, with training subsequently provided to support the implementation of these processes. Audits will be

completed by the end of January 2023 to assess and ensure adherence with the updated policies and procedures.

Control of Asbestos Regulations 2012 (ref. – Row 8) - Re-inspections of the Estates have been completed with no concerns raised and just a minor action to be completed by 31/03/2023.

Health Technical Memorandum (HTM) Decontamination (ref. – Row 12**) -** It should be noted that all equipment associated with decontamination has been taken out of Service across the Trust and as such no longer requires inspection going forward.

Health Technical Memorandum (HTM) Medical Gases (ref. – Row 13**) -** All actions have been closed out with the exception of tasks listed against staff resource. The Trust has run two recruitment initiatives to on-board specialised technical staff to support provision of qualified technical positions. Staff are currently being trained to fulfil these roles although further recruitment is required.

Health Technical Memorandum (HTM) Water (ref. – Row 15**) -** NHS Wales Shared Service Partnership (NWSSP) audit completed in November 2022 highlighted an improved standard compared with the previous assessment. Only minor actions were identified to be addressed by 31/03/2023 with audit documentation referencing a “good standard of management achieved”.

Fire Risk Assessment (ref. – Row 16**) -** Fire Risk Assessments [rolling programme] – this area has been assessed as having limited assurance due to the number of actions identified. There is an action plan in place to deliver all identified issues by 31/03/2023 which is being managed by Estates, and is on target.

Environmental Legislation (ref. – Row 19**) -** An external surveillance audit was undertaken during November 2022. The audit was the first physical assessment undertaken onsite since the onset of Covid and was conducted in detail by the external auditor. The outcome was favourable for the Trust with no non-conformances identified.

Health and Safety at Work Act 1974 (ref. – Row 20**) -** No ad-hoc or planned inspections undertaken by the Health and Safety Executive (HSE). However, internal audits to assess compliance with Managing for Health and Safety Guidance (HSG65) are planned for Corporate Estates, Digital, Research Development and Innovation for completion by 31/03/2023. Priority Improvement Plans are to be developed as necessary following audits for each

Division, with a view that this will support development of an overarching Trust Strategic Plan to be developed by 31/03/2023.

3.1.2 **Trust-wide: FINANCE (ref. –** Row 23**)**
HM Customs and Excise have confirmed completion of their review and advised that the Trust are classed as low business risk.

3.1.3 **Trust-wide: Information Governance (ref. –** Rows 27 - 51**)**
The key message in regards to Information Governance compliance is that an internal audit is underway in Quarter 3, policies have been updated and are next due for review in 2025. Further work overall is being developed to support Information Governance compliance status level 3. It is currently anticipated this will be achieved by June 23. The Trust has also updated our payment to the Information Commissioner's Office (ICO) with the next review date being November 23.

3.1.4 **Trust-wide: Nursing, Quality and Safety (ref. –** Rows 54 - 62**)**

Healthcare Inspectorate Wales (ref. – Row 54**) -** The Nursing, Quality and Safety Directorate received an inspection of the First Floor Ward on the 12th and 13th July 2022. The formal inspection report received in October 2022 was largely positive with oversight of the recommendations and action plan at the November 2022 Quality, Safety & Performance Committee.

Nurse Staffing Levels (wales) Act 2016 (ref. – Row 57**) -** The recommendations identified for each unit following the establishment reviews for all Nursing areas have been fully completed.

All Wales Endoscope Decontamination (ref. – Row 62**) -** The recommendations and supporting action plan following the informal review undertaken in May 2022 by a specialist Engineer from NHS Wales Shared Services Partnership have been fully completed.

3.1.5 **Workforce & Organisational Development (ref. –** Rows 65**)**
The recommendations to improve Welsh Language Compliance for Radiotherapy in connection with the Active Officer have been addressed by providing signage that specifies the Active Offer. The first patient through the improved system has been received with information and treatment communication provided in Welsh.

3.1.6 **Welsh Blood Service**

Medicines and Healthcare products Regulatory Agency (MHRA) (ref. – Row 6**) -** The actions to address the findings following the June 2022 inspection of the north Wales arm of the Service remain on track for completion within agreed timescales.

Human Tissue Authority (ref. – Row 8**) –** Inspection carried out in October 2022 was positive with just 5 minor non-compliances. Action plan in place and remains on track for completion.

European Federation of Immunogenetics (ref. – Row 10**) –** Inspection carried out in November 2022 was also positive with action plan in place and certificate to be issued for 2023/24.

United Kingdom Accreditation Service (ref. – Row 13**) –** Inspection carried out in October 2022 for full re-assessment. Agreed action plan completed and fully implemented.

3.1.7 **Velindre Cancer Service**

Natural Resources Wales **(ref. –** Row 11**) –** Following the inspection carried out in July 2022, report and actions fully completed with oversight by the Quality, Safety & Performance Committee in November 2022.

Operational Arrangements for Medical Gas Pipeline **(ref. –** Row 14**) –** Following internal audit conducted in April 2022, all resulting actions now complete, bar one with a recommendation to train an additional Quality Controller for Medical Gas Pipeline Systems or obtain the service of a Quality Controller from another Trust for any occasions when this is required.

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 **DISCUSSION** and **REVIEW** and to examine any entries on the Register in full provided at ***Appendix 1***.

	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	No scheduled inspection however Hse can visit at any time to inpect a project or in response to an incident	Risk Assessments for Health & Safety Management in place across the Trust. All construction projects of all sizes are managed in accordance with CDM	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. 12/22 Paperwork to support management of Principal Designers and Principal Contractors provided by Glleds. Training provided to managers. Paperwork to support the management of contractors also rolled out to Estates Department and Operational Services. Further roll out to Digital and rest of Trust who employ contractors planned. In house HSG 65 audit 01/2023 and external audit by Gleeds of implementation of CDM.	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 Audits to be completed by 31/01/2023
Estates, Environment & Capital	Health and Safety Executive	Control of Asbestos Regulations 2012	03/12/2021	Management Plan Updated	Recommendations completed October 2022. Re-inspection survey planned for 2022, date to be confirmed. Re inspection complete minor recommendation to be addressed 31/03/2023	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	Environment Agency	F Gas Regulations	12/05/2022	Compliant	Annual Review planned for 2023	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	05/08/2022	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		11/11/2023
Estates, Environment & Capital	ISO Audit 14001	Energy Performance of Building Regulation 2007 TM44	11/08/2022	Compliant	Surveillance audit held in October / November - no non conformities raised	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 - this is no longer applicable. All equipment associated with decontamination taken out of service	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	01/03/2022	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 recruitment campaign was unsuccessful in securing a suitable candidate.	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		25/07/2023
Estates, Environment & Capital	Welsh Health Estates, H&S Executive,	Health Technical Memorandum (HTM) Water	01/11/2022	Reasonable Assurance - Good Standard of management	Exceptional audit outcome two minor actions to adress.	Director of Strategic Transformation, Planning & Digital	Assitant Director of Estates, Environment and Capital Development	Quality, Safety and Performance Committee	31/07/2023		11/11/2023
Estates, Environment & Capital	Fire and Rescue Services, NWSSP - SES	Fire [RRO, DSEAR, WHTM05]	Fire Risk Assessments [rolling programme] / Annual audit [May 2022] / NWSSP Independent Review [2021]	Limited 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	01/10/2022	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	01/08/2023		01/10/2023
Estates, Environment & Capital	Natural Resources Wales	Enforces Environmental Legislation	07/11/2022	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.	Surveillance audit held in October/ November 2022. No non conformities 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

	A	B	C	D	E	F	G	H	I	J	K	L
1	**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 internal audit process was initiated In March 2021 to develop and align Health and Safery Gudance (HSG 65) audits Trust wide No scheduled inspection by HSE but HSE can visit at any time to carry out a proactive inspection or in response to an incident	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 HSG65 Audits in Corporate Division Estates, Digital,RD&I Q3 and Q4 2022/2023. Priority Improvement Plan to be reconfigured into a plan for each division including Corporate and an overarching Trust strategic plan by 01.03.2022.	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 2023
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. Update December 2022: HMRC have confirmed completion of the review and advised the Trust are classed as low business risk.
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	Nov-23		Q3 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	Action Plan to further increase level and work towards level 3 are contained with the IG Workplan submitted to QSP in July 2022. Completed 14 Jul 22 - next review due 2025.		Internal Audit underway Q3 2022/23
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 underway Q3 2022/23

	A	B	C	D	E	F	G	H	I	J	K	L
1	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
2	**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 underway Q3 2022/23
3	**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 followd 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 underway Q3 2022/23
4	**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 underway Q3 2022/23
5	**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 underway Q3 2022/23
6	**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 underway Q3 2022/23
7	**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 underway Q3 2022/23
8	**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 underway Q3 2022/23
9	**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 underway Q3 2022/23
10	**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 underway Q3 2022/23
11	**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 underway Q3 2022/23
12	**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 underway Q3 2022/23
13	**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	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 underway Q3 2022/23

	A	B	C	D	E	F	G	H	I	J	K	L
1	**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**
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 underway Q3 2022/23
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	Achieved, but need to maintain the standard year on year.		Internal Audit underway Q3 2022/23
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 underway Q3 2022/23
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 underway Q3 2022/23
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 underway Q3 2022/23
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 underway Q3 2022/23
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 underway Q3 2022/23
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 underway Q3 2022/23
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. HIW 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 HIW inspection within nuclear medicine still pending.~~ Report (published 21st September 2022) and recommendations subsequently received. 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.~~ Report (published 12th October 2022) and recommendations subsequently received.	Noted at Senior Leadership Team March 2021. Executive Management Board and the Quality, Safety and Performance Committee ~~to be~~ were informed of the positive result at the May 2021 Committee. Report reviewed by respective senior team and an action plan developed and sighted at November 2022 QSP Committee. ~~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.~~ Quotes for digital information screens were received December 2022 and funding for these is currently being finalised. Welsh Language appointment letters - Mosaiq issue unresolved and full implementation to be achieved through IRS programme. Report reviewed by respective senior team and an action plan developed and sighted at November 2022 QSP Committee.	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. Operational Senior Nurse.	Quality, Safety and Performance Committee	N/A. ~~Report for Nuclear Medicine IRMER inspection still pending.~~ March 2023, although this may be subject to extension due to anticipated system challenges. ~~Outstanding actions following Radiotherapy IRMER inspection to be completed by July 2022 (revised date).~~ IRS implementation plan to be agreed and communicated by March 2023.	**COMPLETE** **ACTIONS POTENTIALLY NOT ON TARGET FOR COMPLETION BY AGREED DATE** **ACTIONS ON TARGET TO BE COMPLETED BY AGREED DATE** **ACTIONS ON TARGET**	HIW will undertake unannounced inspection visits/spot checks, special reviews, and investigations on a planned and unannounced basis.
55	**Nursing and Quality & Safety**	HIW, Internal Audit and Self-assessment	Health and Care Standards (2015)	May 2021 (no inspection undertaken during 2022 in line with NWSSP approach to internal audit plan for all organisations across Wales).	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		**Due March 2023.**

	A	B	C	D	E	F	G	H	I	J	K	L
1	**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**
40	**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. December 2022 update - Trust-wide Nursing Standards published October 2022, of which standard 1 is as follows: "Maintain your NMC professional registration (for registered practitioners)".	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.
42	**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. Acuity Audit undertaken June 2022. Establishment reviews for all Nursing areas completed during Oct/Nov 2022.	HIW inspection undertaken regarding stafing levels and the process around ensuring safe staffing levels. No requirements for any improvements. Recommendations identified for each area to be completed within 6 months.	6 monthly internal reviews of safe staffing levels will continue as per the national safe staffing Act. Outcomes accepted at each unit.	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse for Professional Standards & Digital, and Head of Nursing VCC	Quality, Safety and Performance Committee	May 2023.		~~Next review will take place- September 2022.~~ Next establishment review to be undertaken May 2023.
43	**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
44	**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. There has been no specific inspection of the Deprivation of Liberty Safeguards process, however, the HIW inspection of First Floor Ward (detailed line 54) identified that staff possess an understanding of the process.	N/A	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse Safeguarding & Public Protection	Quality, Safety and Performance Committee	N/A		N/A
45	**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
46	**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 (all actions completed and no review has been undertaken since).		N/A
41	**Nursing and Quality & Safety**	NHS Wales Shared Services Partnership - Specialist Estates Services/MDT	ALL WALES ENDOSCOPE DECONTAMINATION SURVEY 2018	01/07/2018 (no formal inspections undertaken since 2018, however an informal review was undertaken on 16th May 2022 by Specialist Engineer (NWSSP).		~~A workshop will be arranged post implementation of the high level disinfection systems & ultraviolet light environmental decontamination system.~~ Representatives for PFE Medical Anti-Germixs UVC attended site to provide annual user refresher training for staff on site (16th June 2022). Annual refresher ~~e-~~learning Nanosonics Trophon training provided online (July 2022). Action plan developed to address recommendations: Documentation aligned across departments. Compliance with All Wales Policy, evidencing best practice. IPC team member passed decontamination lead course, annual refresher training undertaken by all disinfectors. Validation reports now being forwarded to NWSSP for authorisation.	Executive Director of Nursing, AHPs and Health Scientists	Head of Infection Prevention & Control	Quality, Safety and Performance Committee	Training conducted during June/July 2022. Actions completed.		Date of next inspection not confirmed.
47	**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
48	**Workforce & OD**	Corporate Health Standard	Standards	PLATINUM achieved October 2016 GOLD achieved 2020		The Trust was due to seek reaccreditation of its gold status in 2022 however both levels were postponed by Public Helath Wales due to the pandemic. The assessment process is undergoing changes therefore Public Helath Wales have re-aligned assessment dates to support the transition to the new scheme. The Trust's Gold accreditation was extended and the Enhanced Status Check is now booked for 25.1.23.	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		Gold Enhanced Status Check 25.01.2023
49	**Workforce & OD**	Welsh Language Commissioner	Welsh Language (Wales) measure 2011	21 June 2021	Reasonable Assurance	4 Recommendations accepted - Audit actions being driven and monitored by the WL Development group. The recommendations are for Radiotherapy in connection with the Active Offer. The department have implemented recommendations by providing signage that specifies the Active Offer and it has seen its first patient through the system. The patient received information in Welsh and treatment communication in Welsh.	Executive Director of Organisational Development & Workforce	Welsh Language Manager	Quality, Safety and Performance Committee	Audit actions completed		No formal inspection scheduled

	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
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) submitted to MHRA by 11th July 2022. WBS QA Team are working with the relevant operational managers to resolve these issues. Action plan formally accepted by MHRA. Progress of actions is 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-December-2022		North Wales June 2024 (Awaiting MHRA confirmation)
			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)
			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		
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)	03-04 Oct 2022	No critical or major non-compliances reported. 5 minor non-compliances	Action plan to be submitted to HTA that will address findings	Chief Scientific Officer	Head of Welsh Bone Donor Registry	Quality, Safety and Performance Committee	Actions to be completed		HTA Inspection Oct 2024 (Awaiting HTA Confirmation)
WBS	European Federation of Immunogenetics	EFI standards, Peer review	Nov-22	3 Mandatory findings that require action and 1 recommendation	Action plan created	N/A Accreditation only	Head of Welsh Transplantation and Immunogenetics Laboratory	Quality, Safety and Performance Committee	Actions to be Completed. Certificate to be issued for 2023/2024		EFI Inspection 2025 (Awaiting EFI Confirmation)
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		WMDA Inspection 2023 (Awaiting Confirmation)
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	29-30 Sep 2022	**NEQAS for H&I** 1 Mandatory findings and 1 recommendation (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 and fully compliant		UKAS Inspection Sep-2023 Full Assessment (Awaiting Confirmation)
WBS	UKAS	ISO 15189/IEC:2012 Medical Laboratories - requirements for Quality and Competence Accreditation Regulations 2009 (SI No 315/2009) EC 765/2008	05-06 Oct 2022	**AT / RCI / WTAIL Labs** 5 Mandatory findings that require objective evidence and 4 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		UKAS Inspection Oct 2023 Surveillance Assessment (Awaiting Confirmation)

	A	B	C	D	E	F	G	H	I	J	K	L
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	**WASPS** 7 Mandatory findings (Evidence required for 6), 2 recommendations (Full Assessment)	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		UKAS Inspection Mar 2023 (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 Aug 2021 21/22 Financial Year No NWSSP Audits of H&S to date in 2022/23	Health and Safety at work Ect. Act 1974 Management of Health and Safety Regulations 1999	Internal audits and inspections throughout the financial year and 2022/23	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		Ongoing Internal Audits and Inspections throughout the Financial Year 2022/23. Health and Safety Management Arrangements HSG 65 Audits ongoing during 2022/2023 by Health and Safety and Environmental Compliance Manager

VELINDRE CANCER CENTRE

	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.	10th May 2022	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		2023 - 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/ Head of Radiotherapy Physics Responsibility delegtated from Steve Ham - ref. Trust Radiation Protection Policy	Quality, Safety and Performance Committee	Improvement plan is monitord by the Radiotherapy Management Group. Actions and implementation plan to conclude by March 2023.		To be determined (unannounced visits every 2-3 years).
VCC	British Standard Institute - Radiotherapy	ISO9001 - 2015 International Quality Management Standard	Radiotherapy - August 2022	One new non-conformity identified One opportunity for improvement idfentified.	Report presented and agreed by VCC Senior Leadership Team.	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			TBC
VCC	British Standard Institute - Medical Physics	ISO9001 - 2015 International Quality Management Standard	Radiotherapy Physics - February 2022	1 new minor non-conformity and 2 opportunities for improvement were identified.	Report sent to VCC Senior Leadership Team and made available to the Quality, Safety and Performance Committee.	Chief Operating Officer	Head / Deputy Head of Radiotherapy Physics	Quality, Safety and Performance Committee	Actions complete corrective action plan sent to BSI within 2 weeks of inspection		Feb-23
VCC	Lloyds Register Quality Assurance our ISO 9001:2015 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. Work completed to address minor N/Cs.	Chief Operating Officer	Radiology Manager	Quality, Safety and Performance Committee	Actions to be concluded prior to next inspection January 18th -19th 2023 All minor non-conformances reviewed and wholly or partially addressed to-date. Additional work to be completed prior to ISO visit in January.		Jan-23
VCC	Natural Resources Wales	Environmental Permitting Regulations - Radioactive Substances Regulation Compliance Assessment Report (RSRCAR)	Inspection - July 2022	No non-conformities identified. All actions required following previous RSRCAR acknowledged to have been completed.	The report has been tabled at RPMESG and a highlight report discussed at QS&P November 2022 and is due to be re-discussed at QS&P May 2023.	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). As per DGM97(5)	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 the Principal Pharmacist, 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. To be completed by next audit April 2023.		Apr-23

	A	B	C	D	E	F	G	H	I	J	K	L
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**	Operational Management Arrangements for Medical Gas Pipeline Systems (MGPS) - INTERNAL AUDIT	Audit	Apr-22	One action currently outstanding but underway: It is recommended that the Trust arrange to train an additional Quality Controller (QC) (MGPS) or obtain the service of a QC (MGPS) from another Trust in order to provide cover on the Occasions that it is needed.		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).	One action outstanding otherwise completed.		2023
15	**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 REPORT OVERDUE AND COMPLETED RECOMMENDATIONS ACTIONS

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB RUN	05/12/2022	NOTED
EMB RUN	03/01/2023	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 includes all audit report recommendation actions for all status for information and to provide the Committee with an indication of the changes from the October '22 report, but the Audit Committee is asked to focus on:

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

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

1.3 The Audit Committee is requested to consider the contents of the report and the attached action plan which focusses on overdue i.e. passed the identified implementation date (**Red Status**) and those actions that have been completed **(Green Status).**

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Context

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

2.1.2 At the July '22 Audit Committee it was decided to review all audit report actions twice a year to ensure focus is maintained on actions, which took place at the meeting 4th October 2022. The full tracker will next be reviewed approximately 6 months from then depending on allocated 2023 Audit Committee dates. At this meeting the Audit Committee is requested to review **Red and Green Status** actions only.

2.1.3 The Audit Committee requested that extension dates identified by each Executive / Director lead for the red and orange status actions be shared with Audit Committee members within 3 weeks of the Audit Committee of 4th October for their consideration out of Committee.

2.1.4 Following responses from Action Leads the Tracker was circulated on 9th November 2022 to Audit Committee members seeking Out of Committee **APPROVA**L for the requested extension dates. **APPROVAL** was received from 3 Independent Member by the 24th November 2022. The requested extension dates have now been added to the Action Tracker 'Agreed Implementation Date' column. Many of the actions have now been changed to Action on Target (Yellow Status).

2.1.5 Following the October '22 Audit Committee, further updates from Action owners on implementation progress were sought for November updates by 28th November 2022 and December updates by 20th December 2022 and responses have been added to the 'November 2022 Updates' and 'December 2022 Updates' column in the Tracker. Any further extensions to implementation dates were also requested to be provided in the 'Requested Extension Date' and 'Extension (Months)' columns of the Tacker.

2.1.6 To aid forward planning, a table was shared with Executive / Director Leads which provided the deadlines for responses on all Tracker updates until March 2023, and the Committee meetings these updates will be presented at:

Audit Action Tracker Update Month	Deadline for Responses	EMB Run Meeting Date	Audit Committee Date
November	28 November 2022	05 December 2022	
December	20 December 2022	03 January 2023	12 January 2023
January	30 January 2023	06 February 2023	
February	21 February 2023	02 March 2023	

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

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

2.2 Internal Audit Actions Analysis

2.2.1 2 Internal audit reports were added to the Audit Action Tracker following the October' 22 Audit Committee and consisted of 11 recommendations. In response to these recommendations management identified 14 actions in total, of which 6 were medium priority and 8 low priority. The 2 reports added were:

- nVCC Enabling Works Final Internal Audit Report
- Finance & Service Sustainability: Budgetary Control & Savings Plans

One advisory report was added, which is listed below:

- Staff Wellbeing Final Advisory Review Report

2.2.2 The table below summarises the Internal Audit Reports included in the 2022-23 Audit Plan and their status, rating, summary of recommendations and Audit Committee approval date:

- 7 reports issued, 6 as final and 1 in draft;
- 5 audits are in progress (Fieldwork)
- 5 audits in planning stage

				Summary of Recommendations				
Review	**Year**	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
Finance & Service Sustainability: Budgetary Control & Savings Plans	22/23	Final Report	Reasonable	0	4	4	8	Oct-22
Staff Wellbeing	22/23	Final Report	Advisory					Oct-22
Research & Development	22/23	Final Report	Substantial	N/A	N/A	N/A	N/A	Oct-22
Divisional Deep Dive (Managing Attendance at Work)	22/23	Final Report	Reasonable	1	3	4	8	Jan-23
Digital Health & Care Record	22/23	Final Report	Substantial	N/A	N/A	N/A	N/A	Jan-23
Ways of Working	N/A	Cancelled	N/A					
Quality & Safety Framework	22/23	Deferred	N/A					
Private & Overseas Patients	23/24	Deferred	N/A					
Clinical Audit	22/23	Draft Report	Reasonable	1	3	3	7	Out of Committee
Patient & Donor Experience	22/23	Final Report	Reasonable	0	3	0	3	Jan-23
Capital Provision	22/23	Planning						
Cyber Security	22/23	Planning						
Information Governance	22/23	Planning						
Performance Management Framework	22/23	Draft Report	Reasonable	0	3	8	11	Provisionally Jan-23
Follow Up	22/23	Not Started						
Strategic Transformation Assurance	22/23	Not Started						
Capital & Estates								
Estates Assurance - Decarbonisation	22/23	Final Report	Advisory					Jan-23

				Summary of Recommendations				
Review	**Year**	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
New VCC Integrated Audit and Assurance Plan:								
Enabling Works Security Contract	22/23	Final Report	Advisory					Jul-22

				Summary of Recommendations				
Review	**Year**	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
Enabling Works (deferred from 21/22)	22/23	Final Report	Reasonable	0	2	4	6	Oct-22
Enabling Works	22/23	Fieldwork						
MIM Contract Management	22/23	Final Report	Limited	1	0	0	0	Jan-23
MIM Design & Change Management	22/23	Planning						
MIM Approvals	22/23	Not Started						
MIM Planning	22/23	Not Started						
MIM Procurement	22/23	Not Started						
Validation of Management Actions	22/23	Not Started						
Total				**3**	**18**	**23**	**44**	
Final Report				**2**	**12**	**12**	**26**	
Draft Report				**1**	**6**	**11**	**18**	

2.2.3 Work undertaken by Management / Officer leads to complete actions since the October '22 Audit Committee has resulted in 11 Internal Audit actions being completed which are recommended to the Audit Committee for closure.

2.2.4 The table below provides a summary of the movement in total internal audit actions from October '22 to January '23 Audit Committee:

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
October '22 Audit Committee					
Total Outstanding Actions	63	5 [1]	35	20	3
Less: Completed Actions (Green) – Agreed to close (Changed to Blue)	(21)	(4)	(9)	(5)	(3)
January '23 Audit Committee	42	1	26	15	0
Add: Total Actions from new reports	14	0	6	8	0
Total Outstanding Actions @ January '23	**56**	**1**	**32**	**23**	**0**
Completed Actions (Green) - propose close (Blue)	11	0	4	7	0

[1] x1 Orange status action added to Oct '22 Audit Committee table in error

2.2.5 The tables below provide a summary of the audit action status position reported at the October '22 Audit Committee to provide an indication of the changes in Actions from September '22 to December '22.

September '22 – Internal Audit

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

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
High	6	1	1			4	
Medium	35	8	9	9	2	7	44
Low	20	6	7	2	2	3	27
N/A (Advisory Audit)	3					3	7
Total	**64**	**15**	**17**	**11**	**4**	**17**	78
%	**100%**	**23%**	**27%**	**17%**	**6%**	**27%**	**N/A**

Action Status by Executive / Director Lead

Executive Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Executive Director of Finance	11	4	2	1		4	36
Director of Strategic Transformation, Planning & Digital	4				1	3	13

Executive Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Director of Governance & Chief of Staff	19	4	15				1
Director of Nursing, AHPs & Health Science	0						1
Director of OD and Workforce	9	2		3	1	3	4
Chief Operating Officer	2				1	1	20
TCS nVCC Project Director	10			7		3	
Executive Director of Finance and Chief Operating Officer	2				1	1	
Chief Operating Officer and Director of Governance & Chief of Staff	7	5				2	3
Total	**64**	**15**	**17**	**11**	**4**	**17**	78

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

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

December '22 – Internal Audit

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports	1	2	5	17	**25**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE	0	1	2	53	**56**

Action Status by Prioritisation Timescale

Priority	Total	Implement ation date passed - Action not complet	Action not on target for completio n by agreed date	Action on target to be completed by agreed date	Action complete December 2022	Action complete November 2022	Action complet e October 2022	Closed
High	1			1				5
Medium	32	2		26	1	3		52
Low	23			16		3	4	32
N/A (Advisory Audit)	0							10
Total (Blue Status Actions)	**56**	**2**	**0**	**43**	**1**	**6**	**4**	99
% (Blue Status Actions)	**100%**	**4%**	**0%**	**76%**	**2%**	**11%**	**7%**	**N/A**

Action Status by Executive / Director Lead

Executive Lead	Total	Implementation date passed - Action not	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete December 2022	Action complete November 2022	Action complete October 2022	Closed
Executive Director of Finance	15	2		6	1	4	2	44
Director of Strategic Transformation, Planning & Digital	0							17
Director of Governance & Chief of Staff	19			19				1
Director of Nursing, AHPs & Health Science	0							1
Director of OD and Workforce	4			4				4
Chief Operating Officer	0							22
TCS nVCC Project Director	13			12			1	3
Executive Director of Finance and Chief Operating Officer	0							2
Chief Operating Officer and	5			2		2	1	5
Total	**56**	**2**	**0**	**43**	**1**	**6**	**4**	99

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

Priority	2021/22	Total
High		
Medium	2	2
Low		
N/A (Advisory Audit)		
Total	**2**	**2**

2.2.6 There are 2 actions (4%) for which the implementation date has passed and management action is not complete (Red).

2.2.7 There are 11 actions (20%) since the October '22 Audit Committee that have been completed. The January '23 Audit Committee will be asked for agreement to close these actions.

2.2.8 There are 43 actions (76%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.3 External Audit Actions Analysis

2.3.1 Management / Officer leads have completed 6 further actions since the October '22 Audit Committee which are recommended for closure.

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

September '22 – External Audit

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

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

Action Status by Prioritisation Timescale

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

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete September 2022	Action complete August 2022	Closed
Executive Director of Finance	7			2	1	3	1
Director of Governance & Chief of Staff (Change from August '22 as 2 Actions were with the COO below)	14	9				5	
Director of OD and Workforce	6				1	5	
Chief Operating Officer	2				1	1	
Total	**29**	**9**	**0**	**2**	**3**	**14**	**1**

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

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

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

2.3.4 2 actions (8%) are identified as action on target (yellow) and 17 actions (58%) are identified as compete (Green). The October '22 Audit Committee is asked to formally close these actions.

December '22 – External Audit

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

Priority	2019/20	2021/22	Total
No. of Audit Reports	1	3	**4**
No. of Actions Outstanding i.e. not yet agreed by Audit Committee to CLOSE	2	9	**11***

* 29 in Oct Audit Committee Report minus 17 closed @ Oct Audit Committee minus 1 as total in Oct report incorrectly included x1 Blue status action

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 November 2022	Action complete October 2022	Closed
High	1				1		2
Medium	2			2			1
Low	0						2
N/A (Advisory Audit)	8			3		5	13
Total	**11**	**0**	**0**	**5**	**1**	**5**	**18**
%	**100%**	**0%**	**0%**	**45.3%**	**9.3%**	**45.4%**	**N/A**

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 November 2022	Action complete October 2022	Closed
Executive Director of Finance	2			1	1		5
Director of Governance & Chief of Staff	9			4		5	5
Director of OD and Workforce	0						6
Chief Operating Officer	0						2
Total	**11**	**0**	**0**	**5**	**1**	**5**	**18**

2.3.5 No External audits have been added since the October '22 Audit Committee.

2.3.6 There are no actions for which the implementation date has passed and management action is not complete (Red).

2.3.7 5 actions (45.3%) are identified as action on target (yellow) and 6 actions (54.7%) are identified as compete (Green). The Audit Committee will be asked to formally close these complete (Green) actions

2.4 Summary of the position as of 12 January 2023:

- 21 Internal Audit Report actions and 18 External Audit report actions were closed (Blue Status) following the October '22 Audit Committee.
- 11 (20%) Internal Audit Report actions and 6 (54.7%) External Audit Report actions have been completed **(Green Status)**.
- 43 (76%) Internal Audit and 5 (45.3%) External Audit report actions are on target for completion by the agreed date **(Yellow Status).**
- 2 Internal Audit report action and no External Audit report actions that have passed their agreed implementation date (**Red Status**).

3. IMPACT ASSESSMENT

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

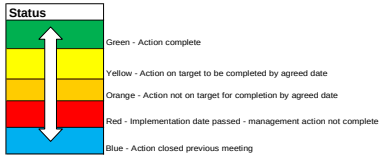
4. RECOMMENDATION

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

4.2 11 Internal Audit report actions (20%) and 6 External Audit report actions (54.7%) have been completed since the October '22 Audit Committee **(Green Status).** The Committee is asked to **APPROVE** closure of these actions. If agreed these actions will be formally Closed **(Blue Status).**

4.3 2 Internal Audit report actions (4%) have passed the agreed implementation date **(Red Status)** which the Executive / Director lead has asked for agreement to a revised extension date. The Committee is asked to **APPROVE** the extension dates identified.

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Final Internal Audit Report 2020/2021 New Velindre Cancer				Assurance Rating: Substantial			Date received at Audit Committee: 08 July 2021							
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for October 2021 Committee	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Requested Extension Date
2	Succession planning for vacant posts should be considered in readiness for the next stage of the project (O).	Low	Agreed. The Project reviews organisational structures for each phase of the EW and nVCC Project(s). If any post becomes vacant, the Project(s) will review the requirements of the Project(s) and a decision on recruitment is made. In addition, the Project Director will consider internal staff development opportunities as part of the review.	David Powell, Project Director	David Powell, Project Director	Ongoing	Complete	The project were subject to an Organisational Change Process which concluded on 6th August 2021. Existing project staff secured roles in the next phases of both projects and vacant posts (structure was approved by the Trust Board on 19th April 2021)are being recruited into. Developmental opportunities have been / will contine to be identiied for existing project staff to ensure, staff development, continuity and succession planning are in place at all times	David Powell Update: We have continued the process of internal development/growing the talent within the team such that we can promote into vacancies should they arise during the project. Andrew Davies Update: This approach is still current. The nVCC Project is in the process of filling the remaining posts that were approved by Trust Board on 19th April 2021 and were outstanding post OCP. The project promotes developmental opportunities which has been successful in not only recruiting staff but also the retention of these staff members. This will continue	David Powell Update: The internal development process is on-going with all staff getting opportunities to get exposure to the Competitive Dialogue sessions in order to broaden understanding and knowledge.				Update October 2022: Closed this recommendation within the 2021/22 MIM Governance report (issued February 2022) so can be closed on the tracker. The following narrative was reported: From Internal Audit attendance at the Project Board meetings, it is recognised that there has been a recruitment campaign to appoint into vacant posts, with some appointments having been made. However, it is also noted that some posts (i.e. Digital) have been difficult to appoint to; but that steps are being taken for discussions with recruitment agencies, as well as the standard NHS jobs application route, to continue to look for appropriate candidates. Conclusion: Closed, recognising that whilst the requirements of the recommendation have been addressed by the Trust, the successful appointment of individuals into the vacant posts remains an ongoing process.	Update October 2022: Closed this recommendation within the 2021/22 MIM Governance report (issued February 2022) so can be closed on the tracker. The following narrative was reported: From Internal Audit attendance at the Project Board meetings, it is recognised that there has been a recruitment campaign to appoint into vacant posts, with some appointments having been made. However, it is also noted that some posts (i.e. Digital) have been difficult to appoint to; but that steps are being taken for discussions with recruitment agencies, as well as the standard NHS jobs application route, to continue to look for appropriate candidates. Conclusion: Closed, recognising that whilst the requirements of the recommendation have been addressed by the Trust, the successful appointment of individuals into the vacant posts remains an ongoing process.

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

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

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
	New Risk Management Framework (Design). 1.1 a. The Trust should • publish the new Risk Management Framework and supporting documents on its intranet as soon as possible; and • ensure the divisions are aware of the new Framework and its application in practice (see also matter arising 2). o	Low	1.1a Recommendation agreed	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear Director of Corporate Governance, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extention to 30 June 2022 requested. November 2022 out of Commiteee Extention agreed: 31 January 2023.	On Target	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subjct to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over reaminder of July. Level 1 training will then follow in August.		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.				
	1.1 b. Divisional management should: • ensure local risk management procedures are updated to reflect the new Framework; and • ensure all relevant staff are aware of the updated procedures.	Low	1.1 b. Divisional response: • WBS: This is an established and documented process at WBS. The audit trail will be kept in Q-Pulse. •	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Extention to 30 June 2022 requested.	Action Closed	Relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Aligned Trust and WBS agreed and reflected in May Executive Management Board Risk paper	The training has been drafted and is due for approval by 24/06/2022 and delivery to managers by 10 July 2022.	Action completed. All documentation updates completed by July 17th with updated documents issued via Q-pulse with associated training records. Cutover from Datix v12/14 to Datix v14 commenced on July 22nd.	n/a	n/a		n/a	n/a
		Low	– The Quality & Safety Team is in the process of developing a divisional Standard Operating Procedure to align with the Trust Risk Management Framework. Once completed, this will be shared with Directorate leads for review and comment before review and sign off by the VCC Senior Leadership Team. The updated SOP will then be widely circulated to all relevant staff.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Tracey Langford VCC Quality & Safety Officer	October 2021 Update May 2022: Extention to 30 June 2022 requested. Extension requested to August 2022. Extension requested to November 2022. November 2022 out of Commiteee Extention agreed: 30 November 2022.	Complete	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.**	The SOP will be produced once the Revised Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales. **Extension requested to November 2022.**	The SOP is currently being produced and will be finalised once the new Risk Management Policy has been approved by Trust Board and received by VCC Q+S team. The date has been changed to reflect the new timescales. Extension requested to November 2022 Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	**Action Complete.** Following the approval of the Trust risk policy and procedures it has become apparent that the development of a SOP for VCC is not required and is deemed to be duplication of effort, therefore this action can be closed on the basis that the SOP is no longer required.			
	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. o	Medium	2.1 a. Recommendation agreed	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	October 2021 Update May 2022: Extention to 30 June 2022 requested. November 2022 out of Commiteee Extention agreed: 31 January 2023.	On Target	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subject to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over remainder of July. Level 1 training will then follow in August.		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.				
	2.1 b. Divisional management should ensure that attendance at risk management training is monitored at appropriate forums.	Medium	2.1 b. Divisional response: • WBS: WBS Divisional Management will support the roll out of training once finalised and will capture all records of attendance for audit purposes.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Action Closed	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session.	DATIX form complete. Policy drafted and with Executives for sign off. Training due for delivery to managers 10 July 2022.	Action completed. Training on new policy delivered to all managers by July 17th. Records of attendance are available for audit.	n/a	n/a		n/a	n/a

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable		Date Received at Audit Committee: 14 October 2021									
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
		Medium	2.1 b.• VCC: − The training on the new risk management programme, including training materials, is currently in development and due to be finalised by 5th October 2021. − Training will be made available to all directorates and training compliance will be captured and monitored by Directorate leads and regularly reviewed by at the VCC Quality & Safety Management Group as an assurance measure. − The Senior Leadership Team will monitor training compliance by exception.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen VCC Quality & Safety Manager	October 2021 Update May 2022: Extention to 30 June 2022 requested. Extension requested to August 2022. Extension requested to November 2022. November 2022 out of Commiteee Extention agreed: 30 November 2022.	On Target	The SOP will be produced once the Trust Risk Policy and Training Documents are received. The date has been changed to reflect the new timescales.,	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	VCC are waiting for Trust to confirm the training materials/guides. **Extension requested to August 2022.**	VCC are waiting for Trust to confirm the training materials/guides. **Extension requested to November 2022.**	VCC SLT due Level 2 training on 29th September 2022. Names being sought from SLT for senior colleagues that also require Level 2 training to arrange. All other staff will receive Level 1 trainig via e-learning which is not currently available. Extension requested to November 2022 for Level2 training to be completed. Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	Level 2 training was delivered to VCC SLT on 29th September 2022. Level 2 training sessions have been booked to deliver training to VCC senior staff from each Directorate. Dates are 14th November, 18th November and 8th December. First session was well attended. Level 1 training via e-learning for all other staff is currently not available. Awaiting Level 1 Training e-learning is the only element needed to complete this action.			
	Consistency of approach to risk mangement (Design). 3.1 a. The Trust should implement a mechanism to ensure risk management practice is consistent between the divisions and good practice can be shared. 3.1 b. The Trust should ensure that WBS follows the risk scoring system set out in the Risk Management Framework when reporting to the Board and its Committees.	Low	3.1 Trust response: a & b Recommendation agreed.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extention to 30 June 2022 requested. November 2022 out of Commiteee Extention agreed: 31 January 2023.	On Target	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	New Risk Management Policy and Corporate Level Procedure needed to be completed before training could commence. During the period the Policy and Procedure have been finalised and the Policy endorsed by Executive Management Board (EMB) for Trust Board approval, subject to Audit Committee's Assurance in July meeting. Level 2 and Level 3 training commenced following the EMB endorsement. Currently over 100 staff trained, over 7 sessions to date with the remainder booked in or being confirming for booking over remainder of July. Level 1 training will then follow in August.		Work has been undertaken that will combernate in a Workshop on the 13 October 2022. Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.				
		Low	WBS: a. The WBS Risk Management Team is engaged with the Corporate Governance team to agree an approach to risk management practice that meets the specific regulatory needs of WBS and can be applied consistently across the Trust.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance& Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extention to 30 June 2022 requested.	Action Closed	Recommended by March 2022 - as relates to training content being finalised so that content avaiable to staff all aligned at each source. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	**Complete.** The Policy is with EMB for approval and training is due to be delivered by 10 July 2022.	n/a	n/a	n/a		n/a	n/a
		Low	VCC: a. Further discussions needed with Trust Risk Management leads and in turn, Senior Leadership teams of VCC and WBS to agree consistent approach to risk management and sharing of good practice	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance	Lauren Fear, Director of Corporate Governance& Chief of Staff / Paul Wilkins, Interim Director of VCC / Alan Prosser, Director of WBS	October 2021 Update May 2022: Extention to 30 June 2022 requested. **Requesting extention to September 2022.** **Requesting extention to November 2022.**	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	A Workshop with representative from both divisions and corporate services is planned for late July 2022. **Requesting extention to September 2022.**	VCC - A Workshop with representative from both divisions and corporate services is planned for late July 2022. **Requesting extention to November 2022.** WBS Update: The trust-wide process for managing risks has now been agreed and incorporated into revised SOPs at Welsh Blood. WBS team are supporting roll-out of training across both divisions and the corporate team to assure a consistent approach.	Work has been undertaken that will combernate in a Workshop on the 13 October 2022. Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	Closed October 2022: Meeting was held on the 13 October 2022 with representatives from the Divisions and all Corporate Services that identified a range of ways of working to enable consistency and sharing of best practice.		Closed October 2022: Meeting was held on the 13 October 2022 with representatives from the Divisions and all Corporate Services that identified a range of ways of working to enable consistency and sharing of best practice.	n/a

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021								
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
	Scrutiny of Directorate Risk Registers (Operation). 4.1 a. The Divisional Management Teams should ensure directorate risk registers are monitored and scrutinised frequently at directorate meetings and that meeting minutes evidence this process. 4.1 b. Whilst we appreciate the challenges of the Covid-19 pandemic, the Trust should ensure that it always appropriately evidences governance processes at all levels of the organisation. This requirement should be communicated to the divisions and directorates.	Medium	4.1a WBS response: a. WBS will introduce a review of open risks consistently across all departmental OSG meetings. b. N/A – VCC action only.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	December 2021 Update May 2022: Extention to 30 June 2022 requested. November 2022 out of Commiteee Extention agreed: 30 November 2022.	Complete	Recommended by March 2022. Timeline also reflects current service pressues	Datix form completed. Policy drafted and being finalised for with Divisions. Both dependencies for the training being able to be finalised and rolled out. To complete by end June 2022 Board training scheduled as part of Board Development June session. Extension Requested to 19 July 2022	Whilst open risks are shared in OSG meetings, following the training on the new policy further consideration will be given to how these open risks are reveiewed in a consistent manor and this will be taken forward in line with 3.1a. This will be implemented following delivery of training week commencing 13 July 2022.	Training on the new VUNHST Risk policy has been completed and migration of risks to Datix v14 is now underway with completion of migration due by the end of September 2022. Dashboard development will take place in parallel with migration to support reporting into OSG meetings from October onwards. Anticipate this action being closed before the December Audit committee meeting.	Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.	Migration of high scoring (12 and above) risks complete, all other risks on target for transfer by end of November 2022.			
		Medium	4.1 a & b. Risk registers will be added as a standing agenda item on all directorate meetings. Minutes will capture discussions had regarding risk.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	All Directorate leads	Oct-21	Action Closed	VCC - Risk registers are being reviewed by each Directorate. This has now been completed and directorates have now been set up. This action is complete.	n/a - Complete January 2022	n/a - Complete January 2022	n/a	n/a	n/a		n/a	n/a
		Medium	4.1 a & b. Governance processes for risk management to be standardised across the divisions and directorates providing assurance to the Quality & Safety Management Group. Modify and set up within Datix to enable dashboards to be produced by directorates	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen, VCC Quality & Safety Manager Sarah Owen, VCC Quality & Safety Manager	October 2021 **Recommended March 2022** **February 2022**	Action Closed	VCC governance processes are in place. The risk registers are discussed at departmental level, where they are scruitnised. Any for escalation will be received and discussed at the VCC Quality & Safety Management Group. For Corporate and WBS - Recommended by March 2022 Timeline also reflects current service pressures The Q&S Team have been set up on datix to have the ability to push dashboards out to departments. This action is now closed.	n/a - Complete January 2022	n/a - Complete January 2022	n/a	n/a	n/a		n/a	n/a

Audit Action Plan

Status

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements | **Assurance Rating: N/A** | **Date Received at Audit Committee: 11 January 2022**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Exhibit 1: 2021 Recommendations	**Transparency of Board business** R1 Some committee meeting papers are missing from the website, as are links to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign off and timely publication of: • committee meeting papers; and • recordings of Board meetings.		The Corporate Governance team have introduced a new end to end Board Committee tracker, to strengthen and tighten the process for effective management of Trust Board and Committee meetings and papers.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Action Closed	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	n/a		n/a	n/a
Exhibit 1: 2021 Recommendations			A review of the website content has been completed and all missing content has been added	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Action Closed	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	n/a		n/a	n/a
Exhibit 1: 2021 Recommendations			All of the Corporate Governance team are to be trained to upload papers directly on the Trust website to further increase resilience.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	March 2022 November 2022 out of Commiteee Extention agreed: 31 January 2023.	On Target	n/a	n/a		Project scope of 20 projects under the Governance, Risk and Assurance workstream have been agreed. This action fits withing first proprity of work - to be completed by December 2022.				
Exhibit 1: 2021 Recommendations			An error led to the deletion of the June 2021 Board meeting recording. A governance note to explain the missing recording was added to the minutes of the July 2021 Board meeting. On the website, the links to the Board meeting recordings were updated to make clear the June 2021 recording is unavailable.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Action Closed	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	n/a		n/a	n/a
Exhibit 1: 2021 Recommendations	**Articulation of strategic priorities** R2 Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.		We recognise that there are differences in the granularity of the information provided by the service divisions, which in some cases is due to the different type of strategic priority, however, we acknowledge that there are improvements to be made including the identification of timelines and this will be included in the Integrated Medium Term Plan 2022-25.	Cath O'Brien, Chief Operating Officer	Cath O'Brien, Chief Operating Officer and Carl James, Director of Strategic Transformation Planning and Digital	March 2022	Action Closed	n/a	n/a		All of the objectives within the IMTP are SMART. The Trust strategy 'Destination 2032' and supporting strategies agreed in May 2022 will further enhance the solidification of strategic priorities supported by SMART objectives	n/a		n/a	n/a
Exhibit 2: progress made on previous year recommendations	**Transparency of Board business 2018** R1 The Trust publishes agendas for public committee meetings in advance of meetings, but not the full set of papers. The Trust should publish all committee papers in advance of public meetings.		Superseded We have made a new recommendation that the Trust should ensure that it strengthens the process for the collation, sign off and publication of committee meeting papers in advance of meetings, and unconfirmed minutes added shortly after meetings. See 2021 Recommendation 1.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	N/A	Action Closed	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	n/a		n/a	n/a

Audit Action Plan

Velindre UNHS Trust

Status

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

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

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

External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A		Date Received at Audit Committee: 11 January 2022							
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Exhibit 3: progress made on previous year recommendations	Closing capacity and capability gaps 2018 R8 The Trust should prioritise a review of support services in the two divisions to identify areas that could be integrated to reduce the duplication of effort, increase organisational learning and to inform plans to address capacity and capability gaps.		Complete The Trust has aligned some business support functions where similar services are provided by separate teams within the two divisions. The Trust told us that aligning support functions has enabled it to work more efficiently and ensure organisational learning across the divisions.	Cath O'Brien, Chief Operating Officer	Cath O'Brien, Chief Operating Officer		Action Closed	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a				
Exhibit 4: progress made on previous year recommendatio	**Monitoring delivery of strategic priorities 2019** R3 The Board should agree the information it requires to support its scrutiny of progress made to deliver all strategic priorities (and supporting actions) set out in the Integrated Medium Term Plan. Information should include as a minimum, progress to date and, where milestones are not met, resulting remedial actions.		Complete The Board has agreed the information need to scrutinise delivery of strategic priorities, and reviews progress on a quarterly basis.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	N/A	Action Closed	n/a	n/a	Complete on May 2022 Audit Committee Report	n/a	n/a		n/a	n/a
Exhibit 5: progress made on previous year recommendatio	Risk management 2016 R7c The Trust should standardise the format of its various risk registers, ensuring the good practice elements of each register are spread across the organisation.		In progress (overdue) The Trust is reviewing all operational risks. Risk registers will be migrated to a new version of DATIX. The Trust has developed a standardised approach to reporting and escalating risks Trust-wide.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2022 out of Commiteee Extention agreed: 31 January 2023.	On Target	N/A	N/A		Policy signed off - training to complete by December for all level 1. Level 3 and the majority of level 2 is complete.				

Audit Action Plan

Velindre UNHS Trust

Status

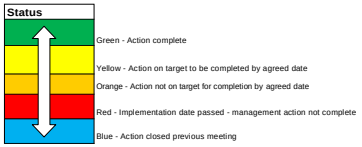
- Green - Action complete
- Yellow - Action on target to be completed by agreed date
- Orange - Action not on target for completion by agreed date
- Red - Implementation date passed - management action not complete
- Blue - Action closed previous meeting

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

* Unless a more appropriate timescale is identified / agreed

External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022								
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Exhibit 5: progress made on previous year recommendatio	Board assurance and risk management 2019 R2 The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up to date risk management arrangements. Specifically, the Trust should ▪ review the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; ▪ update the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and ▪ provide risk management training to staff and Board members on resulting changes to the risk management framework.		In progress (overdue) The Board Assurance Framework template and key strategic priorities are complete. Key controls and sources of assurance are being developed. The aim is for the Board Assurance Framework to be operationalised in September 2021. Work on the Risk Management Framework and Risk Appetite is complete. Work on operational risks and risk registers is ongoing, with the aim of completion by the September 2021 Board meeting. Risk management training for staff has been developed and due for roll out later in 2021.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2022 out of Commiteee Extention agreed: 31 January 2023.	On Target	N/A	N/A		Policy signed off - training to complete by December for all level 1. Level 3 and the majority of level 2 is complete.				
Exhibit 6: progress made on previous year recommendations	Tracking Internal and External audit recommendations 2018 R4b Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close the action.		No progress (overdue) No progress has been made on this recommendation.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		DoF led on improvements to format and process for action tracking with new Procedure completed	Closed in October 2022.		n/a	n/a
Exhibit 7: progress ma	Clinical audit scrutiny 2018 R5a The Quality and Safety Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	Closed in October 2022.		n/a	n/a
Exhibit 7: progress made	Clinical audit scrutiny 2018 R5b Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	Closed in October 2022.		n/a	n/a
Exhibit 7: progr	Clinical audit scrutiny The Quality and Safety Committee should assure itself that clinical audit findings are addressed.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	Closed in October 2022.		n/a	n/a
Exhibit 7: progr	2018 R5d Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff		Complete	n/a	n/a		Closed - actioned via Medicial Director for QSPC	Closed in October 2022.			

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Extension (Months)	Extension (Months)
Matter arising 1	**Matter arising 1: Late payment of invoices (Operation)** 1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary;	Medium	1.1 a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Matthew Bunce, Executive Director of Finance	N/A	Complete	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 1	1.1 The Trust should: b. liaise with NWSSP Procurement Services and Accounts Payable to understand: i. why such late fees are being charged by BT; and why they have signed agreements that they cannot deliver on; ii. how late fees are accounted for (i.e., are they coded to an appropriate loss account in Oracle); and iii. what the wider performance monitoring and accountability mechanisms are to ensure invoices are paid by their due dates (when this is less than 30 days) and to monitor the level of late payment fees	Medium	b. The recommendation is accepted. Will liaise with NWSSP Accounts Payable to review and understand as per the recommendations and implement as necessary. 31/07/2022	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/07/2022 November 2022 out of Committeee Extention agreed: 31 December 2022.	Overdue	In process. The telephone lines are currently under review with an option to migrate service onto the SIP circuit.	This is currently still in process with additional work required to migrate service which will remove any potential charges from BT, and expectation that overall costs of the service will be reduced. The initial implication date did not consider a complete review of the service which explains the reason for the delay in implementation.	W ork still ongoing with Digital colleagues. Implementation requires additional work not initially anticipated. Extenstion requested until end of December.	The procurement process has started with implementation expected before the end of the financial year In the meantime BT have been contacted to negotiate a payment term in order to align with the Trust 30 day policy, however this was rejected. The Trust will continue to work with AP colleagues in order to improve performance during the period up until implementation.	Latest update remains the same as November where Capital funding has been allocated to support implementation of the SIP circuit with Digital colleagues progressing. In the meantime the Trust continues to work with AP colleagues to try and improve performance.	28 February 2022	7 months
Matter arising 2	Matter arising 2: Exception reporting (Operation) 2.1 The Finance team should: a. undertake a formal, documented monthly review of the exception reports, even if no specific matters are identified through the informal weekly reviews;	Medium	2.1 a. The recommendation is accepted. The Divisions will undertake a more formal review which will be signed off by a senior finance business partner. The review will be put in place by the target date.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	**Complete** - The Divisional Finance Teams operate a monthly review of reports, the formal sign off has been established from Q1 2022.	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 2	2.1 The Finance team should: b. take action to address the aged items on the exception reports; and	Medium	2.1 b. The recommendation is accepted. Discussion will take place amongst the Senior Finance Team to agree action to be taken on aged invoices to address the immediate issue and long-term approach which will form part of the review process under item 2.1.a	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	**Complete -** SFT has requested a T&F Group to review causation of aged items and establish an action plan for improvement. T&F Group met in May and June 2022, with feedback to be discussed at July Financial Management Meeting	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 2	2.1 The Finance team should: c. formally monitor progress in clearing aged items at an appropriate forum to ensure action is effectively implemented	Medium	c. The recommendation is accepted. This will be added to the standard agenda of the Financial management meeting under PSPP.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	**Complete -** PSPP is a standard agenda item, on the Financial Management Meeting, supported by the T&F Group for improvements	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 3	Matter arising 3: Authorisation of proforma invoices (Operation) 3.1 The Trust should: a. remind its authorised signatories only to approve proforma invoices for payment under appropriate circumstances; and	Low	3.1 a. The recommendation is accepted. A reminder will be issued to all staff.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	28/02/2022	Action Closed	A Financial Guidance note in this respect has been developed and was shared with all Trust staff via the Trust newsletter issued on 22/06/2022. It is therefore requested that these actions are **COMPLETED**. To support this work, in addition, Finance Business Partners will highlight this to budget holders via emails / meetings as appropriate.	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 3	3.1 b. consider producing documented guidance on authorisation of proforma invoices.	Low	b. The recommendation is accepted. Consideration will be given to producing documented guidance on authorisation of proforma invoices.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Action Closed		n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 3	3.2 The Finance team should investigate the specific circumstances of the exception noted in our testing (details have Low been provided) to understand: a. whether a duplicate payment has been made;	Low	3.2 a. The recommendation is accepted. The item has been investigated and no duplicate payment made.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 3	3.2 b. whether the goods were received; and	Low	b. The recommendation is accepted. The item has been investigated and goods received.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Extension (Months)	Extension (Months)
Matter arising 3	3.2 c. why the proforma was authorised for payment, liaising with NWSSP Accounts Payable if necessary.	Low	c. The recommendation is accepted. NWSSP has advised that this specific supplier operates a cash account requiring payment against estimate before items are released. Practice is not local to the Trust and NWSSP would be required to undertake any further actions in particular ensuring the process for this supplier (and any other suppliers operating cash accounts requiring payment against estimate) is incorporated into any existing documented guidance in place or developed for proforma invoices.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 4	Matter arising 4: Compliance with Fixed Assets FCP (Operating effectiveness) 4.1 The Finance team should remind the divisions of the requirement to complete, approve and submit asset disposal forms prior to asset disposal, not least to ensure value for money is obtained from assets' residual values.	Medium	4.1 The recommendation is accepted. Reminders will be provided at the Capital Planning Group and Divisional Business Planning Group meetings.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed	**Complete -** This was discussed at the Capital planning group. Capital team are also now emailing out to the Divisional capital leads as part of month end closedown querying if there are any disposals within month.	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 4	4.2 a. The Trust should update its Fixed Assets FCP to: – reflect actual practice regarding maintenance of the FAR, capital ledgers and AUC and the related reconciliations to the general ledger; and – incorporate the asset verification coverage target of 80%.	Medium	4.2 a. The recommendation is accepted and the FCP will be updated.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed	**Complete -** FCP has been updated per recommendation and is currently going through due process for final approval by audit committee.	n/a	n/a	n/a	n/a	n/a	n/a
Matter arising 4	4.2 b. The Audit Committee should approve the updated FCP.	Medium	4.2 b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee. .	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	31/05/2022 November 2022 out of Commiteee Extention agreed: 26 January 2023.	On Target	The FCP is currently going through the due process for final approval by audit committee.	FCP has been circulated to Capital Planning group and will go to next audit committee in October for final approval.	Following feedback work is ongoing to fully review and update the Captial FCP to fully align with other Capital Procedures, manual of accounts and Trust SO SFIs. Will now require approval at next Audit committee which is not until January following EMB approval.	FCP is currently on hold until the TOR are agreed for the new Capital strategic board which is currently being created. Will still be working to previously agreed extension timeline.	FCP still on hold until TOR are agreed for now Capital Strategic Board. Still working to agreed extension deadline.		
Previous Matter arising 1	Previous Matter arising 1: Pursuance of Private Patient (PP) debts (Operating effectiveness) 1.1 a. We concur with the actions taken by the Trust to address the aged Private Patient debt balance. The Trust should maintain its focus on this area through formal continuous monitoring, including reporting to Audit Committee until an acceptable position is reached.	Medium	1.1 a. The recommendation is accepted. A detailed aged debt position has been documented, with monitoring arrangements in place including the status of each debt line and the outcome of actions taken to-date. A standard report will be developed for continuous monitoring by the VCC SMT and EMB and reported to the Audit Committee detailing the position and progress made until the Audit Committee agree they have assurance that private patient debt management is acceptable.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	31/05/2022	Action Closed	20.06.22 A report template has been submitted and approved by the Audit Committee to support on-going monitoring arrangements of the Private Patient Debt position. The report is submitted to the VCC SLT via the Operational Delivery Directorate Highlight Report.	16.08.22 An Aged Debt Report template has been approved by the Audit Committee. This Report is submitted to the VCC Private Patient Management Group, VCC Senior Leadership Team and the Trust Audit Committee. Good progress has been made and acknowledged. Regular reporting and monitoring to continue.	15.09.22 Standard Report, which includes agreed KPIs has been developed to monitor the aged debt position. This Report is included as part of the regular reporting cycle to the Private Patient Management Group, VCC Senior Leadership Team and Audit Committee. Standard Operating Procedures are in place and significant aged debt reduction has been achieved. Healthcode, electronic billing/incoiving solution (Insurance Companies) introduced 15.09.22. The timeline for payment of	n/a	n/a	n/a	n/a
Previous Matter arising 1	1.1 b. To support reporting on Private Patient aged debt, the Trust should consider identifying formal key performance indicators with clear targets, for example: • split of debt between self-payers and insured; • percentage of aged amounts vs total debt; • percentage of debt recovered vs total debt (with a similar sub-metric for aged debts); • maximum accepted level for Private Patient aged debts (by percentage and / or value) and monitoring performance against this at an appropriate forum to ensure accountability.	Medium	b. The recommendation is accepted. Key performance indicators are being collated from a patient and financial perspective and the measures identified within this recommendation will be considered and presented to VCC SMT and then EMB for formal approval / sign off.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	30/04/2022	Action Closed	20.06.22 The Audit Committee are asked to agree an extension of the delivery date to the 31st August 2022. A report template has been developed which details the debt position against private patient classifications, the movement between each month and the position against key performance indicators. The report will be presented to the VCC SLT	16.08.22 Aged debt key performance indicators have been drafted and approved by the Trust Audit Committee. These indicators are included within the Aged Debt Report submitted and monitored by the VCC Private Patient Management Group, VCC Senior Leadership Team and the Trust Audit Committee.	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022							
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Extension (Months)	Extension (Months)
Previous Matter arising 2	Previous matter arising 2: Unallocated and Unidentified Receipts (Operating effectiveness) 2.1 a. The Trust should: i. discuss the aged unallocated/unidentified receipts position with Counter Fraud, Audit W ales and W elsh Government to understand their view on how this balance should be addressed; and ii. based on the above discussions, take appropriate action to address the aged unallocated/unidentified receipts balance.	Medium	2.1 a. The recommendation is accepted. Discussions will take place with relevant parties and appropriate action taken. Due to the upcoming year end, it is likely that Audit W ales and W elsh Government will wish to prioritise discussions on that, and the target date is therefore reflective of that.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	30/06/2022 **Extension requested to 30/09/2022** **Extension requested to 30/11/2022.** November 2022 out of Commiteee Extention agreed: 30 November 2022.	Complete	Counter Fraud have advised that they would not get involved with this as there is no false representation, no failure to disclose information, no abuse of position, and no financial gain to individuals. A view from Audit Wales has been sought and is awaited. W elsh Government will then be asked for their view. **An extension to 30/09/2022 is requested to enable conversations to take place and conclude, and then agreed action taken.**	Audit W ales have confirmed that if all reasonable efforts have been exhausted, they can't foresee any issues in the values being written back, as long as records are held in case of future queries. W elsh Government have confirmed that they are content to agree with the advice of both Counter Fraud and Audit W ales.	W ork is now underway to review the appropriate action needed to clear the aged receipts. **Extension requested to 30/11/2022.**	W ork is continuing but has stalled due to staff vacancies and the need to prioritise debt collection activities. Extension requested to 31 January 2023 to complete the action.	Senior Finance team (SFT) agreed that credits should not be cleared without review. Will continue to be reviewed on a low priority basis given that these are credits given to us by organisations / individuals rather than debts owed to us. SFT direction to team is still to prioritise debt collection. **Request to close action and treat as business as usual low priority task.**		
Previous Matter arising 2	2.1 b. We concur with the Finance team's intention to increase the frequency of its Long Term Agreement reconciliation. We recommend that the Finance team should undertake this review at monthly to support and ensure aged unallocated and unidentified receipts balances are reduced to a minimum level, ensuring the review is documented, and evidenced.	Medium	b. The recommendation is accepted. Monthly reconciliations of LTA money due and received are now standard practice.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	Complete on May 2022 Committee Audit Report Action Taken: Monthly reconciliations of LTA money due and received are now standard practice	n/a	n/a	n/a	n/a	n/a	n/a
Previous Matter arising 2	c. The Trust should ensure the SOP for Private Patients unallocated and unidentified receipts is approved at an appropriate forum (e.g., by the Audit Committee).	Medium	c. The recommendation is accepted. A Departmental SOP has been drafted for the management of unallocated and unidentified receipts, with significant work undertaken to date resulting in a reduction in the reported aged debt position. The SOP will be submitted for approval to the Audit Committee.	Cath O'Brien, Chief Operating Officer	Ann-Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Service	30/04/2022	Action Closed	15.06.22 SOP drafted in readiness for submission to the Private Patient Operational Management Group, scheduled for 06.07.22.	16.08.22 SOP submitted to the VCC Private Patient Management Group for comment on 06.07.22 and formally approved by the Group on 03.08.22.	n/a	n/a	n/a	n/a	n/a
Previous Matter arising 3	Previous matter arising 3: Management of Aged Debts (Operating effectiveness) 3.1 We concur with the Trust's continued focus on general and charity aged debts. We further recommend: a. Charity debts: the Trust should formally review its processes for charity invoicing and debt collection, both internally between finance and the divisions and through discussions with relevant charities (particularly Macmillan and Marie Curie) to identify inefficiencies within the process;	Low	3.1 a. The recommendation is accepted. Increased frequency of liaison and enhanced formal processes will be put in place both internally and with partners	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/03/2022	Action Closed	This action is **COMPLETE**. In parrallel with systems audit, historic aged debt balances were cleansed, with periodic reconciliations established with cash receipted, volume of aged debt significantly reduced. Regular meetings with Divisional Leads to ensure Charity submissions are completed on time and bi-annual meeting with Charity.	n/a	n/a	n/a	n/a	n/a	n/a
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	Complete	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 **the October 2022 Committee meeting** to allow review and update of the metrics as appropriate.	Reports being sent to SFT as per action.	Reports being sent to SFT as per action. Discussions taking place as required. Request that the action is closed.	Update October 2022: Complete. Action should have been marked as complete for October 2022 Audit Committee.	n/a	Update October 2022: Complete. Action should have been marked as complete for October 2022 Audit Committee.	n/a

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Requested Extension Date
New Matter Arasing	**Trust Audit Action Tracker (Design)** 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; 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.	High	1.1 a. Recommendation accepted Meeting held with Internal Audit on 5th May to discuss to the governance process for the Audit Action Tracker and how this process can be improved. 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 documented process covering items set out in 1.1(a) and using other learning from examples provided from other NHS Wales organisations	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	Jun-22	Action Closed	A Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking Paper was endorsed for Committee approval in EMB 01 July 2022 and was taken to the Audit Committee 19 July 2022. The paper identified learning and recommended improvements to the Audit Action Tracker process and included documented processes.	n/a	n/a
New Matter Arasing	1.1 b. The Audit Committee should approve the Audit Action Tracker Governance process.	High	b. Recommendation accepted Action: Paper to be presented to EMB and documented process for Audit Action Tracker to be approved by Audit Committee.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	19th July 2022 Audit Committee	Action Closed	The Audit Committee noted, discussed, reviewed and approved all recommendations in the Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking Paper that was brought to the Audit Committee 19 July 2022	n/a	n/a

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Requested Extension Date
New Matter Arasing	1.1 c. The approved process should be communicated to all relevant staff, for example, through inclusion of a link when Internal Audit (or other reports) are sent out.	High	c. Recommendation accepted Action: The approved process will be communicated to all relevant staff	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	By end July 2022	Action Closed	The Audit Action Tracker governance process was approved by the Audit Committee on 19 July 2022. The process document will be sent out by 31/8/22 to all staff that were asked to proivde audit action updates un August. It will also be included as an attachment to the Action Tracker update requet e-mails that will be sent to relevant staff each month. A link to the procedure will also be embedded in the Audit Trackeritself.	DoF led on improvements to format and process for action tracking with new Procedure completed	n/a
New Matter Arasing	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.	High	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.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	19th July 2022 Audit Committee	Action Closed	The Audit Action Tracker is now circulated monthly for updates to Responsible Manager and Executive Leads, with their BSOs Ccd in an attempt to obtain clarity on specific actions and target dates. A paper will be taken monthly to EMB to follow up on any outstanding recommendations with Executive Leads. All past closed action have been agreed by the Audit Committee to remain on the tracker and be marked as Blue. The DoF has reviewed the tracker to ensure: • all recommenations are included; • the governance procedure sets out requirement for justifications to deadline extensions and action updates are clear; • all relevant info is included in tracker where parts of recommendations with multi-part responses have been closed	n/a	n/a
New Matter Arasing	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).	High	Recommendation accepted Action: As the report states the Trust has already decided it would be more helpful to keep all action updates (not just the previous two) to create a more robust audit trail, assist the action lead in the quality & consistency of their action updates and enable effective trend monitoring. Action: The Trust has already	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	Already Actioned Already Actioned	Action Closed	n/a	n/a	n/a

Audit Action Plan

Velindre UNHS Trust

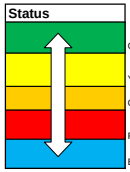
Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - Action not complete
	Blue - Action closed previous meeting

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

* Unless a more appropriate timescale is identified / agreed

Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	**Recommendation**	**Priority**	**Management Response**	**Executive/Director Lead**	**Responsible Manager/Officer Lead Department where lead works**	**Agreed Implementation Date**	**Status**	**Update August 2022**	**Update September 2022**	**Requested Extension Date**
Previous Matter Arising	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.	Medium	2.1 Recommendation accepted The Action plan for VCC WLWG is being developed along with the introduction of new meetings and attendances. Deadlines for compliance against WL actions are set by the WL Standards document itself and the RAG rating demonstrates these timescales. Internal timescales will be set by the WLWG once the action plan has been finalised. Action: Action plan including deadlines to be agreed by VCC WLWG and WLDG.	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jul-22	Action Closed	Welsh language Action plan developed and agreed. New meeting shedule agreed.	n/a	n/a
Previous Matter Arising	**Velindre Cancer Centre Working Group (Operation)** 2.2 The ToR for the WLWG and WLDG should be updated and approved, including: • ensuring reference to appropriate group names throughout the ToR; • clearly defining roles and responsibilities of Group members; and • completing the quorum section (or deleting if not considered necessary).	Medium	2.2 Recommendation accepted Action: The TOR for the VCC WLWG and WLDG will be updated in line with recommendations	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jun-22	Action Closed	Action Ccmplete. The TOR for the VCC WLWG and WLDG have been be updated in line with recommendations.	n/a	n/a
Previous Matter Arising	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	2.3 Recommendation accepted 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	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jun-22	Action Closed	Action complete. WLDG and VCC WLWG have agreed the attendance monitoring process.	n/a	n/a
Previous Matter Arising	Medical Workforce Planning – Action Plans (Design) 3.1 We concur with the approach taken by the Trust to incorporate workforce planning into the Velindre Futures programme. To provide assurance to the Audit Committee that medical workforce planning is in hand going forward, the CSQR Programme's Senior Responsible Officer should provide the Audit Committee an update report on work undertaken around medical workforce planning, for example, annually. This should be included on the Audit Committee Cycle of Business.	Low	3.1 Recommendation accepted Action: The CSQR Programme / medical workforce planning update report will be added to the Audit Committee Cycle of Business to be presented annually.	Sarah Morley, Director of Workforce and OD	Sarah Morley, Director of Workforce / Lauren Fear, Director of Corporate Governance / Senior Responsible Officer	Jun-22	Complete		Update October 2022: Complete Thr CSQR Programme / medical workforce planning update report has been added to the Audit Committee Cycle of Business.	Update October 2022: Complete Thr CSQR Programme / medical workforce planning update report has been added to the Audit Committee Cycle of Business.

Audit Action Plan



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

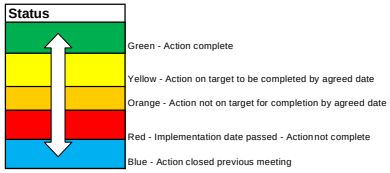
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Audit of Accounts Addendum Management Letter					Assurance Rating: N/A			Date Received at Audit Committee: 19 July 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Matter Arising 1	Exhibit 1: Recommendations from 2021-22 audit of accounts **NWSSP IT assets with a gross book value of £570,000 that were disposed of in year remained in the Trust's Financial Statements in error .** Procedures for recording and approving the disposal of IT assets should be reviewed to ensure that all disposed assets are removed from the FAR on a timely basis, and prior to the production of the Trust's Financial Statements.	High	It is agreed that all assets should be disposed in a timely manner in line with the Trust Financial Control Procedure (FCP), "management of non-current / fixed assets and maintenance of asset register". This procedure will be reviewed in line with the recommendation and amended as appropriate. We will then ensure all staff across the Trust are familiar with the procedure and any amendments resulting from the review. NWSSP will in addition provide awareness sessions to all staff with responsibility for capital asset verification during 2022/23 to ensure they are fully aware of their obligations with regard to the disposal and reporting of fixed assets.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting & Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services	31/12/2022	Complete	Capital asset verification and disposal training to be provided to NWSSP staff at the Capital Planning Group meeting in September 2022	Capital Planning Meeting scheduled for 28th September for training on asset verification and disposal.	ACTION COMPLETED - Training undertaken for all Capital Service leads on 28th September 2022 in addition to recirculation of the asset validation process via email	n/a	n/a	n/a
Matter Arising 2	**Our analysis of the FAR has identified that a significant percentage of some classes of asset have been fully depreciated but are still in use.** A review of the asset lives should be undertaken and consideration given as to whether there is sufficient evidence to depart from the suggested asset lives in the Manual for Accounts.	Medium	A review will be undertaken to see whether there is significant evidence to warrant departing from the manual of accounts.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting	31/08/2022	Action Closed	It is extremely difficult to determine an asset life and unless there is clear evidence that can support the true lifespan then the Manual of Accounts will be followed. The Trust is currently benefiting which is in part due to the prolonged life of owned assets, but also the sound use of resources which is linked to the building of the new Cancer Centre. All new assets will be reviewed in line with evidence of asset life, the Manual of Accounts and in conjunction with current assets held by the Trust.	n/a	n/a	n/a	n/a	n/a
Matter Arising 3	**There are weaknesses in the process for producing the TFR6 and we anticipate this will may impact on the LMS2 return for the Whole of Government Accounts.** The process of identifying the NHS Matrix agreed transactions in the ledger needs strengthening so that the production of the TFR6 can be produced more efficiently and reduce the risk of any balancing figures being needed. This should include once again reminding colleagues to ensure that transactions are coded to the appropriate codes.	Medium	We will continue to build on the work done last year to improve coding of transactions in the financial ledger. This will include reminding colleagues to ensure that the transactions are coded to the appropriate codes.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2023	On Target	Meeting in diary 13th September for leads in Financial Accounts to discuss approach for 2022/2023 accounts.	Meeting postponed due to illness. Will be rearranged for late October. Action still on track to be completed by the deadline.	Work continuing to improve process. Still on track to have strengthened process in place by deadline.	Work continuing to improve process. Still on track to have strengthened process in place by deadline.		

Audit Action Plan

Velindre UNHS Trust



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

* Unless a more appropriate timescale is identified / agreed

External Audit Report - Audit of Accounts Addendum Management Letter					Assurance Rating: N/A			Date Received at Audit Committee: 19 July 2022					
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Matter Arising 4	**The Accounts Receivable Control account reconciliation has had an unreconciled difference of £141,000 since October 2021.** This reporting issue should be investigated to see if this issue can be resolved to remove this reconciling item from future reconciliations.	Low	This reporting issue has been subject to ongoing investigation since it occurred in October, and discussions will continue to identify both the cause and the action required to correct the AR reconciliation going forward.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2023	Action Closed	Review at the end of period 4 indicates this has been resolved. Suggest reviewing again at the end of period 5 before closing action.	Reviewed again post August close and the item still appears resolved. Request to close action.	n/a	n/a	n/a	n/a
Audit Year 2020-21	Exhibit 2: progress against previous years' recommendations Losses relating to a Structured Settlements have not been correctly recorded in the Trust's accounts Note 26.3 within the Trust's 2021-22 Financial Statements should include losses relating to Structured Settlement cases and discussions should be held with Welsh Government for the prior year figures to be restated.	High	Addressed in the 2021-22 Financial Statements Recommendation implemented	Matthew Bunce, Executive Director of Finance	n/a	2021/22 Accounts submission	Action Closed	Complete on July 2022 Audit Committee Report	n/a	n/a	n/a	n/a	n/a
Audit Year 2020-21	Coding of transactions for the production of the FR6 return and WGA (LMS2) return We recommend that those officers posting transactions are reminded of the need to use the appropriate coding	Low	Not fully addressed Recommendation included in the 2021-22 recommendations above. See Matter arising 3	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Action Closed	Complete on July 2022 Audit Committee Report	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

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

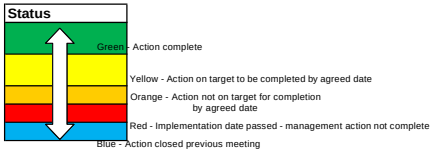
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Finance & Service Sustainability: Budgetary Control & Savings Plans							Assurance Rating: Reasonable				Date Received at Audit Committee: 04 October 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Matter Arising 1	**Availability of the BC FCP (Operation)** 1.1 The BC FCP should be made available to all BHs. BHs should be made aware of its location.	Low	Recommendation accepted with the FCP already been made available on the Trust Intranet site. BHs will be informed of its location.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting /David Osborne, Head of Business Partnering	31.10.2022	Complete	**Complete.** The BC FCP has been made available on the Trust intranet site. BHs have been made aware of its location.	n/a	n/a	n/a
Matter Arising 2	**Budget Approval (Operation)** 2,1 The Trust Board should formally consider if it receives sufficient information to approve the annual budget and meet the requirement of the SO/SFIs.	Low	Prior to the development of the 2022-23 budget submission to Trust Board Management will review the SO/SFI requirements with regards to Budget Setting (Section 5.1), taking into account the Responsibilities and Delegation outlined in Section 2.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	30.04.2023	On Target	In line with the agreed implementation date this will be picked up as part of 2022/23 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2022/23 budget setting exercise.		
Matter Arising 3	**Distribution / Acknowledgement of Budget Sub-Delegation Letters (Operation)** 3.1 Budget sub-delegation letters should be formally issued and acknowledged by all BHs, in line with the sub- delegation requirements of the budget delegation letters.	Medium	The BC FCP requires both Directors via chief Executive and Divisional Directors via the Chief Operating Officer to formally acknowledge the delegation with letters issued. There is flexibility for further sub-delegation with budget packs issued to BHs. Formal acknowledgement of sub-delegation to all BH's however will be incorporated as a requirement from next year.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering / Steve Coliandris, Head of Financial Planning & Reporting	30.04.2023	On Target	In line with the agreed implementation date this will be picked up as part of 2022/23 delegation exercise	In line with the agreed implementation date this will be picked up as part of 2022/23 budget setting exercise.		
Matter Arising 3	3.2 The Trust should consider including timeframes for the issue and acknowledgement of delegation letters within theBC FCP.	Low	Management will review and update the FCP to include timescales for DECL letters being sent and expected acknowledgement of receipt and acceptance in line with Budgetary Delegation expectations set in Section 5.2 of the SO/SFIs.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting	30.01.2022	On Target	In line with the agreed implementation date this will be picked up as part of 2022/23 delegation exercise	In line with the agreed implementation date this will be picked up as part of 2022/23 budget setting exercise.		
Matter Arising 4	**Timelines of Budget Holder Reporting (Operation)** 4.1 The Trust should ensure BH information is issued in a timely manner. Inclusion of reporting and BH meeting timeframes in the month-end financial timetable may support this.	Medium	Management acknowledges some occurrences of delayed reporting due to temporary resource issues, however regular reports and meetings do take place. Timeframes to be included and adhered to within monthly timetable, with formal confirmation and records of completion.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering	31.10.2022	Complete	Complete - BH reporting have been added to the finance timetable and a schedule of BH reports and meetings are being kept by Divisions.			
Matter Arising 4	4.2 The Finance Team should liaise with the divisions to ensure the divisional management team meetings receive and consider written finance reports.	Low	Verbal updates have been provided on occasion due to timing issues. Management will ensure that written reports are available to Divisional Teams and will be retained in the records of SMT meetings.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering	31.10.2022	Complete	Complete - Formal reports have and will continue to be provided to respective SLT and SMT within VCC and WBS.			
Matter Arising 5	**Plans to Support Realisation of Savings (Operation)** 5.1 The Trust should develop clear implementation plans (or an appropriate alternative dependent upon the savings plan) for its savings plans. The implementation plans should: • cover financial and non-financial actions, including timescales and responsible individuals; and • be monitored at an appropriate forum (plan dependent) within the Trust. Significant changes to savings plans should be formally approved at an appropriate level within the Trust, and the related implementation plan updated accordingly.	Medium	Accountable leads and associated actions plans to be reported at mothly Divisional SMT's and /or Executives with a review of actions required to deliver the plans on time. Assurance to the Trust Board will continue to be provided via established financial reporting mechanisms whereby the Finance Report includes details of any corrective actions required as a result of saving plans reviews at Divisional or Corporate level.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering /Steve Coliandris, Head of Financial Planning &Reporting	31.10.2022	Complete	All savings plan are on course to be delivered in this financial year, where two schemes have not delivered mitigation / replacement schemes have been found. Due to delivery this year no requirement to formulate action plans, however next financial year recommendations will be implemented to ensure effective monitoring of saving schemes.			

Audit Action Plan

Velindre UNHS Trust



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

* Unless a more appropriate timescale is identified / agreed

Finance & Service Sustainability: Budgetary Control & Savings Plans					Assurance Rating: Reasonable			Date Received at Audit Committee: 04 October 2022			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2022	Update December 2022	Requested Extension Date	Extension (Months)
Matter Arising 6	**Evidencing Budget Monitoring / Actions to Address Variances (Operation)** 6.1 The Finance team should: • ensure BH meetings are evidenced with notes/action logs; • track whether BHs and FBPs are meeting in a timely manner (see also recommendation 4.1); and • ensure actions to address adverse variances are clearly identified and trackable, including responsible individuals and timescales. We can provide the Finance team with example templates used elsewhere for BH meeting notes / actions if required.	Medium	Management accepts that Budget Holder and FBP capacity has occasionally been limited during the COVID recovery period due to operational pressures on the service. Management will schedule and formally record meeting attendance and note reasons for non-compliance. Notes and actions are taken with examples provided during the audit. Actions and escalations will be formally logged in a consistent manner across all Divisions. Enhancement and consistency of budget reporting to be picked up as part of Divisional team review/ PADR.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering / Steve Coliandris, Head of Financial Planning & Reporting	31.10.2022	Overdue	In progress and partially achieved. BH meetings continue to be evidenced through meeting requests and a schedule is being kept at Divisional level. Finance teams are preparing standard templates in order to capture actions and escalations.	Templates to capture actions and escalations on course to be completed by revised extension date.	31.12.2022	2 months

AUDIT COMMITTEE

AUDIT WALES AUDIT COMMITTEE UPDATE

DATE OF MEETING	12/01/2023

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, 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	

1. SITUATION/BACKGROUND

1.1 Audit Wales' Audit Committee update at December 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: December 2022

Document reference: APS202212

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:

About this document 4

Accounts audit update 4

Performance audit update 5

Good Practice events and products 6

NHS-related national studies and related products 6

Audit Committee Update

About this document

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2021-22 Financial Statements	We have completed the audit of the 2021-22 financial statements in June 2022 and presented our recommendations in an additional 2021-22 Financial Audit report which went to the Audit Committee in July 2022.
Audit of 2021-22 Charitable Funds Financial Statements	Our audit is ongoing, and we are on-track to complete our work within the Charity Commission deadline of 31st January.

4 Whilst planning for our 2022-23 audit will commence shortly, the exact timing of our 2022-23 audit work is uncertain at this stage. This is due to the fact that 2021-22 audit work is continuing at many of our client sites, particularly in the local government sector, and we will be working through the impact of a new auditing standard (ISA 315) that requires external auditors to fundamentally review their approach to audit risk at audited bodies. Both of these factors could result in a delay to our 2022-23 audit work.

Performance audit update

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

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.	**Completed** Final report and management response to be considered by the Audit Committee in January 2023. The report was considered by the Quality, Safety, and Performance Committee in November 2022.
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; and • Use of resources (such as digital resources, estates, and other physical assets).	**Commenced** Final report to be considered by the Board in January 2023. The Audit Committee will consider the report, along with the management response, at its subsequent meeting.

Topic and relevant Exec. Lead	Focus of the work	Current status and Audit Committee consideration
All-Wales Thematic work Director of Corporate Governance / Executive Director of Organisational Development & Workforce	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	**Commenced** Project brief has been issued. Fieldwork will commence in January 2023. We are aiming to report our findings in April 2023.
Local study	Short piece of work either to review setting of Wellbeing and Future Generation Objectives or for a deeper dive module in an area covered by Structured Assessment.	**To be confirmed** 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.

NHS-related national studies and related products

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

9 **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
'A missed opportunity' – Social Enterprises	**November 2022**
Time for change – Poverty in Wales	**November 2022**
Cyber Resilience Follow-up	**October 2022**
National Fraud Initiative 2020-21	**October 2022**
Equality Impact Assessments: More than a Tick Box Exercise?	**September 2022**
NHS Wales Finances Data Tool - up to March 2022	August 2022
Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report	July 2022
Public Sector Readiness for Net Zero Carbon by 2030	July 2022
The Welsh Community Care Information System update	July 2022
Tackling the Planned Care Backlog in Wales	May 2022
Unscheduled Care in Wales	April 2022
Joint working between Emergency Services	January 2022

Title	Publication Date
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

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	2023
NHS quality governance	2023
Collaborative arrangements for managing local public health resources	2023

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

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

E-mail: info@audit.wales
Website: www.audit.wales
We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

AUDIT COMMITTEE

AUDIT WALES REPORT: REVIEW OF QUALITY GOVERNANCE ARRANGEMENTS – VELINDRE UNIVERSITY NHS TRUST

DATE OF MEETING	12/01/2023

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' report in respect of their review of quality governance arrangements within the Trust is attached for the Committee's attention.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Management responses drafted by the Trust are attached as a separate document for review by the Committee.

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, and consider the management responses attached separately.

Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Velindre University NHS Trust

Audit year: 2020

Date issued: August 2022

Document reference: 3034A2022

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 to the Senedd 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 and Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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

Contents

Summary report

About this report 4

Key messages 5

Recommendations 5

Detailed report

Organisational strategy for quality and service user safety 8

Organisational culture 13

Governance structures and processes 20

Arrangements for monitoring and reporting 24

Appendices

Appendix 1 – management response to audit recommendations 27

Appendix 2 – staff survey findings 28

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and service user safety first more than anything else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of 'quality governance' arrangements is to help organisations and their staff monitor and where necessary, improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes, but is not limited to, the effectiveness and safety of health services and the experience of service users. Statutory guidance in relation to the Duty of Quality and the Duty of Candour are yet to be consulted upon but expected in autumn 2022. The date for enactment of both duties is yet to be determined but anticipated to be part way through 2023-24.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality whilst responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approaches to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Velindre University

NHS Trust (the Trust) carried out between June 2021 and May 2022[1]. To test arrangements from 'floor to board', we examined the arrangements in both the Velindre Cancer Centre (VCC) and the Welsh Blood Service (WBS).

Key messages

6 Overall, we found **that significant progress has been made to improve the Trust's quality governance arrangements.**

7 The Trust has approved a new Quality and Safety Framework. It sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies roles and responsibilities and sets out the ambition to ensure learning and improvement are embedded. The Trust has set out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved. Good progress has been made to improve risk management arrangements, but there is scope to make improvements to enhance scrutiny of risk registers and strategic priorities.

8 The Trust has an open and learning culture and is committed to learning from service users and staff. There are good arrangements to collect service user and staff feedback and experiences and to share these. Some staff perceive that the Trust may not act in response to concerns or take action to deal with bullying or harassment. Work to understand views expressed in the NHS Staff Survey is in motion.

9 The new Quality and Safety Framework and planned work to operationalise the Quality Hubs have articulated the operational quality and safety governance structures and flows of assurance to support quality governance. There are appropriate identified resources for quality governance and plans to address gaps in resources.

10 The agendas of Quality, Safety and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information is a challenge to effective scrutiny.

Recommendations

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

[1] At varying points in the review, we paused our work, to allow the Trust to respond to the pandemic.

Exhibit 1: recommendations

Recommendations
Quality priorities R1 At the time of writing, the Trust had recently developed ten new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions.
Board Assurance Framework R2 To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and: a) provide appropriate consideration of each of the controls and sources of assurance, and b) scrutinise progress to address gaps in controls and assurances.
Risk information for scrutiny R3 Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action); b) if risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report; and c) executive risk owners should lead discussions on risks within their areas of responsibility.

Recommendations

Action to address staff survey results

R4 Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and:

a) undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse; and

b) undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.

Quality and safety flows of assurance

R5 Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide:

a) ensure that the group structures and meeting remits avoid unnecessary duplication of coverage;

b) ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines; and

c) ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.

Quality and safety information

R6 Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods..

Detailed report

Organisational strategy for quality and service user safety

12 Our work considered the extent to which there are clearly defined priorities for quality and service user safety and effective mitigation of the risks to achieving them.

13 We found that **the new Quality and Safety Framework sets out clear quality and safety arrangements and responsibilities. There are ambitious quality priorities with appropriate arrangements to monitor delivery, however, they do not easily allow assessment of whether they have been achieved. Good progress has been made to improve risk management arrangements, but there is scope to make improvements to enhance scrutiny of risk registers and risks to achieving strategic priorities.**

Quality and safety framework

14 We found that **progress to review and finalise the Trust's Quality and Safety Framework was adversely impacted by the pandemic. However, the new Quality and Safety Framework sets out clear quality and safety arrangements and responsibilities**.

15 The Trust has long recognised that the Quality and Safety Framework (the Q&S Framework) needed a significant overhaul. In 2019, work commenced to develop a new Q&S Framework, with the intention to complete the work in 2020. However, work did not proceed as planned due to significant adverse operational pressures resulting from the pandemic.

16 Early in 2021, the Trust consulted with executives, senior leaders, and health care standard leads, and a Trust-wide staff consultation took place in June 2021. An early draft was issued at this time to stimulate further comment.

17 Work to progress the Q&S Framework was adversely impacted by a further peak of COVID-19. The Trust intended to take the Q&S Framework to the January 2022 meeting, However, a committee paper indicated that it would be postponed to the March meeting due to pressures caused by the pandemic. However, there was no challenge when it was excluded from the March meeting agendas. Similarly, the Board Assurance Framework shared at the May 2022 committee meeting stated that the Q&S Framework would be tabled at that same meeting, but there was no challenge when it was excluded from the agenda.

18 In 2022, several changes were made to the draft Q&S Framework, as a result of the consultation undertaken in 2021. In July 2022, following endorsement from the Quality, Safety and Performance Committee, the Board approved the Q&S Framework and supporting Implementation Plan.

19 Completing the Q&S Framework was an important and necessary priority for the Trust. The new Q&S Framework sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies

roles and responsibilities and sets out the ambition to ensure learning and improvement are embedded. There is clear alignment between the Q&S Framework and the new Trust Strategy and supporting enabling strategies.

20 The supporting Implementation Plan sets out the actions needed to ensure arrangements set out in the Q&S Framework are fully operationalised. For each action there is an identified lead and delivery timescale. The Trust recognises that fully implementing the Q&S Framework will take time. However, the Trust told us that work undertaken over the previous three years has laid the foundations, both organisationally and culturally. The Trust has set an ambitious, but achievable timescale for the actions in the Implementation Plan to be embedded and fully operational.

21 Progress against the Implementation Plan will be monitored quarterly by the Executive Management Board and twice a year by the Quality, Safety and Performance Committee.

22 The Trust has committed to reviewing the Q&S Framework in 2023 once the duties set out in the Health and Social Care (Quality and Engagement) (Wales) Act (see **paragraph 2)** are enacted.

Quality and service user safety priorities

23 We found that the **Trust sets out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved**.

24 The Trust included 12 quality priorities in the 2019-2022 Integrated Medium Term Plan (IMTP). Since then, the 2020-2021 quarterly plans and the 2021-2022 Annual Plan included high level quality priorities focused on quality arrangements during the pandemic[2]. However, no reports have been received by the Quality, Safety and Performance Committee to indicate how the Trust did in delivering against these quality priorities.

25 Within the 2022-25 IMTP, the Trust set out a programme of work to progress clinical quality and safety arrangements and ensure delivery of Health and Social Care (Quality and Engagement) (Wales) Act 2020. The IMTP sets out 11 key priorities supported by specific actions with timescales for delivery. The priorities are focused on setting up the arrangements and infrastructure through which the Trust will meet its quality and safety responsibilities, and include;

- implementing the Q&S Framework;
- developing Quality Hubs (VCC, WBS and Trust);

[2] Including optimising infection prevention and control measures; strengthening service user engagement and the capture of service user experiences; and implementing digital initiatives to ensure continued patient engagement throughout the pandemic.

- establishing a Quality and Safety team fit to deliver new legislation;
- implementing Duty of Quality and Candour requirements;
- planning for and implementing new Quality Standards;
- ensuring there are clear service delivery to Board quality metrics;
- implementing a Trust Quality Management system;
- ensuring robust mechanisms for capturing service user experiences, with learning and improvement mechanisms;
- ensuring robust clinical leadership, and establishing a Clinical and Strategy Board; and
- optimising working at top of license and optimising advanced practice working.

26 It is our understanding that the Quality, Safety and Performance Committee will monitor delivery of these priorities as part of its quarterly review of monitoring delivery of priorities set out in the IMTP.

27 In conjunction with the new Q&S Framework, the Trust developed ten new Quality Improvement Goals for 2022-23. These are in addition to the 11 priorities set out in the 2022-25 IMTP (see **paragraph 25**). The focus of the ten new Quality Improvement Goals is service redesign to meet increasing predicted demand and to deliver further service improvements. Going forward, the Trust should ensure that the Quality Improvement Goals are SMART. They should indicate what specific actions will be taken, by when, and what the intended outcome is, and thereby allow assessment of whether they have been fully achieved. The Trust should also reflect on including more service user reported outcome measures/experience measures as well as pure quality indicators (**Recommendation 1**).

28 The Trust told us it intends to consult with staff to develop annual Quality Improvement Goals by 31 January each year for inclusion in the IMTP. Each Quality Improvement Goal will have a defined outcome and delivery plan and will be managed by an identified operational lead and executive director sponsor. Delivery will be monitored through relevant quality teams, and by exception through to Executive Management Board and quarterly to the Quality, Safety and Performance Committee.

Risk management

29 We found that the **Trust has made good progress to improve risk management arrangements. However, the Board and its committees need to ensure they scrutinise progress to address gaps in controls and assurances of strategic risks. There are opportunities to improve scrutiny of risks appearing in risk registers both operationally and by the Board's committees**.

30 In 2020, the Trust produced a Board Assurance Framework which identifies ten principal risks to achieving strategic priorities. During 2021 and 2022, work progressed to populate each principal risk with key controls and sources of assurance and identify any gaps. Each risk is assigned to a responsible executive lead, and an appropriate Board committee for monitoring purposes.

31 Whilst the Board Assurance Framework was developing and maturing, it has been considered by the Board, the Strategic Development Committee and the Audit Committee to ensure the direction of travel is right, more so than considering the controls and assurance in place or yet to be developed. However, to achieve the next level of maturity, Board committees need to begin to review their assigned strategic risks more methodically, receive and monitor progress against associated action plans and ensure that Board committee cycles of business provide appropriate consideration of each of the controls and sources of assurance.

32 The Board Assurance Framework contains a strategic risk specific to quality and safety[3]. At the time of writing, the Quality, Safety and Performance Committee had not received the Board Assurance Framework or any paper specifically on the quality and safety strategic risk. As set out in **paragraph 31,** we expect to see the Quality, Safety and Performance Committee's cycle of business to be updated to include the Board Assurance Framework for regular review and ensure regular consideration of the sources of assurance (**Recommendations 2a and 2b**).

33 The Trust has a limited dedicated corporate risk management team. Previously, it consisted of a 0.2 WTE working to the Director of Corporate Governance. The Trust are trialling a new Risk and Compliance and Assurance Officer role to increase capacity in the team. VCC and WBS both have risk management leads, and there is a risk management lead for the Transforming Cancer Services

[3] The strategic risk is 'the Trust does not currently have cohesive and fully integrated Quality and Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback (patient/donor feedback/outcomes/complaints/claims, incidents) and the 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 (The Health and Social Care (Quality and Engagement) (Wales) Act, 2020) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.'

programme[4] team. The risk management leads in VCC and WBS are not dedicated risk management resources, and they both have wider portfolios of work.

34 In September 2020, the Board approved the Trust's new risk management framework, risk appetite statement and associated risk management procedures and user guides. In our 2021 Structured Assessment, we reported that the Trust had made good progress to develop new risk management arrangements.

35 The Trust undertook a significant review of all open risks on operational risk registers during 2021. The review was necessary to ensure risk information was current and complete prior to the migration of all risks to a new version of Datix[5] and to ensure information was recorded consistently with the new requirements in the new risk management framework. The review of open risks took longer than anticipated and at the time of our fieldwork there remained some work to complete, including:

- migrating WBS risks to the new version of Datix;
- updating procedures within the Risk Management Framework as a result of refinement following implementation;
- delivering training to operational and corporate staff; and
- ensuring consistency and clarity in the way that both existing controls and planned additional controls are recorded.

36 Since our fieldwork, rollout of risk management training has largely been completed and each of the other areas of outstanding work have been finished.

37 The divisional risk leads meet weekly with the Director of Corporate Governance to manage any risk management issues and ensure that risk scoring is appropriate and consistent across the Trust.

38 We observed the scrutiny of divisional risk registers at a number of VCC Quality and Safety Group meetings and WBS Regulatory Assurance and Governance Group meetings between June 2021 and February 2022. Whilst there was reasonably good scrutiny of the risks on registers (particularly at the WBS meetings), the ability to scrutinise was hampered by the way risk information was presented. Our observations took place during the time the risk registers were being reviewed and updated, this led to omissions in the data provided. For example, in the February 2022 VCC Quality and Safety Committee meetings, only the current risk score was provided (but not the initial or target scores) and the mitigating control information was unclear (and in some cases omitted) meaning it

[4] Transforming Cancer Services is a programme of work to keep pace with the increasing demand and complexity of cancer care and to deliver more care closer to home. The programme comprises several projects. These include the construction of a new cancer centre, the development of a new radiotherapy satellite centre, procurement of clinical and digital equipment, delivery of more outreach services, and clinical service transformation.

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

was impossible to determine whether there was any progress to reduce risk scores, or what further action was required. The Trust should ensure that risk reports provided for monitoring and scrutiny at all levels include the necessary detail to enable good scrutiny and challenge. There should be agreement on the level of detail provided on risks, but this should include opening, current and target risk scores, and ensure sufficient clarity on existing controls and mitigating action (**Recommendation 3a**).

39 The respective divisional senior management teams review and scrutinise divisional risks. The Trust Executive Management Board reviews risk registers at its monthly meetings. Any risks meeting the risk score of 12 or more are added to the Corporate Risk Register. The Corporate Risk Register is reported to the Board's committees (the Audit Committee, the Quality, Safety and Performance Committee, and the Strategic Development Committee). Risks scored 16 and over are scrutinised by the Board.

40 Our observations of the Quality, Performance and Safety Committee found that when the Corporate Risk Register is tabled, there appears to be little discussion or scrutiny on the risks within the register assigned to the Committee. We believe there are a number of reasons for this:

- currently, the narrative on controls is unclear in the risk registers. It is difficult to differentiate between controls already in place, and those which are intended to be put in place and by when. Therefore, it is impossible to see if any intended mitigating action has been implemented on time, and whether it has had the intended impact (such as a reduction in the risk score) (**Recommendation 3a**).
- for many risks, there are separate agenda items which provided detailed information, and thus the discussion had already occurred. When discussing the Corporate Risk Register, it would be beneficial for the Trust to draw attention to any risks that have previously been discussed within a different agenda item (**Recommendation 3b**).
- discussions have focused on the progress to update and the risk registers, rather than the risks themselves. Whilst the executive risk owners are present, they do not lead discussion on risks within their areas of responsibility (**Recommendation 3c**).

41 Going forward, discussions in Board and committee meetings need to scrutinise the appropriateness of existing controls, ensuring that intended actions to increase and improve controls are timely and having the desired impact.

Organisational culture

42 NHS organisations need to focus on continually improving the quality of their care whilst using finite resources to achieve better outcomes and experiences for service users. Our work considered the extent to which the Trust is promoting a quality and service-user, safety-focused culture. We considered: compliance with

statutory and mandatory training, participation in quality improvement processes integral with wider governance structures, listening and acting upon feedback from staff and service users, and learning lessons.

43 We found that **the Trust has an open and learning culture and is committed to learning from service users and staff. There are good arrangements to collect service user and staff feedback and to share these. However, some staff perceive that the Trust may not act in response to concerns or take action to deal with bullying or harassment.**

Quality improvement

44 We found that **reporting of clinical audit has improved, although opportunities remain to demonstrate how learning from clinical audit is embedded. Good progress has been made to implement the requirements of the Medical Examiner Service**.

Quality cycle

45 The Trust plans to develop an organisation-wide quality management (assurance) system. It is intended that the system will align with the Board Assurance Framework and incorporate the management of risk, internal and external assurance mechanisms, mechanisms for regulatory and legislative monitoring, and quality, safety, outcome and experience oversight.

Clinical Audit

46 Clinical audit is an important way of providing assurance about the quality and safety of services. Each year, VCC participates in relevant clinical audits within the national programme of clinical audits and reviews; while WBS is subject to routine external audits to ensure compliance with regulatory requirements. The Trust also agrees a programme of local clinical audit in both divisions to provide assurance about the quality and safety of services and compliance with expected standards of care.

47 The Trust told us they have no corporate central resources for Clinical Audit. However, the Executive Medical Director is responsible for clinical audit and ensuring that the Trust makes adequate provision to support clinicians and managers undertaking clinical audits. Both VCC and WBS division have designated clinical leads for clinical audit.

48 In VCC, local clinical audit plans are determined and prioritised by the cancer site teams. Local clinical audit plans are linked to national standards set by the National Institute for Health and Care Excellence, findings arising from the review of significant incidents and complaints and to assess the introduction of new technologies. VCC has a dedicated clinical audit team led by the Clinical Audit Manager.

49 VCC and WBS report progress against the clinical and other audits within their respective quarterly divisional reports, which are received by the Quality, Safety and Performance Committee.

50 The Trust introduced its first Trust-wide Clinical Audit Plan in 2020 (previous plans covered just VCC). The Quality, Safety and Performance Committee approved the 2022-23 Clinical Audit Plan in July 2022.The development of the Q&S Framework should strengthen alignment between clinical audit and the quality and safety agenda across the Trust and ensure there is alignment between the co-ordination, oversight, and triangulation of outcomes.

51 The first Trust-wide Clinical Audit Report in 2020-21 was received by the Quality, Safety and Performance Committee in July 2021[6]. In previous years our Structured Assessment reviews have found that the Trust's clinical audit reports have not adequately and clearly identified key actions for improvement, making it difficult to track progress against implementing identified actions. Our view is that whilst the Clinical Audit Report 2020-21 highlights areas for improvement, the report does not set out what action will be taken, or by when. We remain of the opinion that there needs to be a more robust reporting of findings, learning and resulting actions to allow demonstration of how learning has been shared and implemented[7].

Mortality and morbidity reviews

52 Mortality and morbidity review meetings provide a systematic approach for peer review of adverse events, complications, or mortality, to reflect, learn, and improve patient care. The Medical Examiner Service was rolled out across Wales, and became a statutory independent review mechanism for patient deaths from April 2022.

53 VCC already had a specific process to review mortality and morbidity. All inpatient deaths are reviewed by a consultant nurse and input provided by consultants and the ward team that provided treatment. Any issues raised were escalated to the VCC Significant Clinical Incident Forum which has multi-disciplinary membership to conduct reviews and disseminate learning across the Trust.

54 To support the introduction of the new requirements of the Medical Examiner Service, VCC identified a consultant lead for the Significant Clinical Incident Forum and Mortality reviews. In October 2021, VCC commenced a pilot to ensure that requirements for reporting patient deaths to the Medical Examiner Service were complied with. VCC established a Mortality Project Group to lead this work. Training has been provided to appropriate staff. Since the pilot, the Mortality Project Group has been developing a standard operating procedure for the process.

[6] In previous years the Clinical Audit Report contained VCC audits only.

[7] The Clinical Audit Report 2021-22 had not been tabled at a Quality, Safety and Performance Committee by the time of reporting.

55 VCC reported to the March 2022 Quality, Safety and Performance Committee that it is meeting the requirements of the Medical Examiner Service. VCC will present a Medical Examiners Service and Mortality Framework Report to the Quality, Safety and Performance Committee twice a year.

Values and behaviour

56 We found that the **Trust has a well-established Values and Behaviour Framework which encourages an open and learning culture. Compliance with statutory and mandatory training is good but has been impacted by the pandemic**.

57 The Trust's Values and Behaviours Framework was launched in 2018 and supports a quality and service-user focused culture with emphasis on continuous improvement, openness, transparency and learning when things go wrong. When launched, the Trust took steps to publicise the values and behaviours. There have been no recent refresher initiatives. However, we were told that the Trust's Independent Members have requested a refresh for staff and there are plans in place to refresh organisational awareness of the Values and Behaviours Framework to ensure that values are at the forefront of everything that staff do. The Trust's Values and Behaviours are integral to Personal Appraisal and Development Reviews (PADRs), and form part of interview assessments and induction training.

58 Our work revealed a positive picture in relation to the culture of reporting errors, near misses, incidents and raising concerns. Of the staff who completed our survey[8], 53 out of 61 staff agreed or strongly agreed that the Trust encourages staff to report errors, near misses or incidents. Two-thirds of staff (39 out of 61 staff) agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Most staff (48 out of 61 staff) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

59 In the NHS Wales Staff Survey undertaken in November 2020, a proportion of Trust staff indicated they had experienced bullying, harassment, or abuse by another colleague, member of the public or line manager over the previous year (15%, 8%, 6% respectively). Disappointingly, fewer than half (42%) agreed or strongly agreed that the organisation takes effective action (**Recommendation 4a**). The Trust reviewed the NHS Staff Survey Findings results and key messages at their Board in February 2021. It was agreed that the results would be discussed within teams and that a Trust-wide action plan would be developed. Pressures

[8] We invited operational staff working across the VCC and WBS to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. The estimated response rate is 2.9%. Although the findings are unlikely to be representative of the views of all staff across VCC and WBS, we have used them to illustrate particular issues.

arising from the pandemic led to delays, but at the time of writing, the Trust were planning to restart the work.

60 Undertaking annual PADRs is important for identifying training needs. The Welsh Government target for PADR compliance is 85%, WBS were reported to be just below this target at 78.4% and VCC lower at 66.0% (March 2022)[9]. Compliance with undertaking annual PADRs was impacted by the pandemic, and at the time of writing, action to improve compliance included targeting hotspot areas.

61 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. The Trust is required to report compliance to the Welsh Government each month, and the target for compliance is 85%. Figures reported at the May 2022 Quality, Safety and Performance Committee show in March 2022, WBS achieved 92.3% compliance and VCC 84.8%. The pandemic has inevitably impacted the ability for staff to attend training. Therefore, it is not surprising that less than half (26 out of 61) of staff responding to our survey agreed or strongly agreed that they have enough time at work to complete any statutory and mandatory training. Whilst performance in both divisions is near to or above the target, the Education and Development Team continue to work closely with VCC to improve compliance and a training plan is being developed.

Listening and learning from feedback

62 We found that the **Trust demonstrates a strong commitment to learn from service user and staff experiences. There are good arrangements to collect service user feedback, and these have been enhanced by an electronic system to collect real time feedback and a new patient engagement strategy for cancer services. There is a culture of staff feeling able to raise concerns, however, some staff are concerned that the Trust will not act in response to concerns**.

Service user experience

63 Both divisions have designated leads for patient/donor experience with protected time to carry out this role. The Trust have worked with a range of patients, staff and wider stakeholders to develop a Patient Engagement Strategy for cancer services, which was approved by the Board in May 2022. The Patient Engagement Strategy covers a wide range of interactions with patients, including future planning, service design, service delivery and individual care. It sets out a series of goals and underlying principles for VCC to ensure patient engagement is integral to how VCC works.

[9] As reported in the May 2022 Quality, Safety and Performance Committee.

64 The Patient Engagement Strategy sets out plans to create a Patient Engagement Hub in VCC which will be a focal point for patients, staff and stakeholders to contact VCC and to co-ordinate engagement activities.

65 VCC currently has a range of mechanisms to collect patient feedback, including the All-Wales Patient Questionnaire, social media, the Patient Leadership Group and specific surveys developed for Clinical Audits. Whilst some patient experience activities ceased during the height of the pandemic, they recommenced in 2021. The pandemic led to a greater emphasis for digital capture of patient feedback, including social media. VCC are now using a digital platform, Civica, to collect patience experience, which allows the collection of real time data to enable immediate identification of issues and a quicker response.

66 VCC has a well-established Patient Liaison Group. Designated patient 'leaders' from this group are active in helping staff understand things from a patient or carer's perspective. The Trust has adopted a 'You said, we did' approach to demonstrating learning and responding to patient feedback.

67 Learning from patient experience is discussed in the VCC Quality and Safety Management Group and the Trust's Putting Things Right Panel.

68 WBS invites all donors to give feedback via paper, online or SMS surveys. Compliment and concerns cards are available in all donation clinics and social media channels offer further opportunities to provide feedback. Feedback is reviewed each month and key learning is discussed at the WBS Regulatory Assurance and Governance Group meeting. WBS is also using Civica to capture donor experience.

69 The Quality, Safety and Performance Committee receives a range of service user experience, including summaries of each division's survey results. The Trust also produces an annual patient and donor experience report. Service user feedback continues to be very positive.

70 Despite the range of mechanisms to collect data, only half (29 out of 61) of Trust staff responding to our survey agreed or strongly agreed that they receive regular updates on service user feedback for their work area,

71 The Trust produces an annual Putting Things Right Report, and quarterly updates are presented to the Quality, Safety and Performance Committee. The most recent update, Quarter 4 2021-22, was presented to the Quality, Safety and Performance Committee in May 2022. Most concerns were rated as low level, and similarly nearly all incidents were graded as no harm/low harm. Across the Trust, the main themes of concerns were associated with communication, attitudes, and behaviours. The more highly graded concerns related to communication about clinical care, such as perceived miscommunication regarding treatment plans. Lower graded complaints relating to attitude centring on scheduling of appointments. Reports include a summary of the learning captured from reviews of concerns and incidents, and examples of actions taken in response.

72 The Welsh Government target for timely response to complaints is 75% within the 30-day target. The Trust reported in the May 2022 Quality, Safety and

Performance Committee that the Trust's performance for quarter 4 2021-22 was 100% compliance, exceeding the Welsh Government target.

Service user stories

73 Quality, Safety and Performance Committee meetings commence with either a patient or a donor story, which usefully sets the tone for the remainder of the meeting. Service user stories allow a deep dive into events that have not gone so well as well as positive experiences. Stories lead to discussion and challenge to ensure that lessons have been identified and shared. Podcasts are produced and staff are encouraged to consider the stories.

74 Patient Safety WalkRounds provide Board members with an understanding of the experiences of staff, patients and donors and help to make data more meaningful. In 2022, the Trust restarted their programme of 15 step challenge following the cessation during the height of the pandemic. The 15 step challenge visits help to reassure senior staff and independent members that services are welcoming, caring, well organised and safe. They also provide an opportunity for staff to raise concerns and ask questions. The recommendations and actions from visits are taken to a subsequent Quality, Performance and Safety Committee for discussion and a follow-up visit scheduled to ensure recommendations are addressed.

Listening to staff feedback and concerns

75 The Trust is committed to listening and learning from staff experiences and concerns. Quality, Safety and Performance Committee meetings hear staff stories.

76 Staff can report their concerns through the Work in Confidence virtual platform. Comments are reviewed and investigated by staff from the Workforce and Organisational Development team. The Workforce Report for February 2022, presented to the May 2022 Quality, Safety and Performance Committee noted that as a result of low usage of the Work in Confidence Service, they were unable to provide information without it being potentially identifiable.

77 Our interviewees were confident that they and other staff members would feel comfortable raising concerns directly via their manager or more senior managers. However, our survey found that only half (30 out of 61) staff members agreed or strongly agreed that the Trust acts on concerns raised by staff. A similar theme was identified in the NHS Staff Survey 2020. The Trust should set out in their NHS Staff Survey action plan how it intends to explore the reasons why some staff may not feel the Trust adequately acts on concerns (**Recommendation 4b**).

78 VCC staff have daily handover meetings where staff are encouraged to raise any concerns and use the opportunity to share learning. WBS donor collection teams hold a daily de-brief after each donation session where they can raise any concerns. Executive and senior clinicians within the Trust and both divisions are operationally visible, to help them understand the staff experience and be more accessible to staff.

79 Just under half (27 out of 61) of staff agreed or strongly agreed that communication between senior management and staff is effective. This may be a result of the opportunities to meet being more limited during the pandemic. We note that during the pandemic, the Trust stepped up opportunities to communicate with staff via social media, digital and video conferencing. However, the Trust should consider how it may re-stimulate staff engagement.

80 Whilst not universal views, our fieldwork identified that some divisional staff feel remote from the Trust executive team, and consequently distant from strategic decision making. The Trust told us of plans to re-establish the Clinical Advisory Group on a permanent basis (in summer 2022) and to develop a Clinical and Scientific Strategy Board. These fora will provide clinicians from both divisions with the opportunity to inform decision making.

Governance structures and processes

81 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

82 We found that the **new Quality and Safety Framework and planned work to operationalise the Quality Hubs have articulated the operational governance structures and flows of assurance to support quality governance.**

Resources and expertise for quality governance

83 We found that **there are appropriate identified resources for quality governance, and the Trust, in operationalising its new Quality Hubs has plans to address gaps in resources**.

VCC quality governance resources

84 The Director of Velindre Cancer Services holds ultimate responsibility for quality and safety in VCC. Whilst the VCC senior management team has collective responsibility for quality and safety, the VCC Head of Nursing Quality, Patient Experience and Integrated Services is the identified lead. The VCC Clinical Director is responsible for providing leadership for the VCC medical directorate. There are appropriate leads for services such as mortality reviews, quality and safety, radiology quality and safety, complaints, and patient experience.

85 VCC told us they receive support from the corporate quality and safety team and the corporate governance team as required.

86 At the time of our fieldwork, VCC told us that they felt they needed additional quality and safety resources to fully implement new requirements arising from the new Q&S Framework, the Medical Examiner Service requirements and to implement the Duty of Candour, and to improve reporting between VCC and the Trust.

87 As set out in the Q&S Framework, the Trust intends to create a VCC Quality Hub, led by a nominated divisional lead. The intention is for the VCC Quality Hub to support the VCC Senior Management Team in executing quality, safety, regulatory and assurance responsibilities by ensuring effective oversight, co-ordination, learning, assurance and triangulation and effective functioning of Divisional Quality and Safety Group. There are plans to develop and operationalise the VCC Quality Hub during the remainder of 2022, including identifying and filling resource needs.

WBS quality governance resources

88 The Director of the Welsh Blood Service holds ultimate responsibility for quality assurance and safety in the division. Whilst the senior management team has collective responsibility for quality assurance and safety, the Head of Quality Assurance and Regulatory Compliance leads the strategic development, delivery and management of the quality systems throughout the division. The WBS Head of Nursing is responsible for clinical governance, managing concerns and donor engagement. There are designated leads for, infection prevention and control, clinical audit, quality improvement, risk management, Datix, health and safety and data analytics. Some leads do not have protected time to fulfil their role, including the leads for clinical audit and infection, prevention and control.

89 At the time of our fieldwork, WBS told us that resources to support quality assurance and safety were inadequate with a number of vacant posts. Staff told us that there was a pending (overdue) review of WBS quality staff requirements, which was necessary, because staffing needs had changed over time.

90 The Q&S Framework sets out that there will be a WBS Quality Hub with the same purpose as the VCC Quality Hub (see **paragraph 87**). There are plans to develop and operationalise the WBS Quality Hub during the remainder of 2022, including identifying and filling resource needs..

Trust leadership for quality governance

91 There is collective responsibility for quality and safety amongst the Executive Management Board, senior managers and leads within the divisions to ensure the quality and safety of services. However, it is the Director of Nursing, Allied Health Professionals and Health Science (Director of Nursing) who is the executive lead for quality and safety across the Trust.

92 The Director of Nursing has delegated responsibility for ensuring the necessary infrastructure is in place to deliver quality and safe services and is the professional lead for Putting Things Right, Infection Prevention and Control, decontamination, safeguarding, managing incidents and service user experience. The Director of Nursing chairs the Trust's Infection Prevention and Control Group and the Safeguarding and Vulnerable Adults Group and also co-chairs the Clinical Strategy Group with the Trust's Executive Medical Director.

93 The Director of Nursing is supported by the Deputy Director of Nursing, Quality and Patient/Donor Experience, however, at the time of our fieldwork, there were a number of unfilled vacancies within the corporate quality and safety support team. In 2020, the Trust identified the need to strengthen the central quality and safety function. A review of the corporate quality resources was delayed due to the pandemic. More recently, a more integrated structure has been identified to pull together all elements of quality and safety regardless of executive portfolio, with additional funding identified to create new roles within a Corporate Quality Hub. The Trust began a process to populate posts after our fieldwork was completed.

94 The Q&S Framework sets out that the Corporate Quality Hub will be a virtual hub of all quality and safety activity covering the span across a number of executive/director responsibilities and not just those managed through the Corporate Quality Team. The Corporate Quality Hub is planned to interface significantly with national work programmes and bodies, as well as professionally support the two divisional quality hubs. The three Quality Hubs are intended to be accountable for co-ordination, oversight and triangulation rather than delivery of the quality and safety agenda for respective services as this lies with responsible managers.

95 The Director of Nursing works closely with the Trust's Medical Director. The Medical Director is responsible for the quality of medical care, clinical audit and effectiveness and mortality reviews. The Medical Director is supported by five Assistant Medical Directors, each with a lead Trust-wide role (including clinical audit, education and training, and quality and safety). At the time of our fieldwork, there was very little support capacity for the Medical Director and the Assistant Medical Directors. However, since our fieldwork, the Trust has created a senior support role to help support these Trust-wide functions.

96 The Director of Corporate Governance has responsibility for governance, risk, assurance, legal and compliance frameworks and also communications and engagement and Freedom of Information.

Governance structures to support quality governance

97 We found that **the Trust in developing a new Quality and Safety Framework and operationalising in Quality Hubs has articulated the operational governance structures and flows of assurance to support quality governance**.

VCC quality and safety meetings

98 VCC's main forum for discussing quality and safety is the VCC Quality and Safety Management Group (VCC Q&SMG). It meets each month, and is chaired by VCC's Head of Nursing, Quality, Safety and Integrated Care. Meetings cover a range of critical quality and safety information and arrangements. Coverage includes new policies and guidelines, the divisional risk register, incident management and

compliance with health care standards, patient experience, infection, prevention and control, clinical audit, digital, outpatients, radiotherapy and therapies. The VCC Q&SMG reports to the VCC Senior Management Team and the reports are also tabled at Quality, Safety and Performance Committee meetings.

99 We observed the VCC Q&SMG on three occasions in 2021 and early in 2022. We found that meetings were well-structured and well-chaired, and coverage was appropriate. We did observe that on numerous occasions, agenda items were presented, which stimulated very little discussion or questions. VCC Q&SMG attendees told us that some members suggested there was significant duplication of information considered in other fora (**Recommendation 8a**). In addition, historically the VCC Q&SMG has had no or little medical representative attendees, which has limited the ability for multidisciplinary discussions (**Recommendation 8b**). We also noted that some papers would have benefited from the inclusion of a cover paper, providing a summary of the main issues being presented.

100 Whilst we anticipate that once the VCC Quality Hub is fully operationalised, work will be undertaken to address our **Recommendations 8a and b**. However, until the Trust's quality hubs are fully operational, we are unable to make an assessment, and thus our recommendations remain in place.

101 Whilst undertaking our fieldwork we were aware of a number of groups in VCC that cover quality and safety matters, for instance, the Medical Gases Committee, the Medicines Management Group, the Safety Alerts Group, the Controlled Drugs Group, the Radiation Protection Group and the VCC Infection, Prevention and Control Group. We were unable to ascertain where the reporting of quality and safety information and assurance rising from these groups fed. However, the new Q&S Framework sets out the topics which the VCC Q&SMG will consider in its meetings.

WBS quality and safety meetings

102 WBS's main forum for discussing quality and safety is the WBS Regulatory Assurance and Governance Group (WBS RAGG). Meetings are monthly and chaired by WBS's Head of Quality Assurance and Regulatory Compliance. Meetings cover a range of key quality management arrangements.

103 The agenda for the WSB RAGG contains good coverage of quality and safety issues via monthly update reports. There is a good balance of looking at performance issues triangulated with patient and donor feedback.

104 The structure of fora covering quality and safety matters in WBS is straightforward. There are two main groups that report to the WBS RAGG, the Donor Clinical Governance Group and the Patient Clinical Governance Group.

105 Our observations of the WBS RAGG found the meeting to be well structured, and well chaired. We observed good debates and constructive challenges on agenda items. The WBS RAGG reports to the WBS Senior Management Team, and the reports are also tabled at Quality, Safety and Performance Committee meetings.

Trust-wide quality and safety meetings

106 There are a small number of Trust-wide meetings which cover quality and safety, such as the Infection, Prevention and Control Group and the Safeguarding and Vulnerable Adults Groups. Significant work had been undertaken during the 12 months prior to our fieldwork to strengthen and enhance the workplans of the Trust-wide groups.

107 During our fieldwork, we asked the Trust to provide us with a diagram setting out the groups/fora at a Trust level and within both divisions that consider any quality and safety matters, and associated flows of assurance. At the time of our fieldwork, the Trust was unable to provide us with a comprehensive diagram. Whilst there is more clarity in the new Q&S Framework, we are still of the view it would be beneficial to set out all, rather than just some, of the meetings that consider quality and safety matters across the Trust (**Recommendation 8c**).

108 The new Corporate Quality Hub and Divisional Quality Hub leads will formally meet at bi-monthly (from October 2022) as a newly created Quality and Safety Governance Group (Q&S Governance Group). The purpose of the Q&S Governance Group will be to ensure effective triangulated assurance and/or exceptions reporting to the Executive Management Board and the Quality and Safety Performance Committee.

Trust Quality, Safety and Performance Committee

109 The Trust's Quality, Safety and Performance Committee is responsible for providing assurance and advice to the Board in respect of quality and safety. The Quality, Safety and Performance Committee meets on a bi-monthly basis. During the pandemic the Committee increased the frequency of meetings as and when deemed appropriate. We observed the Committee on several occasions and found that there was good challenge and scrutiny from independent members.

Arrangements for monitoring and reporting

110 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

111 We found that **the agendas of Quality, Safety and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information is a challenge to effective scrutiny.**

Coverage of quality and patient safety matters

112 We found that the **agendas of Quality, Safety and Performance Committee meetings are becoming more manageable, with less duplication of coverage,**

and cover papers are now focusing on key matters. However, some information is not timely.

113 The remit of the Quality, Performance and Safety Committee is vast. In our Structured Assessment 2021, we found that the amount of detail provided to the committee on many items was too great, and that further work was needed to agree the amount and level of detail needed to provide necessary assurance to the committee. We said consideration was needed on how to best summarise and synthesise information to help provide focus on key matters. During 2022, we have seen improvements, meetings are generally running to time, there is less duplication of coverage within committee papers, and papers and verbal presentations are providing better focus on key matters.

114 We understand that once operationalised, the Q&S Governance Group will play a critical role in ensuring effective triangulated assurance and/or exception reporting to the Quality, Safety and Performance Committee, and thus ensure that the detail of committee papers is pitched correctly.

115 Every four months, VCC and WBS separately produce divisional Quality and Safety Performance Reports providing a summary of performance information against key quality and safety metrics. The reports are structured around the six domains of quality and safety (Safe Care, Effective Care, Efficient Care, Patient Centred Care, Timely Care and Equitable Care). The reports are comprehensive covering incidents, complaints, risks, claims, clinical audit plan updates, service user experience, external/interview audit findings and training compliance. VCC and WBS present their reports alternatively at Quality, Safety and Performance Committee meetings. Each report provides the most recent month of validated data available. For instance, the May 2022 Committee meeting received the VCC Quality and Safety Performance Report which included February 2022 data. Whilst the report provides useful information on many areas of quality and safety, scrutiny is not completely effective if the data and information presented are not as up to date as possible (**Recommendation 6**).

116 A highlight report of the discussion from the most recent Quality, Safety and Performance Committee is presented by the Chair to the Board meeting. The Committee has a cycle of business which sets out what it intends to cover across the year in its meetings.

Performance information for scrutiny and assurance

117 We found that the **Trust produces lots of information for scrutiny and assurance, but data analytics support is limited. The introduction of quality dashboards would improve the timeliness of data and thus strengthen oversight and monitoring**.

118 The Chief Operating Officer presents a cover paper of the Trust-wide Performance Management Framework to each Quality, Safety and Performance Committee meeting. The cover paper draws attention to key performance metrics across VCC,

WBS, and Workforce. Where performance is off track, the cover paper summarises actions to address performance. There are separate performance reports for VCC, WBS and Workforce.

119 The performance reports provided to the May 2022 Quality, Safety and Performance Committee, contained data from March 2022 (VCC and WBS) and February 2022 (Workforce). Therefore, the data is not as timely as it could be (**Recommendation 6**).

120 The Trust has long intended to make significant improvements to the Performance Management Framework report. Progress has been delayed due to the pandemic. However, following an initial tranche of work, a summary dashboard is now included, and improvements made to explanations of performance and intended actions. Further work is planned in 2022, to fully revise the report and use business intelligence reporting. Plans also include developing more outcome-based measures, adding benchmarking comparisons, and aligning performance reporting to strategic priorities. During 2022, the Trust intends to develop specific performance scorecards for the Board, the Quality, Safety and Performance Committee, Executive Management Board and the divisional senior management teams. The proposed approach is a hierarchy of performance measurements appropriate to the remit and scrutiny requirements at each level and the Board will take assurance from the detailed review and challenge undertaken by each level below.

121 The Trust does not currently have a dedicated data analytics team which means, operationally, there is limited data analytics support available to help divisions manage their data. However, the Trust is seeking funding to increase its data analytics functions. The Trust does not have a live dashboard of key performance data.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response This table will be completed once the report and detailed management response have been considered by the relevant committee(s).

Recommendation	Management response	Completion date	Responsible officer

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	35	18	5	3	0	0	61
2. I am satisfied with the quality of care I give to patients	28	25	8	0	0	0	61
3. There are enough staff within my work area/department to support the delivery of safe and effective care	7	20	7	21	6	0	61
4. My working environment supports safe and effective care	18	24	10	6	3	0	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
5. I receive regular updates on patient feedback for my work area/department	12	17	11	14	4	3	61
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	21	23	9	1	0	7	61
7. My organisation acts on concerns raised by staff	10	20	19	8	3	1	61
8. My organisation encourages staff to report errors, near misses or incidents	30	23	5	0	2	0	60
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	21	18	15	2	1	4	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	17	31	8	3	2	0	61
11. We are given feedback about changes made in response to reported errors, near misses and incidents	13	29	7	8	4	0	61
12. I would feel confident raising concerns about unsafe clinical practice	22	29	3	2	3	2	61
13. I am confident that my organisation acts on concerns about unsafe clinical practice	16	28	10	4	2	1	61
Managing patient and staff concerns							
14. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	17	31	8	3	2	0	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
15. We are given feedback about changes made in response to reported errors, near misses and incidents	13	29	7	8	4	0	61
16. I would feel confident raising concerns about unsafe clinical practice	22	29	3	2	3	2	61
17. I am confident that my organisation acts on concerns about unsafe clinical practice	16	28	10	4	2	1	61

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

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

E-mail: info@audit.wales
Website: www.audit.wales
We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response

Report title: Review of Quality Governance Arrangements – Velindre University NHS Trust

Completion date: June 2022

Document reference: 3034A2022

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
R1	At the time of writing, the Trust had recently developed 10 new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions.	No	Yes	Trust will ensure 2023-24 and future years quality Goals are specific (SMART) and timebound.	March 2023	Executive Director Nursing, AHP and Health Science
R2	To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and: a) Provide appropriate consideration of each of the controls and sources of assurance, and b) Scrutinise progress to address gaps in controls and assurances.	No	Yes	a) Agreement of Committee mapping to Trust Assurance Framework risks complete and endorsed by Strategic Development Committee in October 2022 for implementation through next governance cycles, starting from November 2022. (Cross-reference to the Governance, Assurance and Risk work under the Building Our Future Together Programme (BOFT) - Project Trust Assurance Framework 4.0). b) Further scrutiny and evidence of this, in line with the comments made in the report, will be actioned as part of the	a) January 2023 b) January 2023	Director Corporate Governance and Chief of Staff

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
				next governance cycle review of the Trust Assurance Framework.		
R3	Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) Determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action). b) If risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report. c) Executive risk owners should lead discussions on risks within their areas of responsibility.	No	Yes	a) Quality of data and consistency of reporting is a focus of the current risk work. (Cross-reference to Governance, Assurance and Risk work under BOFT - Project Risk 4.0 & Risk 5.0) b) To be included in new Cover Paper Template and Risk Register report (Cross-reference to Governance, Assurance and Risk work under BOFT - Project GOV 2.0) c) Implement from next governance cycle	a) March 2023 b) January 2023 c) January 2023	Director Corporate Governance and Chief of Staff
R4	Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and: a) Undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse.	No	Yes	a) Trust-wide conversations are underway regarding the way staff feel about working in the organisation. The outputs of this work will give a picture of the culture of the organisation and enable the next iteration of the Trust Values. Part of this engagement work will also be extended to address particular feedback on dealing with bullying, harassment or abuse.	a) January 2023 b) January 2023	Executive Director of Organisational Development and Workforce

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
	b) Undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.			b) The work described at a) will also address the issue of dealing with concerns raised in the workplace.		
R5	Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide. a) Ensure that the group structures and meeting remits avoid unnecessary duplication of coverage. b) Ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines. c) Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.	No	Yes	Integrated Quality and Safety Group to be established (19th October 2022). The Group will take responsibility for reviewing Trust-wide quality and safety related meeting structures, including required representation. Output to be approved by Executive Management Board and the Quality, Safety and Performance Committee. It is noted however, that this will require ongoing review as the Trust and Integrated Quality and Safety Group matures.	March 2023	• Executive Director Nursing, AHP and Health Science; • Director Corporate Governance & Chief of Staff; • Head of Corporate Governance
R6	Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods.	No	Yes	Reporting cover periods to be made explicit as part of Committee agenda setting and work plan.	From January 2023 Quality, Safety and Performance Committee	• Executive Director Nursing, AHP and Health Science; • Director Corporate Governance & Chief of Staff;

Ref	Recommendation	High priority yes / no	Accepted yes/no	Management response	Completion date	Responsible officer
						• Head of Corporate Governance

AUDIT COMMITTEE

AUDIT WALES REPORT – EQUALITY IMPACT ASSESSMENTS: MORE THAN A TICK BOX EXERCISE?

DATE OF MEETING	12/01/2023

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	
EIA	Equality Impact Assessment(s)

1. SITUATION/BACKGROUND

1.1 Audit Wales' September 2022 report in relation to Equality Impact Assessments undertaken by public bodies in Wales is attached for the Committee's information.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report aims to help all public bodies learn from those that are doing well and trying new approaches.

2.2 The report states that it expects "all public bodies to respond to the recommendation that they review their own approaches to EIAs and the quality of individual EIAs used to inform their decisions".

2.3 Management's response is attached following the report.

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

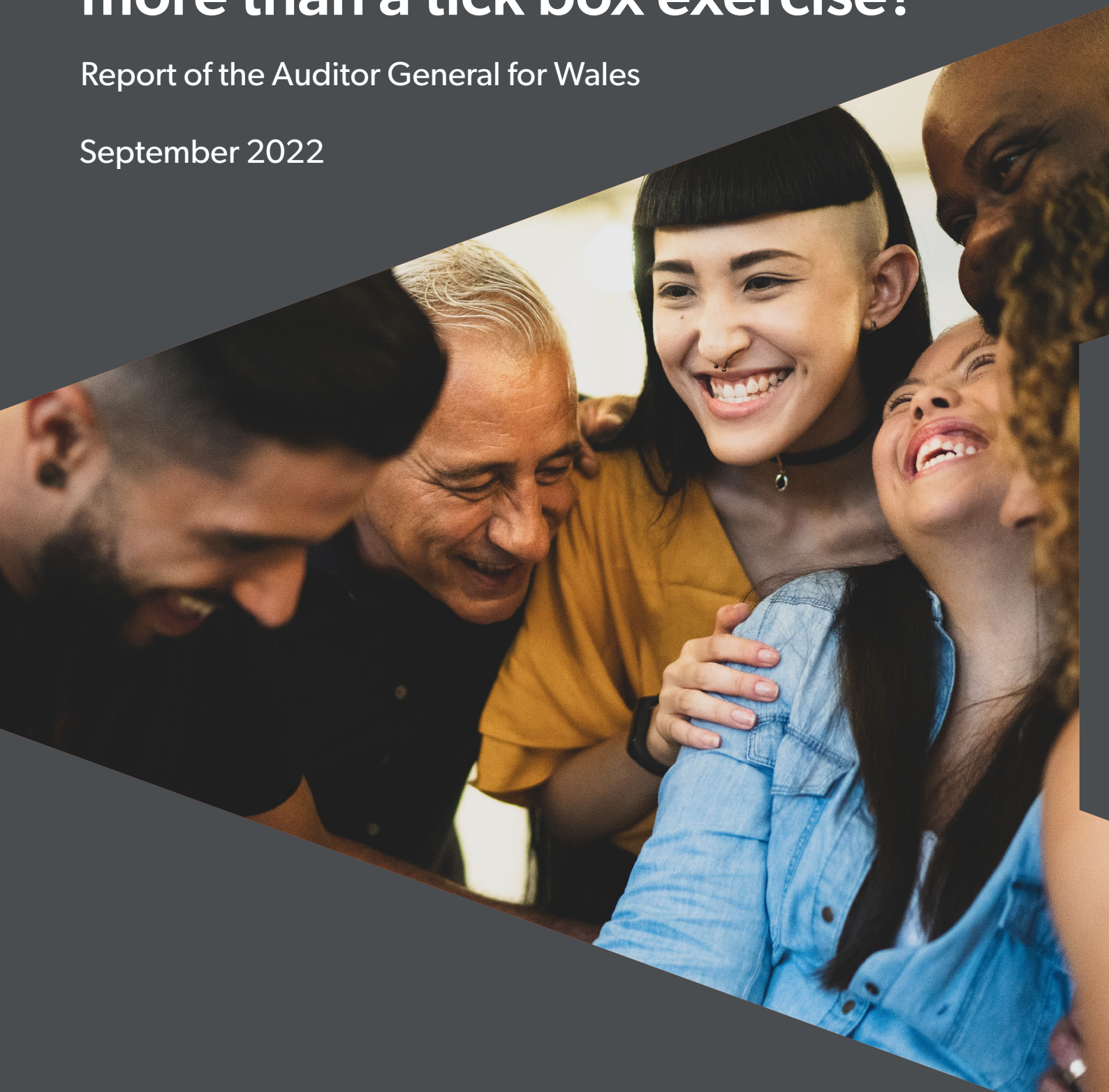
4.1 The Committee are asked to review and note the report.

Archwilio Cymru
Audit Wales

Equality Impact Assessments: more than a tick box exercise?

Report of the Auditor General for Wales

September 2022



This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998.

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

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

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

Audit Wales is the umbrella brand of the Auditor General for Wales and the Wales Audit Office, which are each separate legal entities with their own legal functions. Audit Wales is not itself a legal entity. While the Auditor General has the auditing and reporting functions described above, the Wales Audit Office's main functions are to provide staff and other resources for the exercise of the Auditor General's functions, and to monitor and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/ or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Auditor General's foreword 4

Key facts 6

Key messages 7

Recommendations 16

Detailed report

1 Supporting arrangements for conducting EIAs 18

2 Assessing impacts 27

3 Reporting and monitoring impacts 37

Appendices

Audit approach and methods 43

Auditor General's foreword

Discrimination and inequality continue to impact on the quality of life and life chances of people in Wales. My Picture of Public Services 2021 report highlighted that the COVID-19 pandemic had amplified some of the entrenched inequalities in our communities. Black Lives Matter, MeToo and other social movements have brought issues of discrimination and inequality to the forefront of public policy and debate.

Equality Impact Assessment (EIA) is an important part of the approach to tackling inequality in Wales. EIAs help public services meet their legal duties to avoid discrimination in the decisions they make and to promote equality of opportunity and cohesion.

Done well, EIAs are more than a means to show compliance. They support the growth of a mind-set and culture that put issues of equality at the heart of decision-making and policy development.

Our work shows that within individual public bodies there are good examples of aspects of the process of conducting an EIA. Through this report, I want to help all public bodies learn from those that are doing well and trying new approaches.

However, what we have seen and heard tells us that public bodies in Wales tend to use their EIAs defensively. Too often, they seem like a tick box exercise to show that the body has thought about equality issues in case of challenge. While legal challenge is of course an important risk to manage, this approach means public bodies are not using EIAs to their full potential, especially in terms of promoting equality and cohesion.

I hope this report will be of interest to anybody involved in public services and with an interest in tackling inequality and promoting equality. However, I want this work to be more than interesting. It needs to have an impact. Specifically, I expect:

- the Welsh Government to respond to the recommendations to work with partners to improve and update the overall approach to EIAs;
- all public bodies to respond to the recommendation that they review their own approaches to EIAs, including mindset and culture, drawing on the findings of this report; and
- those involved in scrutiny to use this report to challenge their organisation's overall approach to EIAs and the quality of individual EIAs used to inform their decisions.

I am pleased to say that this work has already had positive impacts. Our fieldwork questions have prompted some public bodies to check aspects of their own arrangements. And we have shared emerging findings with some public bodies that were updating their approach to EIAs. Closer to home, at Audit Wales, we are looking closely at our own processes and procedures to reflect the lessons identified in this work.

Adrian Crompton
Auditor General for Wales

Key facts

We set out below some key facts about the population in Wales in the context of the nine protected characteristics under the Equality Act 2010.

26,754 pregnancies during 2021[8]

16.5% aged under 15[1]

3.9% people who identify as gay, lesbian, bisexual or other[6]

7.8% people from a Black, Asian or minority ethnic community[5]

50.1% people with religious belief[4]

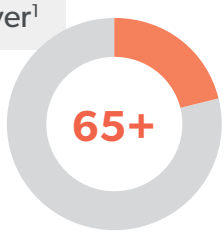
22.1% 16 to 64 year-olds identifying as disabled[2]

51.1% women[1]

48.1% people aged 16 and over who are married or in a civil partnership[3]

59% of transgender women and **56%** of transgender men said they avoided expressing their gender identity for fear of a negative reaction from others (UK)[7]

21.3% aged 65 and over[1]



3,107,500 population of Wales[1]

Sources:

1 Office of National Statistics (ONS), Population and household estimates, Census 2021, June 2022

2 StatsWales, Disability by age and sex (Equality Act definition) (2018-2020)

3 StatsWales, Marital status by age and sex (2018-2020)

4 StatsWales, Religion status by age (2018-2020)

5 ONS, Population estimates by ethnic group, England and Wales December 2021 (data for 2019)

6 StatsWales, Sexual identity by year, 2019

7 Government Equalities Office, National LGBT Survey, July 2018 (survey ran for 12 weeks from July 2017)

8 StatsWales, Initial assessment indicators for Wales, by mother's age, 2021

Key messages

Context

1 Tackling inequality is a long-standing goal of the Welsh Government. It features prominently in the 2021-2026 Programme for Government which includes the objective to 'celebrate diversity and move to eliminate inequality in all of its forms'[1]. The Well-being of Future Generations (Wales) Act 2015 makes 'A more equal Wales' a national goal. It defines this as 'a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances)'.

2 Equality Impact Assessment (EIA) is an important part of the approach to tackling discrimination and promoting equality in Wales. The Equality Act 2010 introduced the Public Sector Equality Duty (PSED) across Great Britain (**Exhibit 1**). The Welsh Government has made its own regulations[2] setting out some Wales specific duties that bodies listed in the Act need to follow to meet the PSED. Public bodies subject to the Act must assess the likely impacts of proposed policies or practices or proposed changes to existing policies or practices on their ability to meet the PSED. In doing so, they must comply with specific requirements to engage with groups likely to be impacted and monitor actual impacts.

1 Welsh Government, Programme for Government: update, December 2021
2 The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Exhibit 1: the Public Sector Equality Duty and protected characteristics

The PSED requires public bodies, in exercising their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act and the Wales specific duties apply to public bodies including councils, NHS bodies, fire and rescue services, national parks, education bodies (further and higher education bodies and maintained schools), and the Welsh Government and some of its sponsored bodies.

3 An EIA can provide evidence that the body has met the PSED. There have been legal challenges to decisions based on the lack or adequacy of an EIA. Moreover, EIAs support good policy and decision-making more generally by:

- **ensuring decisions impact protected groups in a fair way** – EIAs can demonstrate what, if any, action could be taken to mitigate the impact on one or more protected groups negatively affected by a decision and to promote equality and cohesion;
- **support evidence-based policy or decision-making** – EIA is a clear and structured way to collect, assess and present relevant evidence to support decisions; and
- **making decision-making more transparent** – EIAs must be published where they show there is or is likely to be a substantial impact.

4 As well as the PSED, the Equality Act 2010 included provision for a new socio-economic duty for public bodies[3]. The socio-economic duty came into force in Wales on 31 March 2021. It requires that public bodies, 'when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'. The Welsh Government advises public bodies to consider the socio-economic duty as part of existing processes, including impact assessments. We are currently reviewing local government's work to tackle poverty, including aspects of the socio-economic duty and the lived experience of people experiencing poverty.

About this report

5 We looked at the overall approach to undertaking EIAs in public bodies in Wales. To focus our work, we concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The main groups covered by the PSED that we did not include were the education bodies – further and higher education institutions and maintained schools – and Corporate Joint Committees.

6 We focused primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail. **Appendix 1** has more detail on our audit approach and methods. Where we identify individual bodies' practices, this is not to say that they are necessarily alone in having good or interesting practices in that area.

7 Parts one to three of this report set out the findings from our consideration of the EIA process at the 44 public bodies. Below, we set out the main areas for improvement we identified. These include issues that go beyond how public bodies are conducting specific parts of the processes and offer insight about the overall approach to assessing the impacts of policies and practices and the underpinning mindset and culture.

8 The Welsh Government is currently reviewing the PSED Wales specific regulations. We have framed our key improvement areas and recommendations in the context of the opportunity the review offers to clarify aspects of the overall approach to EIAs in Wales.

3 The duty lay dormant on the statute book as the UK Government did not commence it. The Wales Act 2017 gave new powers to the Welsh Ministers and allowed them to commence the duty in Wales. It covers most types of public bodies subject to the PSED.

Key improvement areas

9 Positively, there are examples of good practice in aspects of the EIA process across the public bodies we looked at. There is also non-statutory guidance from the Equality and Human Rights Commission (EHRC)[4] and on the Equality Impact Assessment In Wales Practice Hub (the Practice Hub) about the detailed processes for conducting an EIA. Many public bodies use this guidance to shape their approaches. However, there are areas for improvement (**Exhibit 2**).

Exhibit 2: key improvement areas for EIA

	Greater clarity over which type of policies and practices must be impact assessed
	Greater clarity about the arrangements for assessing the impact of collaborative policies and practices
	Greater clarity about expectations to consider the PSED as part of an integrated impact assessment
	Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect
	More engagement and involvement of people with protected characteristics
	Better monitoring of the actual impacts of policies and practices on people
	A shift in the mindsets and cultures to move EIA away from being seen as an add-on ‘tick box’ exercise

4 Equality and Human Rights Commission, Assessing Impact and the Equality Duty: A Guide for Listed Public Authorities in Wales, October 2014; and Equality and Human Rights Commission, Technical Guidance on the Public Sector Equality Duty: Wales, August 2014.

Greater clarity over which type of policies and practices must be impact assessed

10 There is scope for the Welsh Government, working with partners, to clarify its expectations around which type of policies and practices must be impact assessed. As drafted, the Welsh specific duties require public bodies to assess all new policies or practices, or those under review. However, the EHRC's non-statutory guidance recognises that 'policies and practices' is a broad category and says public bodies may need to prioritise. It introduces the concepts of 'proportionality' and 'relevance', which it says public bodies can apply through a process known as 'screening'.

11 We think the current position is open to interpretation in terms of whether proportionality and relevance mean public bodies should: (a) prioritise big decisions, like budget decisions or major service change; or (b) prioritise decisions that are likely to have a big impact on certain groups, for example, small scale decisions could have a large impact on one section of the population. Further, many bodies have interpreted proportionality as determining the amount of work needing to be done to assess impacts, rather than whether a policy or practice needs an EIA.

12 The EIAs or screening decisions that public bodies publish are usually those that go to their boards or cabinets. They therefore tend to be at the more strategic or impactful end of the scale. While we did not examine in detail practices at individual bodies, we think there is a risk that public bodies may be informally filtering out smaller scale policies and practices that do not require decisions from boards or cabinet, even though they may impact on people with protected characteristics.

Greater clarity about the arrangements for assessing the impact of collaborative policies and practices

13 There is scope to clarify how public bodies should do EIAs in an environment of increasing collaboration. The law places duties on individual public bodies. Since the legislation came into force, public bodies are increasingly developing plans and delivering services through collaborative arrangements. The Welsh Government updated the legislation to extend the PSED and Wales specific duties to Corporate Joint Committees in local government, but there are other collaborative arrangements not covered. These include Public Services Boards and Regional Partnership Boards as well as multiple service specific collaborations.

14 The Welsh Government has not produced stand-alone guidance on the use of EIAs by collaborative arrangements, although guidance for Public Services Boards highlights EIA requirements for individual public bodies[5]. The EHRC's 2014 guidance predates the creation of many of these arrangements and offers high level advice that there should be a shared approach but does not say how this should work in practice.

Greater clarity about expectations to consider the PSED as part of an integrated impact assessment

15 Increasingly, public bodies are integrating their EIAs with other impact assessments. While there is no legal requirement to integrate assessments, the Welsh Government's guidance on the Well-being of Future Generations (Wales) Act[6] emphasises the opportunities for bodies to integrate their approach to different duties, including those under the Equality Act 2010. Many of the equality officers[7] we spoke to said that integrating impact assessments led to a streamlined process and a more rounded approach to thinking about impacts. The key downside can be that the assessment is longer and can appear daunting. Our review of EIAs also identified a risk that integrated impact assessments dilute the focus on the impacts of policies and practices on people with protected characteristics.

16 Public bodies are inconsistent in what they include in an integrated impact assessment. Mostly, they collate separate assessments in one document, rather than produce a truly integrated analysis of impacts. There is no specific guidance to support public bodies in conducting integrated impact assessments. Many equality officers would welcome clearer guidance from the Welsh Government about its expectations.

Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect

17 There are examples of EIAs that clearly identify likely impacts on groups of people. However, many EIAs we reviewed were descriptive. They identified that a policy or practice might impact on a group of people. But they did not show how it would impact people's lives in practice. This makes it more difficult for decision-makers to assess how important the likely impacts are and if any mitigating measures proposed would be sufficient.

5 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 3: Collective Role (public service boards)), February 2016.

6 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 2: Individual Role (public bodies)), February 2016.

7 We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

18 In general, public bodies tend to identify negative impacts that they need to mitigate where possible. They are less likely to identify potential ways that the policy or practice could positively promote equality of opportunity and cohesion, even though this is a requirement of the PSED.Few public bodies have fully grasped the complexity of identifying likely impacts of policies and practices. None of the EIAs we looked at considered what is known as 'intersectionality'; the way that different protected characteristics combine. For example, while an EIA may identify impacts for Muslim people, it may not recognise that impacts could be very different for a Muslim woman compared to a Muslim man.

19 Many public bodies are thinking about how to identify the cumulative impacts of multiple decisions but few are doing so. Most do not have supporting systems that would enable those conducting EIAs to access the information needed about other decisions.

20 Most public bodies' formal processes and guidance say they will start thinking about impacts very early in the policy development process. However, many of the equality officers recognised that in practice EIAs often start late in the process, sometimes very shortly before a decision is due to be taken. This reduces the scope to shape the policy or practice and to mitigate impacts.

More engagement and involvement of people with protected characteristics

21 There are examples of public bodies seeking views from people with protected characteristics and drawing on their lived experience as part of the EIA. However, some third sector bodies are concerned that this does not happen nearly enough. We found that where public bodies seek views these often form part of a broader open consultation rather than focussing on specific groups with protected characteristics.

22 Some third sector organisations said that listening to people with protected characteristics was the action that would most improve EIAs. National representative public bodies could not always respond to the number of requests to take part in EIAs they receive and did not always have knowledge or information to respond to local issues.

Better monitoring of the actual impacts of policies and practices on people

23 Public bodies need to do more to monitor the impact of policies or decisions on protected groups. Equality officers at individual public bodies identified very few examples of public bodies monitoring the actual impacts of a policy or decision once implemented. Those examples put forward generally reflected broader monitoring of a policy's objectives rather than whether the impacts identified in the EIA materialised or whether there were other unanticipated impacts.

A shift in the mindsets and cultures that moves EIA away from being seen as an add-on 'tick box' exercise

24 From what we have seen there has not been a sufficient change in the mindset and culture in public services to put issues of equality at the heart of policy making. The mindset revealed by the EIA is often defensive: using EIAs to prove the body has paid due regard to equality in case of political or legal challenge. Often, the EIA seems like an additional 'tick box' exercise to be complied with rather than a tool to promote equality.

4 Recommendations

Recommendations

Clarifying the scope of the duty to impact assess policies and practices

R1 There is scope for confusion about which type of policies and practices must be subject to an assessment for their impact on the public sector equality duty. **The Welsh Government should clarify its interpretation of the duty, including whether and how it expects public bodies to apply any test of proportionality and relevance.**

Building a picture of what good integrated impact assessment looks like

R2 Many public bodies carry out integrated impact assessments that include consideration of the PSED alongside other duties. But practice is inconsistent and often involved collating multiple assessments in one place, rather than being truly integrated, **to help maximise the intended benefits of integrated impact assessments, the Welsh Government should work with key stakeholders with an interest in the areas commonly covered by integrated impact assessments and those with lived experiences, to share learning and work towards a shared understanding of what good looks like for an integrated impact assessment.**

Recommendations

Applying the equality duties to collaborative public bodies and partnerships

R3 The public sector landscape has changed since the introduction of the PSED and the Welsh specific duties, with an increasing focus on collaborative planning and delivery. **The Welsh Government should review whether it needs to update the Wales specific regulations to cover a wider range of collaborative and partnership arrangements. These include public services boards, regional partnership boards and other service specific partnerships.**

Reviewing public bodies' current approach for conducting EIAs

R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. **Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.**

Supporting arrangements for conducting EIAs

01

1.1 Conducting an EIA can be complicated. Good support can help make the process of conducting EIAs easier and more effective by having a clearly spelled-out approach and process, underpinned by clear guidance and training. And public bodies can have expert advice to hand to support those involved in assessing the impacts of decisions.

Setting out the organisation's approach to EIA

What we looked for

A clearly spelled-out approach to EIA for the organisation, including whether the EIA should form part of a wider integrated impact assessment.

What we found

Almost all public bodies had a set process for conducting an EIA, although these vary from a stand-alone EIA to producing integrated impact assessments covering a wide and varying range of other legal duties and policy priorities.

Strategic equality plans

1.2 All 44 public bodies met the requirement to produce a Strategic Equality Plan (SEP). The SEP must include an organisation's equality objectives, how they will measure progress on meeting objectives, and how they will promote knowledge and understanding of the general and specific duty. The SEP must also set out the public bodies' arrangements for assessing the likely impact of policies and practices on their ability to meet the PSED. However, in our review of SEPs we found that only 17 of the 44 bodies did so and to varying degrees of detail.

1.3 A few public bodies have gone further than simply describing arrangements. For example, Conwy County Borough Council's SEP describes in detail its process for EIA, how its Cabinet uses EIAs to support decision-making, and scrutiny committees' role in ensuring the quality of EIAs. The Council's SEP also explains how it has used EIAs to inform its equality objectives.

Organisational approach – integrated and stand-alone assessments

1.4 Nearly all public bodies (42 of 44) have a set process for undertaking EIAs. Most said that they put information on intranet sites, alongside supporting documents, contacts and most often a Word template for completion. Our review of EIAs found no standard format across public bodies, although most closely followed the approach set out in the Practice Hub. Members of the North Wales Public Sector Equality Network[8] have worked together to develop a standard template which most members of the network have adopted at least in part.

1.5 In around two-thirds (30 of 44) of public bodies we spoke to, the EIA forms part of a wider integrated impact assessment. There is no common approach to integrated impact assessments and no national guidance on what should be covered. There are some assessments that public bodies commonly include alongside the PSED (**Exhibit 3**). Some include other legal duties as well as policy priorities and practical considerations, such as finance. For example, the Welsh Government's integrated impact assessments sometimes cover climate change impacts, health impacts and economic impacts as well as a wide range of other legal duties, depending on the nature of the policy or practice.

8 The North Wales Public Sector Equality Network is an informal network of public bodies working together to advance equality. Representation includes North Wales local authorities, Betsi Cadwaladr University Health Board, North Wales Police and Police Authority, North Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, and Snowdonia National Park Authority.

Exhibit 3: assessments commonly included in an integrated impact assessment alongside the EIA

Well-being of Future Generations	The Well-being of Future Generations (Wales) Act 2015 introduced seven well-being goals for Wales. It also established the sustainable development principle and five ways of working – long-term, integration, involvement, collaboration, and prevention – to demonstrate application of the principle. An integrated impact assessment may also include an assessment of the policy or practice against the seven goals, public bodies' individual well-being objectives and/or the five ways of working specified in the Act.
Welsh Language	The Welsh Language (Wales) Measure 2011 declares that the Welsh language has official status in Wales. It makes provision to promote and facilitate the use of the Welsh language and to treat Welsh no less favourably than English through the Welsh language standards. Part of applying the standards means that public bodies must consider the effects their policy decisions on the Welsh language.
Environmental impacts	There are various duties to carry out environmental impact assessments depending on the nature of the proposed policy or practice. These range from strategic assessments of plans and programmes to assessments of projects that potentially impact on habitats and biodiversity.
UN Convention on the Rights of the Child	The Rights of Children and Young Persons (Wales) Measure 2011 embeds consideration of the United Nations Convention on the Rights of the Child and the optional protocols into Welsh law. The UN Convention consists of 41 articles, which set out a wide range of types of rights including rights to life and basic survival needs, rights to development including education and play, rights to protection, including safeguarding from abuse and exploitation, and rights to participation and express opinions.

Socio-economic	The Socio-economic duty came into force on 31 March 2021. When making strategic decisions, such as deciding priorities and setting objectives, public bodies must consider how they can reduce inequalities associated with socio-economic disadvantage.

1.6 Most integrated impact assessments involve collating separate impact assessments into a document template. Few seem to be a truly integrated impact assessment. Some public bodies are trying to make the connections between assessments and reduce duplication. For example, Carmarthenshire County Council, Powys County Council, Gwynedd Council, Denbighshire County Council and Wrexham County Borough Council have each developed, or are developing, an IT solution to bring together the relevant information needed to inform an integrated impact assessment.

1.7 Very few public bodies solely assess the impact on the PSED even when they do not consider their assessments to be integrated. In those public bodies that report having a standalone EIA process, the EIA often also includes Welsh-language and socio-economic impacts.

1.8 Previous research has found length is a barrier to the use of impact assessments in decision-making[9]. It was hard for us to judge any EIA or integrated impact assessment as too long as many factors affect the length including the nature of the policy or decision and the number of assessments undertaken. We reviewed some documents that were very long; for example, the integrated impact assessment of the Welsh Government's remote working policy was 45,000 words (average reading time 2.5 hours). The majority for which a word count was easily identifiable ranged between 2,500 and 7,500 words (average reading time 8 to 25 minutes).

1.9 Most public bodies that have chosen not to integrate their assessments had considered the option. Reasons for not integrating assessments included a concern that there would be insufficient regard to the PSED. This may be a valid concern. Our review suggests that, in some cases, the PSED is covered in limited detail and appeared secondary to other considerations even though all the public bodies we spoke to who conduct integrated impact assessments felt they sufficiently covered the equality element.

9 Grace, C., Reducing Complexity and Adding Value: A Strategic Approach to Impact Assessment in the Welsh Government, Public Policy Institute for Wales, February 2016.

Specialist support and expertise

What we looked for

That there is specialist support and expertise available in the organisation to those conducting EIAs.

What we found

In most cases, policy leads are responsible for conducting EIAs and can access support from colleagues with knowledge in equality related issues and an in-depth understanding of the organisation's process for conducting an EIA.

1.10 In almost all public bodies, responsibility to undertake an EIA lies with the lead officer developing or reviewing a policy or practice. This is partly pragmatic, due to the number of EIAs public bodies conduct. Equality officers told us this approach meant that EIAs benefitted from policy leads' expertise on the topic area. However, they identified drawbacks, including the difficulty of ensuring consistency, getting EIAs started at the right time and ensuring quality.

1.11 All public bodies have equality officers (or equivalent) with knowledge in general equality issues and a detailed understanding of the organisation's EIA process. In all public bodies, staff conducting EIAs can ask equality officers for guidance when required. EIAs are mostly conducted without the input of an equality officer. The process at Aneurin Bevan University Health Board is one exception to this, where the first step for anyone who thinks they need to undertake an EIA is to contact the Equality Diversity and Inclusion specialist to discuss the proposed policy or practice and agree what actions they need to take, with ongoing support also provided. In smaller public bodies, where an EIA is more likely to relate to staff policies and decisions, the lead for conducting the EIA is frequently an HR officer who is also the equality officer.

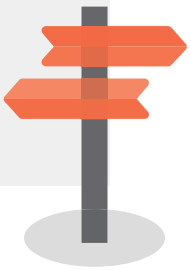
Guidance to support those conducting an EIA

What we looked for

That there is guidance to support those conducting an EIA, setting out what they need to do and when, in line with the duties and their organisation's chosen approach.

What we found

There is non-statutory national guidance and support available setting out some good practice in the stages of an EIA, although there are gaps, notably in terms of integrated impact assessments. Most public bodies have also produced their own guidance to support their EIA process.



External guidance

1.12 The Welsh Government has not published statutory guidance on the application of the PSED in Wales or the Welsh specific duties. The EHRC published non-statutory guidance on the Welsh specific duties in 2014. Welsh Government guidance encourages public bodies to integrate different duties. But there is no specific national guidance on how to conduct integrated impact assessments and what should be included.

1.13 The Welsh Government, Welsh Local Government Association, and NHS Centre for Equality and Human Rights jointly developed the Practice Hub in 2015-16. This online resource provides information and support to public bodies in Wales to undertake EIAs. It provides a detailed eight step guide to good practice in undertaking EIA and gives information on the Welsh specific duties.

Internal guidance

1.14 Internally, most public bodies have produced guidance to support their EIA process. The format and detail of the guidance and quality vary across public bodies. Some provide step-by-step guidance which outlines the process and steps for completing an EIA. Some embed practical information and links within templates.

1.15 A few public bodies do not provide guidance on their individual processes. Some of these provide direct one-to-one support from an equality officer (or equivalent) to the individual completing the assessment. Others signpost staff to the external guidance on the Practice Hub.

Training

What we looked for

That training on conducting an EIA is available for staff involved in developing EIAs and those that use them for decision-making.

What we found

Most public bodies offer training to those involved with EIAs through a variety of media.

1.16 Around two-thirds (31 of 44) public bodies we spoke to provide formal training to officers who are likely to complete or have an interest in EIA. This training frequently extends to elected members, board members and decision-makers.

1.17 Methods of training vary. Some offer face-to-face delivery of training, with much of this via video calls since the start of the COVID-19 pandemic. Many public bodies include online modules and e-learning tools on equality, and EIAs as part of their general staff training. Those public bodies that do not offer formal training nevertheless provide one-to-one support to individuals conducting EIAs and upskill them through the process.

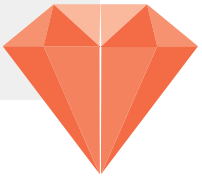
Quality assurance

What we looked for

An approach to ensuring the quality of the EIA process.

What we found

Half of public bodies had an approach to quality assurance, which varied from a simple sign-off on individual EIAs to more comprehensive peer learning to support improvement of the whole EIA process.



1.18 Half (22) of the public bodies have a quality assurance process in place for their EIA. The approach varies greatly. For some, quality assurance is about the quality of individual EIAs. Some require an EIA to be signed off by a senior officer. In Cardiff and Vale University Health Board, the lead officer conducting the EIA will work with an equality officer and a representative from Public Health Wales to review and interrogate the content of the EIA during its development. Other public bodies have begun to take a 'peer review' approach to developing EIA with input from experts from across the organisation.

1.19 A small number of public bodies use quality assurance to test the quality of their overall approach. For example, the Arts Council of Wales conducts an annual sample review of EIAs and uses the findings to improve the process.

Assessing impacts

02

2.1 The Wales specific duties require listed public bodies to assess the likely impact of proposed policies and practices, or those under review, on their ability to comply with the PSED. In doing so, they must have regard to certain types of information that they hold and meet specific requirements to engage with people or organisations that represent people with one or more protected characteristics. EHRC guidance and the Practice Hub set out in detail the steps public bodies can take to fulfil these requirements.

Screening

What we looked for

A clear approach to determining if an equality impact assessment is required.

What we found

Just over half of public bodies have a process for screening although many have stopped using screening, some due to risk of confusion or 'gaming' by staff.

2.2 There are no statutory exemptions setting out policies and practices that do not need to be assessed. However, the EHRC guidance and the practice hub include a 'screening' process to determine which policies or practices should have a full EIA.

2.3 Just over half (24 of 44) of public bodies we spoke to said that they have a screening process. Screening is most often a document template which an officer developing or reviewing a process or policy uses to determine whether they anticipate any impact on protected groups. The approach ranges in practice from a separate short impact assessment to a set of screening questions at the beginning of the full assessment template which determine whether to proceed with the full EIA.

2.4 Where a body decides it does not need a full EIA, they will usually retain a copy of the screening tool as evidence that it has considered the PSED. Most public bodies with a screening process will document the decision not to go ahead with a full EIA in the supporting papers that go to the cabinet or board.

2.5 Most often, the policy lead keeps the detailed record of screening. However, a few public bodies are trying to strengthen practice and ensure central records are maintained. For example, Cardiff Council has developed an online assessment tool to support policy leads through the process and encourage consideration of impact at the earliest stages of policy development. As well as sending advice and guidance to the officer completing the online assessment, the tool also sends a copy of the screening information to the equality officers.

2.6 The 20 public bodies who do not have a screening process had often consciously removed the screening step. Many said screening was an unnecessary step, as there are very few of their decisions that will not have potential to impact on the PSED. Some public bodies said that there was also scope for confusion, with lead officers completing a screening form, thinking it was an EIA. Others were concerned that some officers may 'game' the process: tailoring their responses to screening in a way designed to result in a decision that no further assessment was required.

2.7 Those public bodies that do not have a screening process usually provide additional guidance or a process chart, clarifying when to conduct a full EIA. All public bodies also offer the lead officer an opportunity to consult with an equality officer.

Timing

What we looked for

EIAs being started at an early stage to inform the development of a policy or decision.

What we found

All public bodies intend to carry out an EIA as early as possible, but many recognise this is often not the case in practice, and in some cases EIAs are very late in the policy development or decision-making process.

2.8 All 44 public bodies intend that EIAs should be started as early in the development or review of a policy as possible. But many public bodies acknowledged that this often does not happen in practice.

2.9 The timing of EIAs is affected by whether policy leads know that they are required to do an EIA and if resources – staff and time – are available at the appropriate point. Sometimes, if public bodies must make decisions very quickly, they either do not do an EIA or do them late in the decision-making process. This can be too late to consider changing a policy to lessen any possible negative impact or to build on positive impacts.

2.10 Decisions at the start of the COVID-19 pandemic were often made without an EIA. This reflected the urgency of decisions but meant that the impact on vulnerable people was not formally assessed. In August 2020, the Senedd's Equality, Local Government and Communities Committee[10] recommended that the Welsh Government should ensure that each major policy or legislative decision is accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since August 2020 has published dozens of impact assessments related to the COVID-19 pandemic on its website.

10 Senedd Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020.

2.11 In most public bodies, papers accompanying decisions that go to cabinets or boards contain a box or section that refers to consideration of the equality duties. This serves as a backstop to prevent public bodies from making decisions without any regard to the duties, even though this generally would be very late in the process.

Use of evidence

What we looked for

Use of a range of evidence to support the assessment, including the views of those likely to be impacted and data on lived experience.

What we found

Public bodies use a mix of evidence, although there are gaps in available data on some protected characteristics and the inclusion of the views and lived experiences of people with protected characteristics is patchy.

Quantitative data

2.12 EIAs need a sound evidence base to inform their conclusions. The depth and detail of the information base vary across organisations and by assessment The depth of information and analysis often depends on the scale of the decision and the availability of relevant and specific evidence.

2.13 All public bodies expect to include some quantitative data, such as demographic information or service level data. Around two-thirds (29 out of 44) of public bodies include at least some examples of internal information sources and point to publicly available data in their guidance and templates. Some go further. For example, Merthyr Tydfil County Borough Council includes in its guidance a detailed list of sources where policy leads can find relevant evidence, with embedded links to external data sources.

2.14 There are some significant data gaps in the data that is available to public bodies. Generally, there is little information available about some protected characteristics, particularly sexual orientation, gender reassignment, and pregnancy and maternity. Data that is available at a national level is sometimes not available at a health board, council, or ward level, which makes it difficult for public bodies to understand their local populations with protected characteristics.

Qualitative information

2.15 The inclusion of qualitative information based on the views and experiences of people with protected characteristics is also patchy. When introducing new policies or changing services public bodies often undertake a consultation exercise. In the examples we saw, these were often targeted to the public in general, and it was difficult to see if the public body had sought to engage specifically with people from protected groups.

2.16 Nonetheless, we did see examples of EIAs where evidence from engagement with groups was covered. For example, when Snowdonia National Park Authority undertook an EIA on its communication and engagement strategy, the assessment considered how the strategy could engage with people who speak languages other than English or Welsh. It also considered impacts on those who were digitally excluded, a group that is more likely to include older people and more women than men.

2.17 Some respondents to our general call for evidence said that drawing more on the views and experience of people with protected characteristics would improve the quality of EIAs. This includes engaging with individuals and grassroots organisations as well as national organisations representing protected groups. Some respondents said that public bodies should do more to publicise consultations by a range of means, including but not restricted to social media.

2.18 Some all-Wales third sector bodies responding to our call for evidence said that they were often asked to provide views for EIA and that some cannot respond to all the requests they receive. Sometimes they do not have information on local services and impacts.

2.19 A few public bodies are trying to draw on the lived experience of people with protected characteristics through different forms of consultation. Some use existing networks for staff with protected characteristics to understand different perspectives. Others, draw on existing relationships with third sector groups to understand the lived experience.

Identifying and mitigating likely impacts

What we looked for

Clear identification of likely impacts, including positive impacts in promoting equality, as well as negative ones.

Some consideration of cumulative impacts arising from other decisions that impact the same group or groups and how different protected characteristics combine (intersectionality).

Clear recommendations for mitigating negative impacts that have been acted on before the decision is made.

What we found

While there are examples of public bodies identifying specific impacts, often EIAs describe impacts in very broad terms. Very few identify the cumulative impacts of multiple decisions on groups or consider how different protected characteristics intersect. Very few can show how recommendations for mitigating impacts are followed through.

Specific impacts

2.20 Positively, our review of EIAs found examples of public bodies clearly identifying specific likely impact of policies or practices on protected groups. However, many EIAs included statistics to describe the population of people with protected characteristics without being clear how the policy or practice would likely impact on them. We also observed a tendency for EIAs to focus on negative impacts, thereby missing positive impacts and opportunities to improve cohesion and reduce inequalities.

2.21 We found that most EIAs reviewed provided data and information on each protected group separately. For example, the EIA on Conwy County Borough Council's Older Peoples' Domiciliary Care Finance and Commissioning Project set out the likely impact on people with each protected characteristic.

2.22 Most public bodies' approaches to EIA involve making recommendations to overcome negative impacts. Public bodies should incorporate mitigating actions into the policy development process, recognising it is not always possible to mitigate all negative impacts, such as with reductions in service. Very few public bodies have a process in place to track whether they have implemented the mitigating actions, after a decision is taken. In Hywel Dda University Health Board, the EIA has an associated action plan with a review date. In Aneurin Bevan University Health Board the Equality, Diversity, and Inclusion specialist keeps a database of actions arising from EIAs for monitoring purposes.

Intersectionality

2.23 Increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. However, we did not see examples of such nuanced understandings of inequality in the examples we reviewed.

Cumulative impacts

2.24 Public bodies in Wales make many decisions each year that, taken together, can be very detrimental to people from protected groups. For example, one respondent to our call for evidence gave the example of how individual decisions to reduce or close facilities and services such as public toilets, library services, day centres, and bus services had a cumulative impact on many older people who use the services. They said that, while each individual decision might not be significant, together they meant that some older people were becoming isolated.

2.25 The few instances we found where public bodies have begun to give thought to cumulative impacts tend to be when public bodies are making several decisions at the same time. For example, councils usually undertake a cumulative approach to assessing the impacts of their proposed budget each year. Individual service changes being proposed because of budget changes are assessed simultaneously allowing a better overview of potential impacts for the budget.

2.26 Typically, however, public bodies make decisions separately. One of the respondents to our call for evidence to decision-makers highlighted that it is difficult in principle to predict the likely impacts of multiple decisions in a complex landscape. Practically, the ability to take account of impacts from other decisions relies on the policy lead knowing about other decisions within an organisation and having access to the EIAs. A small number of public bodies are trying to address this information gap by using an IT solution to undertake the EIA (**paragraph 1.6**). This way, the assessment of impact for each policy change and decision is held centrally, making it easier for policy leads to bring together the information.

Decision-making

What we looked for

That the EIA and likely impacts it identifies are considered at the point of decision-making.

What we found

Equality officers' views varied around the extent to which their organisations prioritised the EIA in decision-making. Most respondents to our general call for evidence said public bodies did not pay sufficient regard to protected characteristics. The small number ofresponses from decision-makers suggest a view that the EIA is seen as a 'tick box exercise'.

2.27 The consideration given to EIAs in decision-making varies across public bodies in Wales. In general, equality officers felt that decision-makers take assurance in knowing that the policy lead has completed an EIA. Decision-makers will have access to a summary or the complete EIA accompanying each decision in their cabinet or board papers.

2.28 The equality officers we spoke to had mixed views over the extent to which their organisations placed sufficient weight on the EIA in decision-making. Over three-quarters of respondents to our general call for evidence who answered the question (29 of 37) disagreed that public bodies in Wales give appropriate due regard to people with protected characteristics when developing policies or making changes to services.

2.29 Generally, equality officers were not aware of instances where decision-makers challenged the content or recommendations of an EIA at the point of decision. Most felt that the accompanying EIA should have considered and shaped the policy sufficiently that there would be no need for such challenge at that late stage.

2.30 We only received ten responses to our call for evidence from decision-makers. While it is hard to draw conclusions from such a limited evidence base, it is notable that three of the ten referred to EIAs being used like a ‘tick box’.

Reporting and monitoring impacts

03

3.1 Public bodies must publish reports of the assessments where they show a substantial impact (or likely impact) on their ability to meet the PSED. They must also monitor the actual impact of the policies and practices subject to an equality impact assessment.

Reporting

What we looked for

Public information about decisions and a clear description of how the EIA has influenced the decision-making.

What we found

Most public bodies publish some of their EIAs as part of a wider set of papers and they are often not easy to find.

3.2 Almost all public bodies in Wales publish their EIAs, at least in part. Typically, they publish EIAs with decision-related papers, such as cabinet or board papers. There is usually a section on the body's website which holds all the papers for each meeting and is accessible to the public[11]. There are a few exceptions in some of the smaller public bodies, who do not routinely publish their EIAs.

3.3 It can often be difficult to find EIAs which relate to a specific decision on public bodies' websites. The EIAs which feature more prominently and are easier to locate often relate to strategic decisions such as budgets or key corporate strategies. Newport City Council have tried to bring EIAs into a central location on their website to make them more easily accessible, while recognising that this approach relies on the individuals completing EIAs sharing them for publication, which sometimes does not happen.

11 In some instances, bodies do not publish EIAs if they form part of a paper that is held back from publication due to its confidential or sensitive nature. However, these EIAs can sometimes be obtained via a Freedom of Information request if someone has a particular interest in seeing them.

Monitoring impacts

What we looked for

A clear approach to monitoring the impacts of the decision after it is implemented, including those identified as part of EIA as well as any unexpected impacts.

What we found

Very few public bodies monitor the impact of the decisions in the context of the PSED.

3.4 Some public bodies require those completing EIAs to identify a review date when monitoring is supposed to occur. We saw examples where EIAs set out plans for monitoring. For example, a Powys Teaching Health Board EIA included plans for monitoring service use after a change in surgery opening hours and for and independent evaluation of the service change. Also, Conwy County Borough Council's EIA for its review of domiciliary care included detailed arrangements for monitoring the impact using data and information that are routinely reported, including individual feedback from people receiving care.

3.5 However, equality officers had seen little evidence of the impact of policies and practices being monitored in light of the EIA. Those public bodies that outlined a monitoring process were often referring to the monitoring of an implementation of a policy or practice against its objectives or targets, not the impact that the decision had on people with protected characteristics.

3.6 In general, public bodies do not consider the impacts of policies and practices in terms of the PSED until there is another decision due on the same policy or practice. At that point, the body conducts a new EIA. Many of the equality officers we spoke to seemed unsure about how, in practice, they would monitor the impact of a decision on protected groups and would welcome more guidance.

Challenging EIAs

What we looked for

That the organisation identifies and applies lessons from any challenge to decisions on the basis of equality or the quality of the EIA.

What we found

Many equality officers did not think there had been any challenges to EIAs conducted by their organisation, but where there has been challenge some public bodies are using it as a learning opportunity.

3.7 Decisions made by public bodies can be challenged based on the EIA. Public bodies that do not have a clear record showing that they have considered the likely impacts of their decisions for people with protected characteristics leave themselves open to challenge. This could potentially include a judicial review. Some equality officers did not know what process someone would use to challenge an EIA. The majority said that any challenges would go through their general complaints process, with the involvement of the relevant service, equality officers and legal team.

3.8 Many equality officers thought there had not been any challenge to an EIA conducted by their organisation. Those that were aware of challenge taking place said that it was something that happens infrequently. Almost half of respondents to our general call for evidence who answered the question (17 of 35) said they had challenged some aspect of an EIA. We do not know if this was a formal or informal challenge.

3.9 Equality officers who had experienced challenge to an EIA said their organisation can resolve the issues either by making changes to a policy or practice, or by providing evidence that they had considered the impacts. Respondents to our general call for evidence gave examples of issues they raised being resolved. For example, one had objected to the EIA conducted on a new bus interchange because the council had not sought the views of people with protected characteristics on the proposals. Following their intervention, people with low vision visited the site and suggested changes to make the interchange more accessible.

3.10 While there are positive examples of public bodies responding to challenge, several respondents to our general call for evidence who had challenged aspects of an EIA reported not receiving any response to their challenge. A few equality officers told us that their organisation had learnt from the experience of having an EIA challenged. One had used examples of challenge from other public bodies to inform its EIA training as a particularly useful way of making impacts more easily understood to lead officers conducting EIAs.

Appendices

1 Audit approach and methods

1 Audit approach and methods

Audit approach

Our main aim was to provide insight about the approach to EIAs undertaken across the public sector in Wales. We wanted to highlight good practice and identify opportunities to improve. To help shape our thinking about what good practice to look for, we drew heavily on existing guidance materials, in particular that produced by the Equality and Human Rights Commission (EHRC) and the Equality Impact Assessment in Wales Practice Hub hosted by Public Health Wales NHS Trust.

We set out to explore to what extent public bodies have integrated their approach to undertaking EIAs, including the new socio-economic duty and the cumulative impact of decisions. We also explored what difficulties public bodies experience that affect the quality and timeliness of EIAs. We looked at how public bodies monitor the impact of decisions on their population. Each of the sub-sections in the main body of this report describes what we were looking for through our work.

In looking across the public bodies, we focused on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is the external auditor of each of these bodies, which include local authorities, health boards and some NHS trusts, national parks, and fire and rescue services. They also include the Welsh Government and some of its sponsored bodies. Our audit coverage did not include education bodies – further education, higher education or maintained schools – that are subject to the PSED. It also did not include the four Corporate Joint Committees (CJCs) established by the Local Government and Elections (Wales) Act 2021 and which are subject to the PSED.

Audit methods

Document review: We reviewed documents from each of the 44 public bodies, including those relating to the equality plans and details of the organisation's EIA process. We also reviewed details of their process for integrated impact assessments. We reviewed a sample of 29 EIAs provided by public bodies: 11 by local authorities, eight by health bodies, two fire and rescue, two national parks and six by the Welsh Government or its sponsored bodies.

Interviews: We interviewed the equality officers or their equivalent in each of the 44 bodies. We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

Call for evidence: We sought wider views about people's experience of EIAs through a call for evidence between October 2021 and June 2022. We publicised this generally and in particular to third sector organisations. We received 40 responses, 23 from individuals and 15 responding on behalf of an organisation (two did not say).

We also sought the views of decision-makers through a separate call for evidence open between February and June 2022. We received ten responses (eight from individuals working in local authorities, one health and one fire and rescue).

While the responses we received to the calls for evidence are not necessarily representative of individuals, the third sector or decision-makers, they have provided useful detail which we have included through the report and which informed our overall analysis.

Stakeholder engagement: The EHRC is responsible for promoting and enforcing equality and non-discrimination laws. We met with officials in the EHRC Wales Team regularly throughout our work, discussing our scope and emerging findings. We also met with the Welsh Local Government Association's equality network and the Chair of the All-Wales NHS Equality Leadership Group. We interviewed officials from the Welsh Government with responsibility for equality policy.

Wider audit intelligence: We drew on existing intelligence from our local financial and performance audit work, where that was relevant to equality impact assessments.

Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff

CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

Management response to audit recommendations

Report title: Reviewing approach to Equality Impact Assessments
Completion date: 3.1.23

Recommendation	Management response	Completion date	Responsible officer
Reviewing public bodies' current approach for conducting EIAs R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	A review of the current EIA process was commenced on 13.12.22 with the aim of making it simpler and focused towards action and improvement. This will include input from managers who need to conduct the assessments.	31.3.23	Claire Budgen

Recommendation	Management response	Completion date	Responsible officer

AUDIT COMMITTEE

AUDIT WALES REPORT – THE NATIONAL FRAUD INITIATIVE IN WALES 2020-21

DATE OF MEETING	12/01/2023

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	
NFI	National Fraud Initiative

1. SITUATION/BACKGROUND

1.1 Audit Wales' report in relation to the National Fraud Initiative in Wales 2020-2021 is attached for the Committee's information.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report contains three recommendations for action by the organisation.
2.2 Management responses to those three recommendations are attached for the Committee's information.

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	Yes (Include further detail below)
	The NFI can help the Welsh public sector reduce the value of fraud encountered.

4. RECOMMENDATION

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

Archwilio Cymru
Audit Wales

The National Fraud Initiative in Wales 2020-21

Report of the Auditor General for Wales

This is an interactive pdf

To navigate through the document please use the buttons on the left side of the page and the links marked with underlined text

Key messages

Key messages

Outcomes

Results

Process

Prev Next

Since we last reported on the National Fraud Initiative (NFI) in Wales in October 2020, outcomes valued at £6.5 million have been recorded. The cumulative total of outcomes from the NFI in Wales since NFI started in 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes is now £2.37 billion.

NFI outcomes in Wales decreased by £1.5 million to £6.5 million in the 2020-21 exercise. This was primarily because fewer ineligible claims for Council Tax Single Persons Discount and Housing Benefit claims were detected, reflecting the fact that some local authorities started review of NFI matches later than normal due to Covid-19 pressures.

Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2020-21 NFI exercise helped organisations in other parts of the UK to identify 153 cases of fraud and error with outcomes of £183,045.

While the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by the sector. This suggests that some local authorities have either failed to recognise the importance of the exercise or are unwilling to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

One Welsh local authority, Cardiff Council, agreed to participate in an exercise designed to identify fraud and error in applications for COVID-19 business support grants by verifying applicant bank details and trading status. These checks helped to identify outcomes of just under £0.6 million relating to 41 fraudulent or erroneous applications.

Key messages

Outcomes

Results

Process

Prev Next

Recommendations

- All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.
- Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.
- Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.

Key messages

Outcomes

Results

Process

Prev Next

Outcomes

NFI outcomes

NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. NFI uses data sharing and matching to help confirm that services are provided to the correct people.

An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

The NFI recorded outcomes of £6.5 million in 2020-21.

NFI outcomes cumulatively in the UK since 1996-97

£2.37 billion

NFI outcomes cumulatively in Wales since 1996-97

£49.4 million

NFI outcomes across the UK from the 2020-21 exercise

£443 million

NFI outcomes in Wales from the 2020-21 exercise

£6.5 million

Key messages

Outcomes

Results

Process

Prev Next

Trends in outcomes

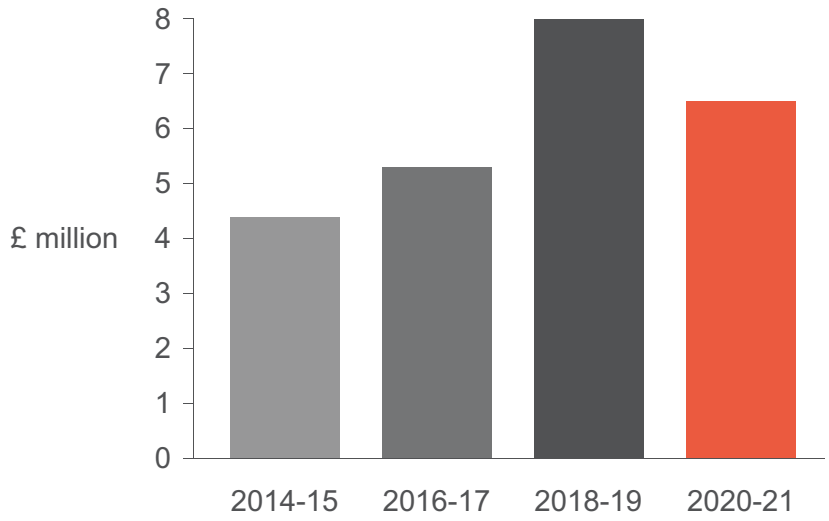
Outcomes in Wales have decreased by £1.5 million to £6.5 million in the 2020-21 exercise. Reasons for the decrease in outcomes include:

- the number of fraudulent or erroneous claims for Council Tax Single Persons Discount detected fell from 3,939 in the 2018-19 exercise to 1,987 in the 2020-21 exercise, resulting in outcomes in this area reducing by £2 million; and
- the number of fraudulent or erroneous claims for Housing Benefit detected fell from 179 in the 2018-19 exercise to 82 cases in the 2020-21 exercise, resulting in outcomes in this area reducing by £0.6 million.

The above fall in outcomes was offset in part by:

- an increase in the number of fraudulent or erroneous applications for social housing detected from 74 in the 2018-19 exercise to 237 in the 2020-21 exercise, resulting in increased outcomes of £0.6 million; and
- the detection of 43 fraudulent or erroneous claims for COVID-19 business support grants resulting in cumulative outcomes of £0.6 million.

Outcomes of £6.5 million were identified in the 2020-21 exercise



While overall outcomes have fallen, this is in part because many NFI participants started review of NFI matches later than normal due to work pressures arising from the COVID-19 pandemic.

The only UK nation which saw an increase in 2020-21 NFI outcomes was England. This increase was due to a significant increase in pension outcomes from matching UK-wide pension scheme data.

Late savings arising from NFI 2020-21 will be reported as part of the NFI 2022-23 exercise.

Key messages

Outcomes

Results

Process

Prev Next

How the latest outcomes compare to the last exercise

Key messages

Outcomes

Results

Process

Prev Next

Seven areas generated almost 98% of outcomes

The areas which generated the most outcomes from the current exercise are as follows:

Category	£	Cases
Council tax discounts	£2.6m	1,987
Blue badges	£1.4m	2,717
Housing waiting lists	£0.8m	237
Housing benefit	£0.6m	84
COVID-19 business support grants	£0.6m	43
Council tax reduction scheme	£0.2m	214
Creditor payments	£0.1m	9

Once overpayments have been identified, public bodies can take appropriate action to recover the money. As at 31 March 2022, 81% of overpayments had been recovered or were in the process of being recovered.

Key messages

Outcomes

Results

Process

Prev Next

Results

Council tax discounts

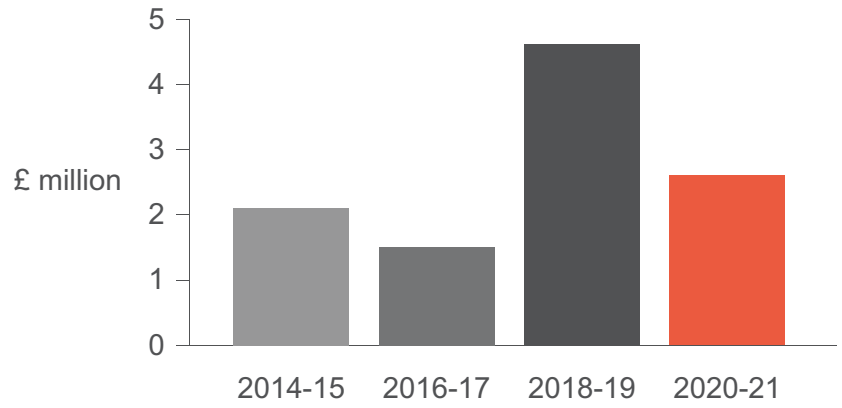
People living on their own, or with no countable adults in the same household, are eligible for a 25% single person discount (SPD) on their annual council tax bill.

Council tax SPD data is matched to electoral register data to help find where people are receiving the discount, but are not the only countable adult at their residence.

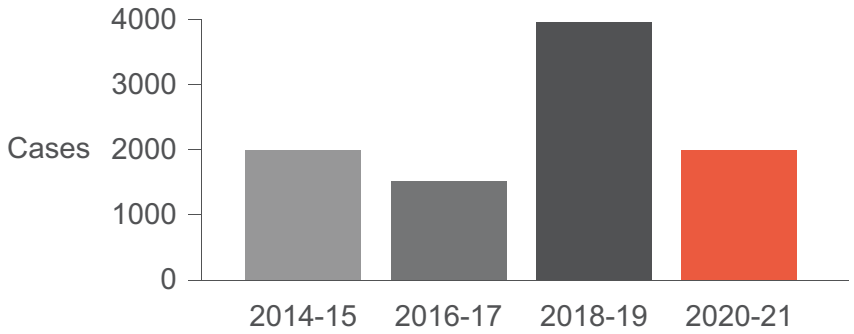
The 2020-21 NFI exercise found that the total council tax discount incorrectly awarded across Welsh local authorities totalled £2.6 million. This is an average outcome of £1,305 for each case (£1,003 per case in the 2018-19 NFI). Review of the NFI matches led to the cancellation of 1,987 SPD claims.

While the number of fraudulent or erroneous SPD claims detected fell from 3,939 to 1,987 in the current exercise, this is partly due to investigation of the matches being delayed due to the COVID-19 pandemic. Many claims have been cancelled since the cut-off date for reporting the NFI 2020-21 exercise and these 'late results' will be reported within NFI 2022-23.

Outcomes of **£2.6 million** in 2020-21



1,987 cases in 2020-21



Key messages

Outcomes

Results

Process

Prev Next

Pensions

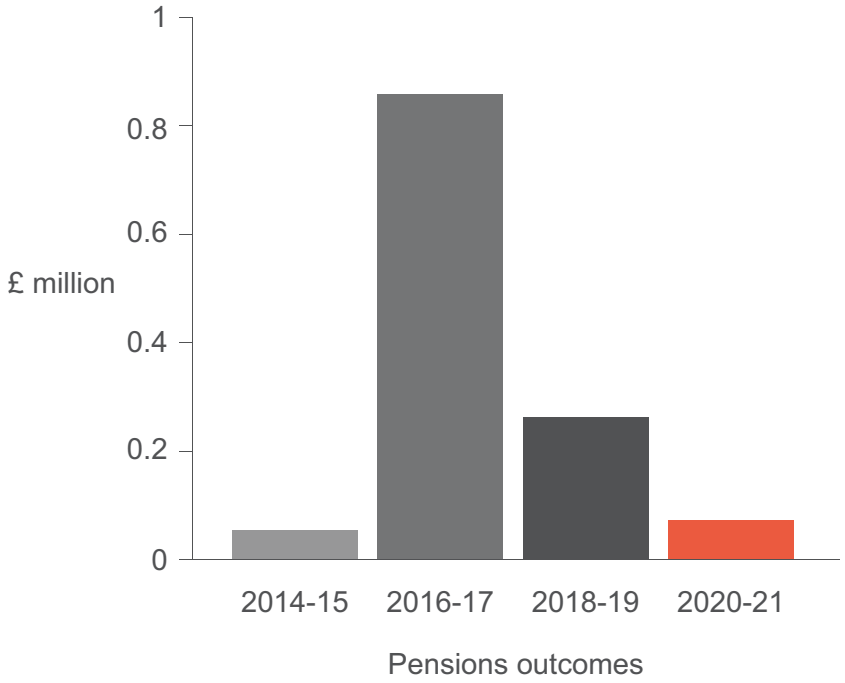
The NFI provides local authorities that administer pensions with an efficient and effective way of checking that they are only paying people who are alive.

The exercise found nine instances where pensions had remained in payment after pensioners had died compared to ten cases in NFI 2018-19.

In total, pensions outcomes for the 2020-21 NFI exercise are £0.073 million.

This is a reduction of £0.26 million from the 2018-19 NFI exercise, and reflects the continuing impact of the 'tell us once' reporting process which is ensuring that local authorities become aware of the decease of pensioners earlier. While the number of cases detected by NFI has remained almost unchanged from NFI 2018-19, the average value of each case has fallen from £26,396 to £8,160, because the period of time pensions remained in payment after pensioners' death was shorter.

Outcomes of **£0.073 million** in 2020-21



Key messages

Outcomes

Results

Process

Prev Next

Housing benefit

The NFI provides local authorities and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors.

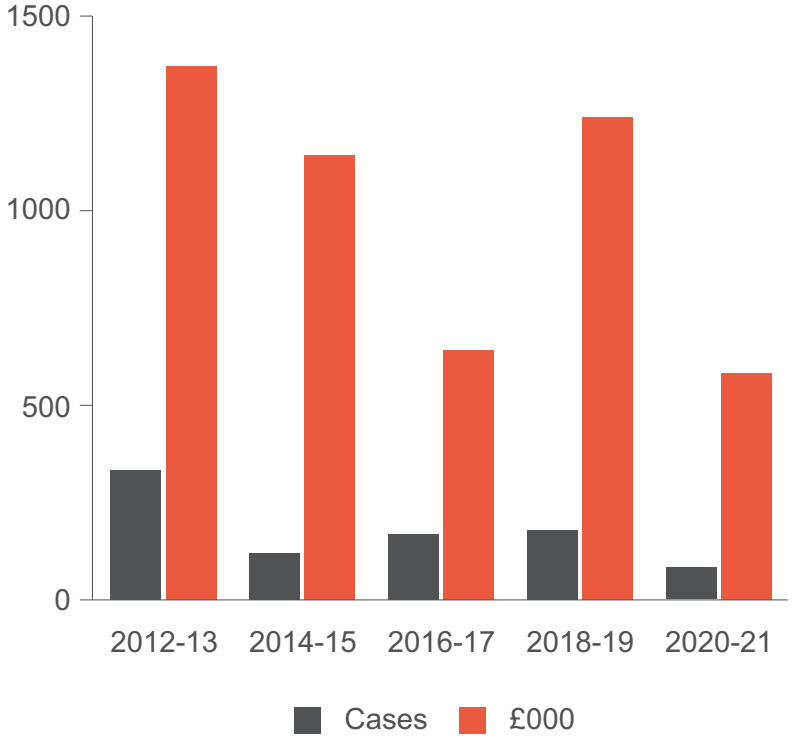
Housing benefit data is matched to student loans, payroll, pensions, housing benefit, housing tenants, licences, deceased person and Amberhill* data to help identify ineligible claims.

The value and number of housing benefit cases recorded with overpayments has reduced from £1.2 million (179 cases) in the 2018-19 exercise to £0.6 million (82 cases) in the 2020-21 exercise.

The fall in housing benefit cases outcomes is mainly due to matches between housing benefit and payroll and pension payments not being included in the 2020-21 exercise. These matches historically identified significant outcomes. These matches were not included as similar data matching is undertaking by the DWP's Verify Earnings and Pensions (VEP) Alerts service which identifies discrepancies between payroll and pension details held by HM Revenue & Customs and council benefits services. Alerts from VEP are sent to local authorities to investigate discrepancies.

*Amberhill is a system used by the Metropolitan Police to authenticate documents presented for identity.

Outcomes of **£0.6 million** in 2020-21



The majority of fraudulent and erroneous claims for housing benefit detected by local authorities in the 2020-21 exercise related to students who were in receipt of housing benefit when not entitled.

Key messages

Outcomes

Results

Process

Prev Next

Case Study: Housing benefit

Carmarthenshire County Council

The Council continues to recognise the value of NFI in protecting the public purse against the threat of fraud risks and considers NFI as being invaluable in the detection and prevention of fraud. The NFI 2020-21 exercise identified 33 housing benefit to student loan matches and of these 13 were high risk matches. Historically the Council has achieved significant results from this specific report and, as in previous exercises, extended the checking process to all matches. Review of the report identified fraud in 30% of the matches, where it was established that benefit customers had failed to declare they were in receipt of student finance/loans. These ten investigations identified overpayments of benefits in excess of £33,000. The Council has recovered the overpayments or remains in the process of full recovery.

Key messages

Outcomes

Results

Process

Prev Next

Blue badges

The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in pay and display bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

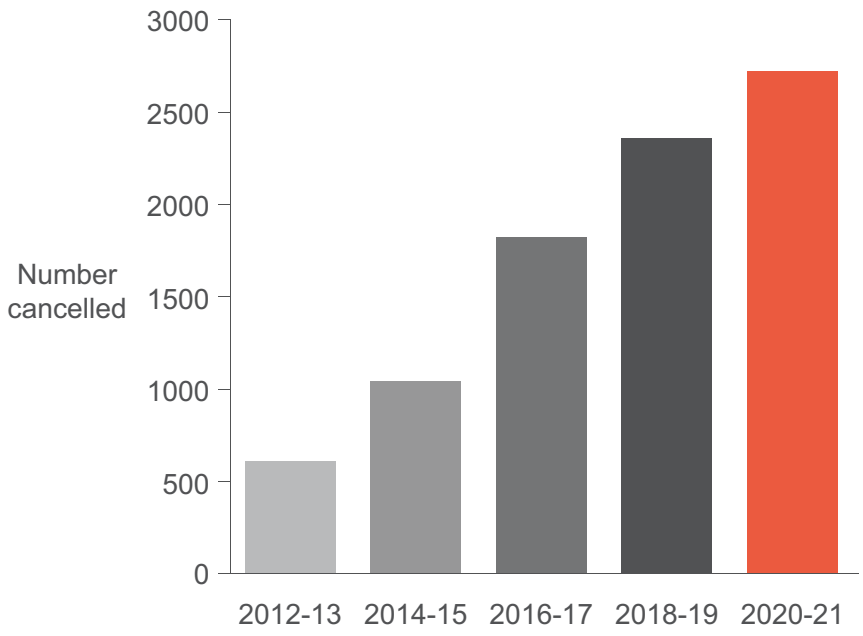
Blue badge data is matched to deceased persons and Amberhill data.

Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

NFI 2020-21 resulted in the cancellation of 2,717 blue badges in Wales. The number of badges cancelled has increased in each NFI exercise since NFI 2012-13. The estimated value of these cases is £1.4 million based on a calculation of the annual estimated cost of lost parking revenue and the likelihood of these blue badges being misused.

The increase in outcomes is due to a growing recognition of the need to prevent misuse of blue badges. Not only does such misuse reduce parking revenues, it also limits the parking facilities available to genuine blue badge holders.

2,717 outcomes in NFI 2020-21



Key messages

Outcomes

Results

Process

Prev Next

Housing waiting lists

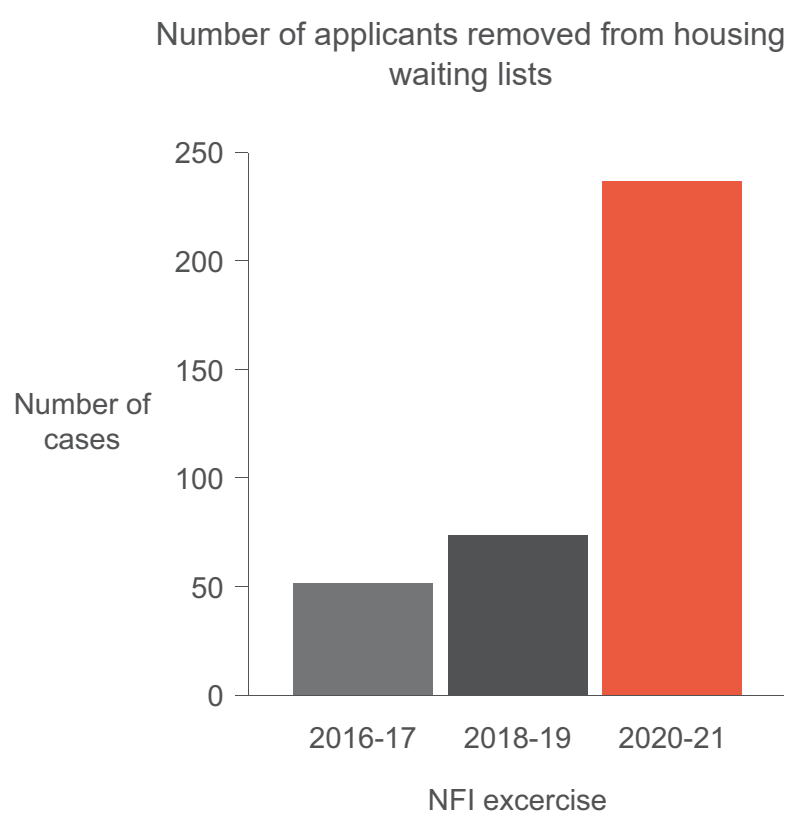
NFI uses housing waiting list data to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016-17 NFI exercise.

Housing waiting list data is matched to waiting list, housing benefit, housing tenants, deceased persons and Amberhill data.

Local authorities identified 237 cases where applicants were removed from waiting lists compared to 74 cases in 2018-19.

The estimated value of these cases is just under £0.8 million based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided with a property.

The increase in the number of applications cancelled is due to increased efforts by local authorities to review the NFI matches thereby helping ensure that social housing is only provided to eligible persons.



Key messages

Outcomes

Results

Process

Prev Next

Creditor payments

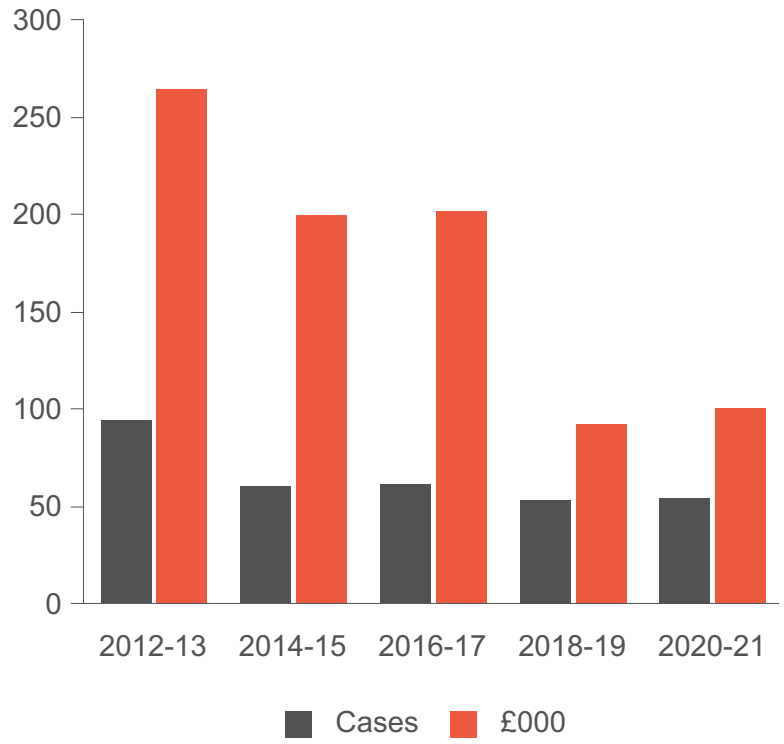
The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors.

Creditor payment data is also matched to payroll and Companies House data to help identify undisclosed staff interests in suppliers.

NFI 2020-21 resulted in 54 creditor payment outcomes totalling just over £0.1 million compared to 53 outcomes totalling just under £0.1 million in NFI 2018-19. Recovery action has already taken place or is in process for all of these overpayments.

Creditor payment outcomes have reduced over NFI exercises as participating bodies have improved their internal control systems.

Outcomes of **£0.1 million** in 2020-21



Key messages

Outcomes

Results

Process

Prev Next

Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills.

The NFI provides local authorities with the opportunity to identify a range of council tax reduction frauds and errors.

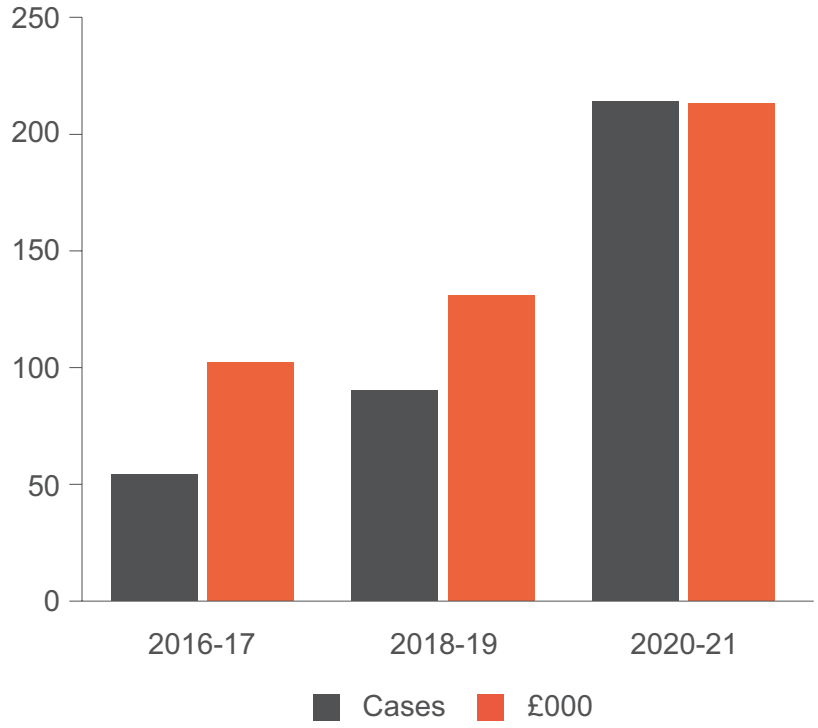
Council tax reduction data is matched to council tax reduction, payroll, pensions payroll, housing benefits, housing tenants, licences, deceased persons and Amberhill data.

The 2016-17 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.21 million were identified in the 2020-21 NFI and claims for council tax reduction were amended or cancelled in 214 cases.

The average value of each case was £1,015 compared to £1,457 in NFI 2018-19 suggesting that fraud and error is being identified earlier.

Outcomes of **£0.21 million** in 2020-21



Key messages

Outcomes

Results

Process

Prev Next

Case study: Vale of Glamorgan Council

The Council has a proactive and comprehensive approach to reviewing all NFI matches. All council tax reduction matches are reviewed by the Investigation Officer against the Council's internal systems to try and establish the current household status of claimants. One such match appeared to show the claimant had not declared an occupational pension that had been in payment since 2018. The Investigation Officer advised the Benefits Team that further investigation was required. The Benefits Team liaised with the Revenues Team and found there was another person residing at the address who was also in receipt of an undeclared occupational pension and who had received a substantial lump sum pension payment in 2018. Despite numerous attempts to verify the current situation with the claimant, the claimant failed to respond. The Council has cancelled the claim and the claimant has agreed to repay an overclaim of £4,775 in monthly instalments.

Key messages

Outcomes

Results

Process

Prev Next

Use of HMRC Data in NFI

In NFI 2020-21, for the first time, Welsh NFI matches were enriched by HMRC data provided under the provisions of the Digital Economy Act 2017. The HMRC data is proving highly effective in helping to identify applicants who have claimed means-tested benefits and discounts but have not declared income that should have been declared on their applications.

Case Study: Denbighshire County Council

The Council proactively reviewed matches between Council Tax Reduction Scheme (CTRS) and HMRC's household composition. One match suggested there was an undeclared non-dependant in the household from 2017, so benefit payments were suspended. The Benefits Team had previously been notified that the person had left the household in March 2017. On investigation, the customer confirmed the failure to declare the non-dependant since May 2017. The NFI match showed the earnings of the non-dependant to be around the threshold at which the highest deduction to the claimant's benefits would apply, so in the absence of further evidence of the non-dependent's income, the is highest deduction was applied. This resulted in an overclaim totalling £20,782. The Council is in the process of recovering the overclaim.

Key messages

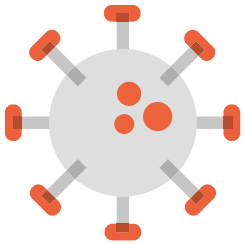
Outcomes

Results

Process

Prev Next

COVID-19 business support grants



In response to the COVID-19 pandemic, the Welsh Government put in place a package of measures to support businesses through the crisis. One of these measures included providing grant funding through Welsh local authorities to some retail, hospitality and leisure businesses and to businesses classified as small businesses for business rate purposes. NFI matched these grants to ensure that businesses were not inappropriately claiming multiple grants and that grants were not being awarded to known fraudsters. These checks only identified two cases of fraud and error amounting to £20,000, providing assurance that these practices were not common.

NFI also made optional tools available to local authorities to confirm that grant applicants were actively trading before the COVID-19 pandemic, and that bank account details provided by applicants related to legitimate business accounts. One Welsh local authority, Cardiff Council, used these tools in conjunction with other internal controls to identify 41 cases of fraud and error with a value of £575,000.

Case Study: Cardiff Council

Following the use of various upfront application and payment controls, the Council used a multi-layered approach to post payment verification and assurance processes for COVID-19 business support grants. NFI provided a useful source of intelligence as part of these post payment checks. The Corporate Fraud Investigation Team and colleagues in Business Rates used a range of investigative techniques and identified £575,000 of payments for recovery. For example, one NFI match indicated that a company had ceased trading, online enquiries suggested the business had closed and a Companies House check showed the company had dissolved prior to the grant eligibility date. The company had not notified the Council that they had ceased trading and were not eligible for the grant. The Council has recovered, or is is seeking to recover the overclaims wherever there is a realistic chance of doing so.

Key messages

Outcomes

Results

Process

Prev Next

Payments to residential care homes

In previous NFI exercises, NFI has matched residential care home data to deceased persons to identify cases where a care home resident has died, but the local authority has not been notified and so has continued to make payments to the care home.

In NFI 2018-19, 11 cases of overpayments were identified where Welsh local authorities were continuing to pay care homes for residents who had died. The average value of these cases was £14,545.

Due to the unintended consequence of a change to legislation affecting Wales, Scotland and England, it was not possible to undertake matching in this area as part of NFI 2020-21. The Auditor General is working with the Cabinet Office and Audit Scotland to find a legislative solution that will allow this matching to be undertaken in future NFI exercises.

Key messages

Outcomes

Results

Process

Prev Next

Matches benefiting other public bodies

One key benefit of a UK-wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Welsh participants for the 2020-21 NFI exercise helped other public bodies outside Wales identify outcomes worth just over £183,000.

Sector of source data	£	Number of outcomes
Local authorities	162,776	135
NHS	15,811	17
Fire	4,458	1
Total	**183,045**	**153**

Most of these outcomes relate to housing benefits, housing waiting lists, and council tax reductions. For example, payroll data from a health board may allow a local authority to identify a housing benefit overpayment.

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that providing their data can help other bodies and sectors identify frauds and overpayments.

Process

Key messages

Outcomes

Results

Process

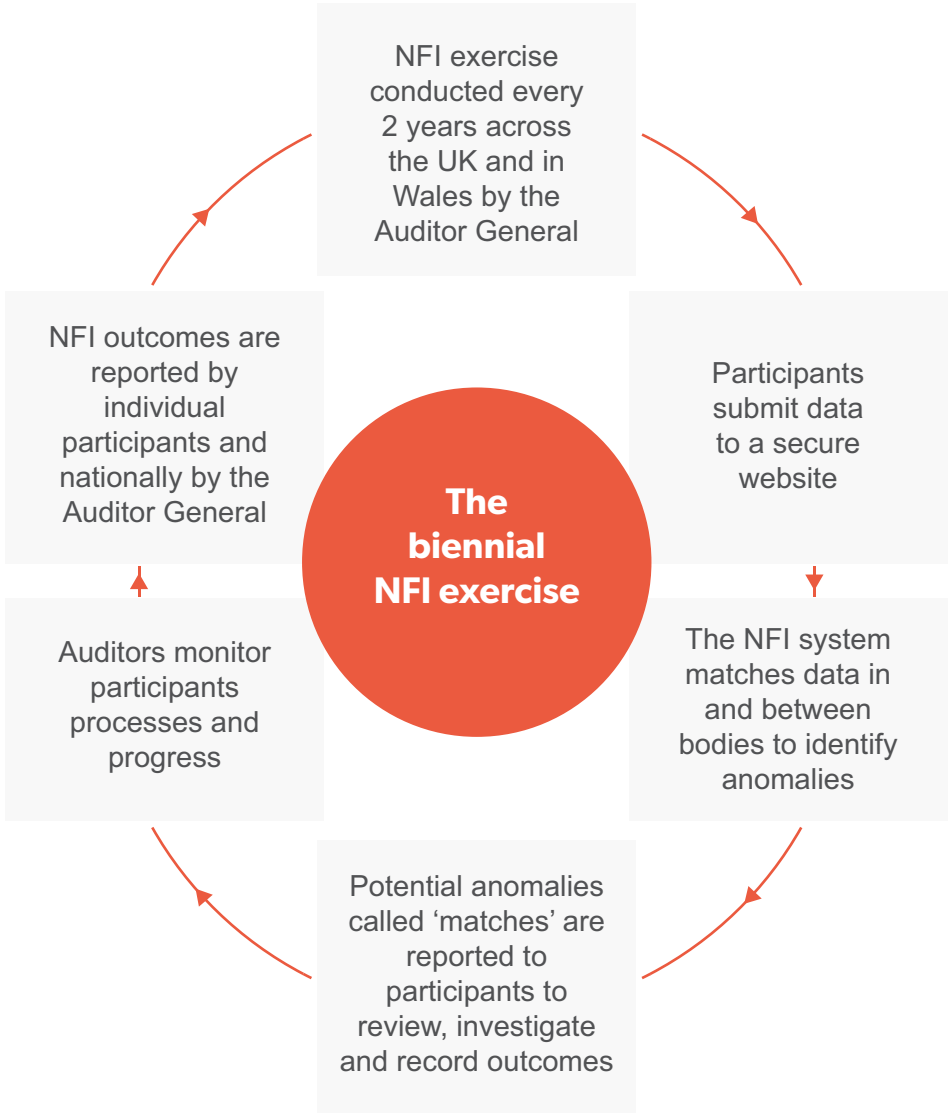
Prev Next

The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Auditor General, Cabinet Office, Audit Scotland, and the Northern Ireland Audit Office lead the exercise in Wales, England, Scotland, and Northern Ireland, respectively. The NFI takes place biennially and enables public bodies to use computer data matching techniques to detect fraud and error.

The main purpose of the NFI is to ensure funds and services are provided to the correct people, but the NFI can also identify individuals entitled to additional services or payments eg housing benefit matches may identify customers entitled to council tax discount or reduction.

We carry out the NFI process under powers in the Public Audit (Wales) Act 2004. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls governing the NFI data matching exercise.

In Wales, the Auditor General has mandated unitary local authorities and NHS bodies to participate in the NFI. The Welsh Government, some Welsh Government Sponsored Bodies, and Audit Wales participate on a voluntary basis.



Key messages

Outcomes

Results

Process

Prev Next

How bodies work with the NFI

The success of the NFI is dependent on the proactivity and effectiveness of participant bodies in investigating the data matches.

Most participating Welsh public bodies managed their roles in the 2020-21 NFI exercise well.

However, some bodies could be far more pro-active in their approach to the NFI. In particular, some local authorities reviewed very few of the matches they received, and as a consequence did not do sufficient work to address potential frauds. This was due to some participants failing to recognise the importance of the exercise and/or an unwillingness to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

Key messages

Outcomes

Results

Process

Prev Next

Future developments

- The Auditor General is considering how to further develop the scope of NFI in Wales and areas of potential data-matching currently being explored include, housing tenancies, GP patient registration, business rates.
- The 2022-23 NFI is now underway. Data sets have been reviewed following a period of consultation and NFI participants are starting to submit data for matching.
- The Auditor General continues to work with the Welsh Government to promote and enhance participation in the NFI across Wales.

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

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

The Auditor General undertakes the National Fraud Initiative in Wales under Part 3A of the Public Audit (Wales) Act 2004 which empowers him to conduct data matching exercises for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales and to publish the results of any such exercise.

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.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff, CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in
Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

Management response to audit recommendations

Report title: The National Fraud Initiative in Wales 2020-21
Completion date: December 2022

Recommendation	Management response	Completion date	Responsible officer
1. All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.	The guidance will be reviewed by the Counter Fraud Manager and Head of Financial Operations, and this will be shared with the NWSSP Accounts Payable team who review the matches on the Trust's behalf.	28/02/2023	Counter Fraud Manager and Head of Financial Operations
2. Where local auditors recommend improving the timeliness and rigour within which NFI matches are reviewed, NFI participants should take appropriate action.	Where these recommendations are made, appropriate actions will be taken.	Ongoing	Counter Fraud Manager and Head of Financial Operations
3. Audit Committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are	The NFI self-appraisal checklist will be shared with the Audit Committee to ensure they are fully informed as described.		Counter Fraud Manager

Recommendation	Management response	Completion date	Responsible officer
fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.			

AUDIT COMMITTEE

2022/23 INTERNAL AUDIT PROGRESS UPDATE

DATE OF MEETING	12/01/2023

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 asked to:

- **RECEIVE** the reports from Internal Audit, note their content and request further action, information or assurances if required; and

- **RATIFY** the out-of-committee approval for the change to the 2022/23 Internal Audit Plan (deferral of the Quality & Safety Framework audit and replacement with an Information Governance audit, as outlined in the Internal Audit Progress Update Report).

2022/23 Internal Audit Progress and KPI Dashboard

Velindre University NHS Trust

4th January 2022

Contents

	Page
Executive Summary	1
Dashboard: Overview of Audit Progress and Key Performance Indicators	2
Reports by Assurance Rating	3
2022/23 Internal Audit Plan Progress and KPI Performance by Audit	4

Executive Summary

Alert / Escalate

KPIs

KPI 4 (Management Response) is RAG rated red. It is reported at 50% (5/10 reports breached the KPI target). This consistent with the November 2022 reported position.

Advise

Change to 2022/23 Internal Audit Plan

We have agreed to defer the Quality & Safety Framework audit to early in the 2023/24 plan due to the overlap with the Audit Wales Quality Governance report. We have replaced this review with an audit of Information Governance. Out-of-committee approval for this change was received in December 2022. The Audit Committee is asked to formally ratify this approval.

2023/24 Internal Audit planning

We have commenced the 2023/24 planning cycle and held meetings with several Directors. These meetings will continue in early January 2023.

Discussions will take place with the Executive Management Board throughout February / March 2023 and the plan will be presented for Audit Committee approval at the next Audit Committee meeting (date TBC).

Assure

Progress

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

- 12 reports have been issued, 10 as final and 2 in draft; and
- 3 audits are in progress.

KPIs

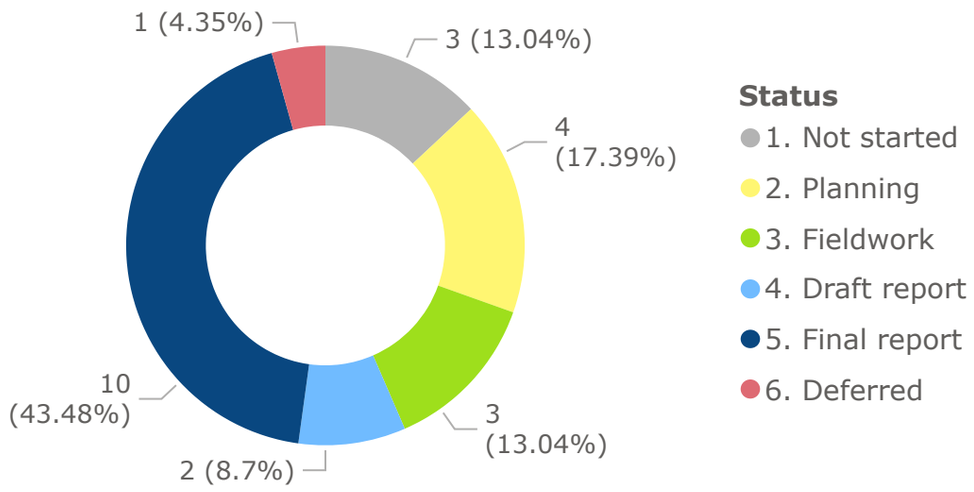
Except for KPI 4 (see alert section), all KPIs are rated green.

Other activities

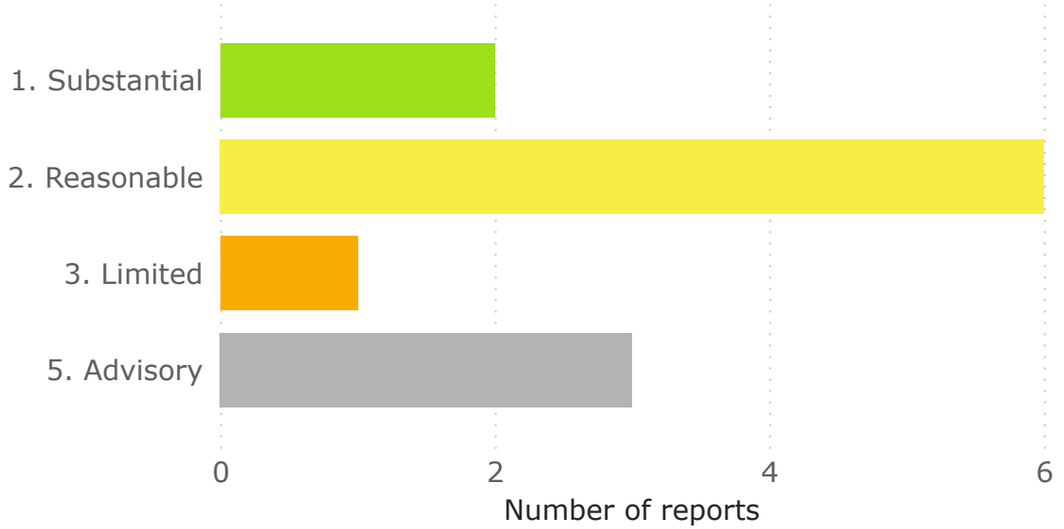
- Regular meetings with the Director of Finance and Director of Corporate Governance;
- Planning meetings with various Executive Directors;
- Attendance at Trust Board and Committee meetings;
- Attendance at Board Development sessions relating to assurance and risk; and
- Learning exercise on the Managing Attendance at Work audit (verbal update to be provided at the January Audit Committee).

Overview

2022/23 Audit Status



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



Key Performance Indicators

KPI	RAG rating	KPI %	KPI Target	KPI Definition
KPI 1 - Annual Plan		100%	Apr-22	Timely approval of Annual Plan
KPI 2 - Month of Delivery		100%	80%	Review delivered in planned month
KPI 3 - Draft Report		92%	80%	Report turnaround: time from fieldwork completion to draft reporting (10 days)
KPI 4 - Management Response		50%	80%	Report turnaround: time taken for management response to draft report (15 days)
KPI 5 - Final Report		100%	80%	Report turnaround: time from management response to issue of final report (10 days)
KPI 6 - Planned Audit Committee		92%	80%	Report delivered to planned Audit Committee

Reports by Assurance Rating

Substantial Assurance Reports

Audit	Status	High	Medium	Low
Digital Health Record - Implementation	5. Final report	0	0	0
Research & Development	5. Final report	0	0	0

Reasonable Assurance Reports

Audit	Status	High	Medium	Low
Divisional Review - Managing Attendance at Work	5. Final report	1	3	4
Finance & Service Sustainability	5. Final report	0	4	4
nVCC Enabling Works (deferred from 2021/22)	5. Final report	0	2	4
Patient & Donor Experience	5. Final report	0	3	0
Clinical Audit (VT)	4. Draft report	1	3	3
Performance Management F/w	4. Draft report	0	3	8

Limited Assurance Reports

Reports	Status	High	Medium	Low
nVCC MIM Contract Management	5. Final report	1	0	0

No Assurance Reports

No 'no assurance' reports have been issued

Advisory Reviews

Audit	Status
Staff Wellbeing (Advisory)	5. Final report
nVCC EW Security Contract	5. Final report
Estates Assurance - Decarbonisation (VT)	5. Final report

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

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

Managing Attendance at Work – Divisional Deep Dive

Final Internal Audit Report

November 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

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 5
Appendix A: Management Action Plan 11
Appendix B: Assurance opinion and action plan risk rating 16

Review reference:	VT-2223-05
Report status:	Final
Fieldwork commencement:	8th July 2022
Fieldwork completion:	13th September 2022
Draft report issued:	20th September 2022
Debrief meeting:	6th September 2022
Management response received:	2nd November 2022
Final report issued:	4th November 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Mair Evans, Principal Auditor
Executive sign-off:	Cath O'Brien, Chief Operating Officer
Distribution:	Sarah Morley, Director of OD & Workforce Alan Prosser, Director of Welsh Blood Service Rachel Hennessy, Director of Velindre Cancer Centre
Committee:	Audit Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

The overall objective of the review was to ensure that all the Trust is adequately managing staff sickness absence at a divisional, directorate and operational service group level.

Overview

Overall, the Trust's processes regarding managing attendance at work are adequately designed. Particularly, we identified that the Trust has robust performance reporting and monitoring processes within the divisions.

However, we identified the following significant matters requiring management attention:

- we were unable to fully assess compliance against the NHS Wales Managing Attendance at Work (MAAW) Policy due to audit evidence not provided, e.g., eight contact logs, two fit notes and two occupational health reports remain outstanding from our sample of 20 absences – we understand this is due to absence documentation not being stored in the appropriate location; and
- delays were noted in holding Long Term Sickness meetings – 42% of meeting tested were not held until over six months after the absence became long term.

Additionally, attention is needed to implement the planned programme of compliance audits (delayed due to vacancies and the Omicron wave of Covid-19) and strengthen attendance at MAAW training.

All matters arising are detailed in Appendix A.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Policies and procedures	Substantial
2	Provision and uptake of training	Reasonable
3	Recording and monitoring absence	Reasonable
4	Compliance with the MAAW Policy	Limited
5	Supporting sustained attendance and return to work	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Recommendation Priority
3.1	Demonstrating compliance with the MAAW Policy	4/5	Operation	High
3.2	Pursuing rollout of centralised personnel files in VCC	4/5	Operation	Medium
3.3	Planned rolling programme of compliance audits	4/5	Operation	Medium
1.1	Sharing MAAW training attendance and feedback with the divisions	2	Operation	Medium

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

1. Introduction

1.1 The Divisional Deep Dive covering Managing Attendance at Work was completed in line with the 2022/23 Internal Audit Plan. The review sought to provide Velindre University NHS Trust (the Trust) with assurance that:

- its divisions[2], directorates and operational service groups are compliant with the All Wales Managing Attendance at Work Policy (the Policy) and local supporting procedures;
- staff sickness absence is being managed appropriately at a divisional, directorate and operational service group (OSG) level; and
- staff are fully supported to remain in work and to return to work after a period of sickness absence.

1.2 The highest recorded sickness absence across the Trust is psychological ill health. Whilst the Trust figures include corporate services and Health Technology Wales, the focus of the review was on how well WBS and VCC are supporting sustained attendance at work and return to work after a period of sickness absence.

Associated risks

1.3 The associated risks to not Managing Attendance at Work are:

- non-compliance with the All Wales Managing Attendance at Work Policy;
- unauthorised or excessive staff absences;
- failure to offer the range of health and wellbeing support and resources at the Trust's disposal to employees in the workplace. This may be linked to greater sickness absenteeism, increased turnover and/or poor staff health and wellbeing; and
- failure to meet Trust and Welsh Government Sickness absence targets.

Limitations of scope

1.4 The review focused on management of attendance and sickness absence and excluded the management of other absences, for example annual leave, special leave, toil and flexi time.

1.5 Monitoring of sickness absence at a corporate / Board level was considered in our 2022/23 Staff Wellbeing advisory review, therefore it has not been repeated in this audit.

Wider application

1.6 Whilst this audit has considered managing attendance within the divisions, it would be best practice to assess whether the findings may be applicable to managing attendance across the whole of the Trust. Therefore, the Trust should consider the report in this light.

[2] Velindre Cancer Centre (VCC) and Welsh Blood Service (WBS)

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	1	3	4	8
Total	1	3	4	8

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

Audit objective 1: There are appropriate policies and procedures in place to manage attendance at work

2.3 The Trust follows the NHS Wales Managing Attendance at Work Policy (the MAAW Policy), which is accessible to all staff on the Trust's Intranet page. The Trust has local templates to support compliance with this Policy.

2.4 The current All Wales MAAW Policy was scheduled for review in 2021. The review is to be undertaken by NHS Employers in partnership with Welsh Government and Trade Unions.

2.5 All Trust staff have been kept abreast of updates whilst this review is awaited, for example, changes to procedures in relation to COVID-19. Updates have been provided via weekly communications/newsletters which are circulated to all staff via email and more specific targeted emails to managers.

Conclusion:

2.6 The Trust has appropriate policies and procedures in place to support compliance with the current NHS Wales MAAW Policy, therefore we have provided a **substantial assurance** rating for this objective.

Audit objective 2: There is adequate provision and uptake of training, guidance and support and to enable effective management of attendance at work

2.7 The Trust has developed specific training materials for Managing Attendance at Work (MAAW). The MAAW training is mandatory for all line managers. We reviewed the training materials and found them to adequately cover the requirements of the MAAW Policy.

2.8 There were nine scheduled training events from June 2021 to June 2022. To sustain services during the Covid-19 Omicron wave (winter 2021/22), the Trust

postponed all non-critical training. Therefore, two MAAW training events (December 2021 and March 2022) were cancelled.

2.9 In our testing on 20 managers across the divisions we noted that, whilst all were experienced managers and had not needed to attend the MAAW training in the past 12 months, there were numerous instances where these managers had enrolled their direct reports with managerial responsibilities on the training.

2.10 In July 2022, there were 202 individuals with managerial responsibilities (aka, line managers) within the divisions (VCC 119 and WBS 83). Of the 56 divisional line managers who enrolled on MAAW training in this period, only 37 (67%) completed the training. Figure 1 shows the split between the divisions.

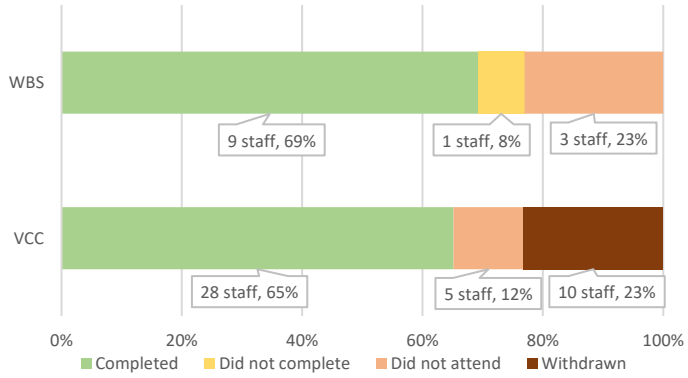


Figure 1: Divisional attendance at MAAW training, July 2021 to June 2022.

2.11 We note that the Trust has reviewed the MAAW training materials to ensure they are streamlined, and that the course can be delivered as efficiently and effectively as possible.

2.12 We were informed that Workforce & OD (WOD) monitors MAAW training attendance and feedback from both course participants and managers who withdrew or did not attend. Given the current level of non-attendance / withdrawal from the MAAW training, WOD may wish to review the feedback mechanisms in place and to share the feedback with divisional and directorate/OSG management to support improved training attendance. See matter arising 1 in Appendix A.

Conclusion:

2.13 Whilst the Trust provides regular MAAW training, we have raised a medium priority finding regarding non-attendance from individuals enrolled on the training. Therefore, we have provided a **reasonable assurance** rating for this objective.

Audit objective 3: Sickness absence is appropriately recorded in accordance with the Policy and monitored at a divisional, directorate and operational group level

Directorate / Operational Service Group (OSG) Monitoring

2.14 Where there is high absence or a recurring absence hotspot, the directorates (VCC) and OSGs (WBS) receive a monthly Health Records WOD Highlight

Performance Report. This report identifies the monthly and rolling twelve-monthly absence percentage for the directorate/OSG and this is then discussed in 1:1 meetings with WOD (usually the directorate/OSG manager and a People and Relationship Advisor). The directorates / OSGs can also request the reports / 1:1s regardless of absence levels.

2.15 We reviewed a sample of three months' performance reports and meeting notes for directorates / OSGs which had received the reports (see figure 2 for analysis by division). We also discussed these in detail with the People and Relationship Advisor. We note that the meeting notes indicate high-level reasons for performance and actions being taken. Between the performance reports, meeting notes and our discussions with the People and Relationship Advisors, it is evident that close monitoring of short and long-term absences is being undertaken at a directorate/OSG level.

	No. reports produced / reviewed		
	VCC	WBS	Total
April 2022	3	-	3
May 2022	6	-	6
June 2022	2	2	4

Figure 2: number of Health Record WOD Highlight Performance Reports produced / reviewed (April to June 2022)

Divisional Monitoring

2.16 The divisional management teams (VCC: Senior Leadership Team / SLT; WBS: Senior Management Team / SMT) receive monthly workforce reports which are reviewed at the monthly respective SLT/SMT meetings. We reviewed a sample of two months' reports / meeting minutes for each division, noting the reports contain KPIs to support absence monitoring and the reports were presented and discussed at the meetings sampled.

Accuracy of KPI data

2.17 To gain assurance over the accuracy of the data used in producing the KPIs, we reviewed a sample of 20 sickness absence cases to verify the absence had been correctly recorded within ESR.

2.18 We found three instances where cases included in the Non-Covid report were Covid related cases. We understand this may be related to changes in guidance on reporting Covid absences, which has caused some confusion amongst line managers. See matter arising 2 in Appendix A.

Conclusion:

2.19 The Trust has robust absence monitoring processes in place at a divisional and directorate/OSG level. However, we raised a low priority finding relating to accuracy of absence recording, which may impact upon the accuracy of absence reporting. Therefore, we can provide a **reasonable assurance** rating over this objective.

Audit objective 4: The Trust is compliant with the All Wales Managing Attendance at Work Policy

2.20 The Trust follows the NHS Wales MAAW Policy, encouraging compassion in its implementation and the use of manager's discretion where appropriate. This includes a standard template for documenting LTS meeting notes which ensures line managers cover the salient points, especially the support available for staff wellbeing.

2.21 We selected a sample of 20 absences from the period April – June 2022 and tested compliance with key aspects of the MAAW Policy as set out below:

MAAW Policy considerations tested	
Fit notes	Occupational Health (OH) referrals and reports
Communication records	Return to work (RTW) interviews and forms
Long term sickness (LTS) meeting timelines and records	

2.22 During this testing, we experienced significant difficulty in obtaining the required supporting evidence. We were informed that this was predominantly due to VCC line managers not being able to store the documentation in the agreed location because of IT access issues. This also resulted in some information not being accessible due to the related line managers being on leave.

2.23 Figure 3 sets out the exceptions we identified in our testing on the supporting evidence for our sample of 20 absences (VCC: 13; WBS: 7) as of 6th October 2022.

Missing evidence	VCC	WBS	**Total**	Of which	
				Confirmed as an exception	Remains outstanding
Fit notes	2	-	**2**	1	1
Contact log	8	3	**11**	3	8
LTS meeting notes	1	-	**1**	-	1
OH report	2	1	**3**	1	2
RTW form	-	-	**-**	-	-

Figure 3: missing evidence in our sample testing of 20 absences

2.24 We also identified that there appears to be delays in holding LTS meetings, with six out of 12 LTS meetings not being held until over six months after the absence was classed as LTS. There may be genuine reasons why this is the case. However, the reason for the delays is not being documented in the absence files. See figure 4 below for an overview of the timeframes for LTS meetings.

LTS meeting held within*:	VCC	WBS	Total
< 21 days	3	1	4
21-60 days	1	2	3
100-200 days	2	1	3
300-400 days	1	-	1
No record of meeting	1	-	1
Total LTS	8	4	12

** from the 29th day of the absence*

Figure 4: overview of timeframes for holding LTS meetings within our sample of 20 absences, 13 of which were LTS

2.25 Due to the outstanding information noted in figure 3, we could not fully assess compliance with the MAAW Policy.

2.26 See matter arising 3 in Appendix A.

MAAW compliance audits

2.27 MAAW compliance audits (undertaken by WOD) were stood down during the Covid-19 pandemic to allow WOD to provide greater support to line managers in managing absence.

2.28 In September 2021, a report was taken to the Executive Management Board (EMB) outlining the intention to re-start compliance audits, with absence hotspots (absence greater than 5%) to be audited between August to November 2021 and remaining departments to be covered between December 2021 and March 2022. The results of these audits were then to form the basis for a rolling 12-month programme of MAAW compliance audits.

2.29 Due to subsequent vacancies within WOD and the Omicron wave of Covid-19, the formal compliance audits were not progressed. However, we were informed that, WOD Business Partners were asked to identify absence hotspots monthly and provide support to the related line managers. This included informally reviewing whether the MAAW Policy was being appropriately followed. Due to the responsive and flexible approach taken during this time, the WOD Business Partners were not required to retain evidence of the informal, ad hoc compliance reviews.

2.30 We understand that WOD intends to re-start the proposed MAAW compliance audit exercise with the intention of developing a rolling 12-month programme.

2.31 See matter arising 3 in Appendix A.

Conclusion:

2.32 Due to outstanding audit evidence relating to sickness absence documentation, we have provided a **limited assurance** rating over this audit objective.

Audit objective 5: Line managers are using the full scope of the Policy to support sustained attendance in work or to support staff returning to work after sickness absence

2.33 In our testing of 20 absences, we noted that, where evidence had been supplied, it was difficult to assess the full extent to which considerations were being made to support sustained attendance or return to work as the considerations had not been fully documented.

2.34 To assess whether line managers are using the full scope of the Policy, we selected three cases from our sample for further investigation. We were provided with explanations of the considerations and discussions that had taken place for each of the three cases. However, no evidence was provided (e.g., meeting notes, correspondence with WOD or the staff member, etc) to support the explanations or demonstrate justification of the actions taken.

2.35 We were assured from these explanations that the Trust took the appropriate action for these cases. We also saw evidence elsewhere (for example, in our review of meeting minutes) that phased returns, redeployments and other

considerations are being used to encourage staff safely back to work. However, it would be beneficial for line managers to keep a more detailed record of what options were discussed as well as the outcomes and the rationale for the action taken. See matter arising 3[3] in Appendix A.

2.36 Our discussions with management indicated that, whilst training has been provided, there may remain some uncertainty in the application of discretion in implementing the MAAW, which may hinder line mangers from developing innovative solutions to support sustained attendance or return to work.

2.37 The Trust may wish to consider mechanisms to further support line managers in this area. See matter arising 1 in Appendix A.

Conclusion:

2.38 Noting the above, we have provided a **reasonable assurance** rating over this objective.

[3] Whilst this matter arising is linked to a high priority recommendation, it is considered to have a medium priority impact on audit objective 5 based on the evidence available.

Appendix A: Management Action Plan

Matter arising 1: Strengthening attendance at MAAW training (Operation)	Potential risk / impact
We identified that of the 56 divisional line managers who enrolled on the MAAW training between July 2021 and June 2022, only 37 (67%) completed the training (figure 1 in section 2 (page 6) provides further details). We were informed that WOD monitors MAAW training attendance and feedback from both course participants and managers who withdrew or did not attend. Our discussions with management indicated that, whilst training is provided, there remains uncertainty in the application of discretion in implementing the MAAW, which may hinder line managers from developing innovative solutions to support sustained attendance or return to work.	Non-compliance with the MAAW Policy due to line managers not being fully aware of their responsibilities. Absences may last longer than necessary. Uncompassionate application of MAAW Policy.

Recommendations		Priority
1.1	Share MAAW training attendance and feedback data with divisional and directorate/OSG management to enable local action to address identified low training attendance.	Medium
1.2	Consider reviewing the MAAW training feedback mechanisms in place and whether they adequately capture the required feedback to assess and respond to current training attendance levels.	Low
1.3	Consider mechanisms to further support line managers in the application of discretion or use of innovative solutions to support sustained attendance or RTW.	Low

Management response		Target Date	Responsible Officer
1.1	Workforce Education Development Manager to ensure this is available/sent to Managers/SLT/SMT as part of their monthly performance feedback.	31st December 2022	Workforce Education Development Manager
1.2	Review current mechanism for obtaining course feedback.	31st December 2022	Workforce Education Development Manager

Management response (continued)	Target Date	Responsible Officer
1.3 Case studies on managing absence are already included in the Fundamentals of Management Training Package, these will also be added to the MAAW Training package to further support learning, on managing absence. People and OD team will continue to consider other mechanisms that may be useful.	31st January 2023	People and Relationships Manager

Matter arising 2: Accuracy of absence recording (Operation)	Potential risk / impact
In our testing of 20 absences, we identified three instances where Covid absences had been recorded as non-Covid.	Inaccurate reporting of absence KPIs.

Recommendations	Priority
2.1 Remind managers of the importance of accurate absence recording and reiterate the process for recording Covid absences.	Low
2.2 Consider requesting that line managers review absences recorded as non-Covid on ESR during the pandemic to ensure they have been recorded accurately.	Low

Management response	Target Date	Responsible Officer
2.1 Managers are regularly reminded of requirement and importance of accurate reporting. Specific feedback will be given to all managers and raised at SLT/SMT meetings.	31st October 2022	Senior People and OD Business Partners
2.2 Managers will be asked to sample their ESR information to assess accuracy but there will not be a formal review due to current service demands and benefits gained.	30th November 2022	Directors of VCC and WBS

Matters arising 3: Demonstrating compliance with the MAAW Policy (Operation)	Potential risk / impact
We tested a sample of 20 absences from the period April – June 2022, identifying the following issues with demonstrating compliance with the MAAW Policy: • we encountered significant difficulty in obtaining appropriate audit evidence; we understand this was predominantly due to VCC line managers not being able to store absence documentation in the agreed location due to IT access issues: as of 6th October 2022 several documents remained outstanding from our requests – figure 3 (paragraph 2.23) provides full details; • delays in holding LTS meetings: 6 out of 12 LTS meetings had not been held until over 6 months after the absence was classed as LTS – figure 4 (paragraph 2.24) provides further details. Whilst there may be genuine reasons for these delays they are not being clearly documented in the absence files; and • where evidence had been supplied, it was difficult to assess the full extent to which considerations were being made to support sustained attendance or return to work as the considerations had not been fully documented. Due to the outstanding information, we could not fully assess compliance with the MAAW Policy. Whilst we were informed that informal, ad hoc MAAW compliance reviews have been undertaken by WOD, the planned formal compliance audit programme was delayed by vacancies and the Covid-19 Omicron wave. We understand WOD now intends to re-start this programme.	Inability to demonstrate compliance with the MAAW Policy. Non-compliance with data protection laws and regulations. Potential reputational or financial damage.

Recommendations	Priority
3.1 Remind line managers of the importance of: • timely storage of absence records in the appropriate location, which is accessible in their absence, including the information noted as outstanding in this audit (a detailed list has been provided to management); and • ensuring absence records contain sufficient information to justify decisions made and actions taken, including for short-term absences, delays in LTS meetings, application of discretion, and discussions around sustained attendance / returning to work.	High
3.2 Pursue the rollout of centralised personnel folders for VCC, in line with the solution implemented within WBS.	Medium

3.3	Implement the planned programme of audits to ensure continued adherence to the MAAW Policy and update EMB on the status of this programme.	Medium

Management response		Target Date	Responsible Officer
3.1	Develop key messages for SLT/SMT members, for cascade to their managers, which defines the process for storage of such information i.e, shared files, use of personal 'P' drives, password protected, accessibility etc.	30th November 2022	People and Relationships Manager
	Develop examples of good practice and checklist examples for cascade through Divisions and use in training events.	31st December 2022	People and Relationships Manager
3.2	Finalise the business requirement case for centralised workforce folders at VCC (in line with WBS) and implement the system.	31st July 2023	Directors of VCC and WBS
3.3	A rolling programme of audits was agreed in September 2021 by EMB; this was impacted by COVID and replaced by spot audits in hotspot areas due to service pressures. The rolling programme agreed is now back on track and is ongoing with targeted dates on updates to EMB in December 2022 and March 2023.	Complete	N/a

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

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

Patient and Donor Experience
Final Internal Audit Report

January 2023

Velindre University NHS Trust

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 4
Appendix A: Management Action Plan 11
Appendix B: Improving Survey Response Rates 14
Appendix C: Assurance opinion and action plan risk rating 16

Review reference:	VT-2223-11
Report status:	Final
Fieldwork commencement:	20th October 2022
Fieldwork completion:	23rd November 2022
Draft report issued:	7th December 2022
Management response received:	23rd December 2022
Final report issued:	4th January 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Rhian Gard, Principal Auditor
Executive sign-off:	Nicola Williams, Director of Nursing, AHP's & Medical Scientists
Distribution:	Nigel Downes, Deputy Director of Nursing Viv Cooper, Head of Nursing (VCC) Zoe Gibson, Head of Nursing (WBS) Peter Richardson, Head of Quality Assurance (WBS)
Committee:	Audit Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

To review the Velindre University NHS Trust's (the Trust) processes for capturing patient and donor reported experience measures, and how data is used to effectively inform service improvement.

Overview

The Trust is on a journey to enhance its collection and use of patient and donor experience feedback to drive service improvement.

Our review identified that the Trust has patient and donor experience governance, reporting and scrutiny mechanisms in place, is using technology to capture feedback data, and is using this data to identify and implement service improvements.

We identified the following areas where further work is needed to ensure the mechanisms in place are robust and embedded throughout the Trust:

- improving clarity in the meeting structure for patient and donor experience reporting;
- streamlining experience reports; and
- enhancing communication of experience feedback to Trust staff.

All recommendations are detailed in Appendix A.

The Trust has identified that survey response rates for Velindre Cancer Centre are currently low. VCC could demonstrate that it is receiving and responding to other forms of patient feedback and is undertaking benchmarking on the response rates. We have identified good practice guidance to potentially improve response rates in Appendix B.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Governance	Reasonable
2	Reporting	Reasonable
3	Technology	Reasonable
4	Service Improvement	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1.1	Clarifying the patient and donor experience meeting structure / reporting flow	1	Design	Medium
2.2	Streamlining experience reports	2	Design	Medium
3.1	Enhancing communication of experience feedback to Trust staff	4	Design	Medium

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

1. Introduction

1.1 The review of Patient and Donor Experience was completed in line with the 2022/23 Internal Audit Plan. The review sought to provide Velindre University NHS Trust (the Trust) with assurance over the processes for capturing patient and donor reported experience and the effectiveness of the use of experience data in informing service improvement.

1.2 The Trust is on a journey to enhance patient and donor feedback and its use in driving service improvement. In recent years, it has tailored the NHS Wales Patient Reported Experience Measure (PREM) questionnaire to form the "Your Velindre Experience" survey and has also developed a friends and family survey. It recently started using CIVICA to capture experience data, providing a more efficient way for patients and donors to give feedback and allowing real-time monitoring of the data.

1.3 The Trust's Divisions should monitor experience metrics and implement service improvements through the quality and safety governance structures. As part of its remit, the newly formed Integrated Quality and Safety group (part of the Trust's new Quality and Safety Framework – inaugural meeting was in October 2022) will provide Trust-level oversight of experience monitoring and related learning and service improvement.

Associated risks

1.4 The key risk is that poor patient or donor experience resulting from:

- the Trust not having a robust governance framework in place resulting in poor service improvement decisions being made;
- patient and donor experience reporting mechanisms not being used to their full potential through the Trust; and
- incorrect investment in technology resulting in capturing data which does not improve the patient and donor experience.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	3	-	3
Operating Effectiveness	-	-	-	-
Total	-	3	-	3

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

Audit objective 1: Suitable patient and donor experience governance mechanisms are in place at all levels throughout the Trust

2.3 The Trust reports patient and donor experience to:

- the Board, Quality Safety & Performance Committee (QSPC) and Strategic Development Committee (SDC);
- Executive Management Board; and
- various operational and divisional forums (see audit objective 2).

2.4 Our testing on reporting is considered under audit objective 2.

2.5 We reviewed Board, QSPC and SDC papers for the previous 12 months, where we saw that patient and donor experience updates and escalation were evidenced when needed. This included the annual Patient & Donor Experience report, feedback performance in divisional performance reports and updates on the implementation of the All Wales CIVICA system.

2.6 Alongside reporting specifically relating to the patient and donor experience survey, we also saw that these meetings considered other patient and donor experience mechanisms (not within the scope of this review) to provide a more rounded view, including patient / donor stories, patient engagement and complaints / concerns.

2.7 The Trust's new Quality & Safety Framework (approved July 2022), which includes patient and donor experience, sets out the quality and safety assurance / meeting structure and the requirements for each meeting therein. From our work, we could see that there are patient and donor experience governance and scrutiny mechanisms within the Trust and that reporting on patient and donor experience is taking place.

2.8 However, we identified in our review of relevant meeting papers/ minutes (see audit objective 2) that, due to reporting taking place at many different forums and the volume of information reported, it was sometimes difficult to:

- see whether the patient and donor experience reporting / escalation routes ensure scrutiny and escalation is taking place at the appropriate forum; and
- follow the flow of reporting from floor to Board.

2.9 We also identified that:

- the Velindre Cancer Centre (VCC) forums had more specific patient experience objectives in their terms of references whereas Welsh Blood Service (WBS) forums had more governance focused objectives and were not specific to donor experience; and

- there was a lack of clarity in the flow of patient and donor experience reporting from 'floor to Board' amongst staff interviewed, including around the purpose of the experience reports at some forums.

2.10 We understand that, as part of the Quality & Safety Framework Implementation Plan, the Trust is reviewing its quality and safety governance and reporting mechanisms. This will include patient and donor experience. See matter arising 1 in Appendix A for recommendations to support this process.

2.11 We reviewed a sample of three job descriptions (two for VCC, one for WBS) for staff with specific patient and donor experience responsibilities. We could see the necessary objectives within the job descriptions.

2.12 We were informed that the VCC Quality & Safety team structure is under review and that the Patient Experience Manager post has been vacant since April 2022. The Trust is in the process of recruiting to this role.

Conclusion:

2.13 There are governance and scrutiny mechanisms within the Trust for patient and donor experience. However, as the Trust is aware, further work is required to ensure these mechanisms are streamlined, clearly defined and communicated. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: Robust patient and donor experience reporting mechanisms are in place at all levels of the Trust

2.14 From a comprehensive review of minutes from a selection of Trust forums (see figure 1 below), we saw evidence of scrutiny, reporting and discussions on patient and donor experience.

Trust-wide	VCC	WBS
Board	Senior Leadership Team	Senior Management Team
Quality Safety & Performance Committee	Quality Safety Management Group	Regulatory Assurance & Governance Group
Strategic Development Committee	Integrated Care Operational Group	Donor Governance Group
Executive Management Board		Operational Services Groups (Clinical Services and Collections)
Integrated Quality & Safety Group		

Figure 1: Forums reviewed during the audit

2.15 Our review of patient and donor experience reports highlighted that the information therein is comprehensive. However, we identified that:

- the reports often contained a high level of information which may or may not be needed by that forum; and
- there is some duplication in reporting to the various forums.

2.16 The volume of information reported could lead to key messages being missed.

2.17 In the new Performance Management Framework (PMF, subject to a separate 2022/23 internal audit), the Trust has a key performance indicator (KPI) and target for overarching patient / donor satisfaction which will be reported separately for each division.

2.18 As part of the Wales-wide vision for PREMS[2] (led by Welsh Government), development and roll out of national PREM sets (i.e., performance metrics) is scheduled to take place in Q2/3 of 2023/24. This will provide the Trust with a consistent mechanism to monitor patient and donor experience performance at all levels.

2.19 As the Executive Director of Nursing lead on this work, the Trust's Director of Nursing, AHPs and Health Scientists has offered to provide support in this development work and informed us that the Trust's experience reporting will be aligned to the national PREM sets once they are available.

2.20 As part of its work on the new PMF and on the Quality & Safety Framework Implementation Plan, we understand the Trust intends to review its quality metrics to ensure streamlined reporting at all levels of the Trust. See matter arising 2 for recommendations to support this process.

Conclusion:

2.21 Patient and donor experience is being reported throughout the Trust. However, further work is required to ensure the reporting is fully streamlined and effective. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: Efficient and effective use of technology to capture meaningful patient and donor experience data

2.22 The Trust uses electronic means to capture patient and donor experience feedback. Paper surveys were used prior to the pandemic but have now been phased out.

2.23 We understand there was an early challenge with accessing WIFI from the various devices used. However, we were informed this has now been resolved.

2.24 The Trust is moving to the All Wales CIVICA system to capture patient and donor experience feedback (see further details below). A CIVICA Project Board was established to oversee implementation of the system and to develop supporting mechanisms such the infrastructure for reporting and a Patient and Donor Experience Strategy.

2.25 CIVICA enables users to produce reports at the click of a button. Each team within the Trust will have access to produce reports and view real-time feedback for their service.

[2] The vision is to "… triangulate reported experience with quality and safety intelligence to get a more rounded picture of services…' with the ability to '… benchmark services based on patient experience'. National Clinical Framework (Welsh Government) 2021

2.26 The Trust is reviewing the patient and donor experience survey questions as part of its move to CIVICA. As CIVICA is a new system, we understand that the questions will be kept under review to ensure the right data is being captured. We were informed that the Trust is also seeking feedback on the CIVICA system itself from staff and patients/donors.

Velindre Cancer Centre

2.27 In July 2021, the Trust began implementing CIVICA in VCC. All VCC teams are now using CIVICA for patient feedback.

2.28 Within the Cancer Centre, there are three fixed devices for patients to access CIVICA, supported by iPads where fixed devices were not appropriate.

2.29 To allow patients to use their own devices, QR codes linking to the survey are publicised in all areas and included in appointment letters.

2.30 The Trust has noted that patient response rates for VCC are low. We understand that it can be difficult due to the nature of the treatment being received by patients.

2.31 This has likely been exacerbated by the lack of a Patient Experience Manager in post (see paragraph 2.12) and due to the Trust not currently using volunteers due to the Covid-19 pandemic. Both would provide a more personal approach to requesting and supporting feedback, so could support an increase in the response rate.

2.32 Due to the low response rates, the Trust's Independent Members requested a benchmarking exercise be undertaken against response rates across other NHS Wales organisations. We were informed this exercise was in progress at the time of our audit.

2.33 We understand that there is constant dialogue between patients and staff within VCC, which helps to pick up informal feedback from patients. Staff highlighted several examples of informal feedback and action taken in recent months, including acting upon feedback received through the Dignity Forum. So, whilst response rates could be improved, we can see that VCC is also receiving and responding to other forms of patient feedback.

2.34 We have provided some guidance on improving survey response rates in Appendix B for the Trust's consideration.

Welsh Blood Service

2.35 Implementation of CIVICA in WBS commenced in August 2022 and was ongoing at the time of our review.

2.36 Per the implementation plan, most of the division will be using CIVICA by early 2023, with the only survey to be transferred at that point being the donor communications one which is currently on the SNAP platform.

2.37 WBS uses iPads to collect donor experience feedback at collection sessions. The donor communications survey is sent out via email from the SNAP platform one month after a donation.

2.38 Response rates for WBS have been good, with almost 4,500 responses being received on CIVICA between August and October 2022. We understand that WBS has received national recognition at the Once 4 Wales Programme Board for this.

Conclusion:

2.39 The Trust uses electronic means to capture patient and donor experience feedback and is in the final stages of implementing the All Wales CIVICA system to ensure consistency and efficiency in this process. Given the status of CIVICA implementation and the need to improve VCC survey response rates, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: Effective use of patient and donor experience data to drive service improvement

2.40 Through review of meeting papers / minutes and discussions with relevant staff, we could see that patient and donor experience data is being used to drive service improvement. We also saw evidence that feedback data is being triangulated with other quality and safety mechanisms, such as clinical audit and concerns / complaints, to provide a more rounded view of experience and outcomes.

2.41 We were provided with evidence demonstrating examples of improvements that have been made based on feedback received.

2.42 There is a six-monthly Establishment Review (chaired by the Director of Nursing, AHPs & Health Scientists) which brings together key staff from across the Trust. The meetings cover operational matters, including sharing learning from concerns and patient/donor feedback. CIVICA responses are also discussed at this meeting.

2.43 As part of its Quality & Safety Framework Implementation Plan, the Trust will implement Quality & Safety Hubs (Corporate, VCC and WBS) to oversee quality and safety matters. Additionally, the Trust is looking to have Patient / Donor Experience Champions in each area to drive local ownership. These planned mechanisms should further support the use of experience data in service improvement.

Communicating feedback and action taken

2.44 The Trust uses a "you said, we did" approach to communicating its response to feedback. This is incorporated into reporting within the Trust and is fed back to patients / donors via "you said, we did" boards.

2.45 Our discussions with key staff during the audit highlighted that, whilst upwards reporting within the Trust and feedback to patients is taking place, there is a need to strengthen patient and donor feedback to staff to fully ensure the process is embedded and service improvements are effectively implemented. See matter arising 3 in Appendix A.

Benchmarking and sharing good practice with other organisations

2.46 Due to the relatively unique nature of the Trust, benchmarking performance / sharing good practice with other organisations can be challenging. However, we were informed that the divisions undertake this where they can. For example, we understand that:

- the Trust engages with the NHS Wales Safety Learning Network, which we understand has incorporated good practice in terms of patient and donor experience alongside learning and service improvement;
- VCC shares learning and best practice with the Clatterbridge Cancer Centre (Liverpool) in terms of immunotherapy services, policies, etc; and
- WBS benchmarks against service improvement with blood services across the UK and work upon UK-wide improvement programmes.

Conclusion:

2.47 We saw evidence that patient and donor experience data is being used in service improvement. We identified a medium priority finding to support strengthening this process and note that the Trust is also taking action to set up Quality & Safety Hubs and use Patient / Donor Experience Champions. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Meeting Structure	Impact
We identified, through our review of relevant meeting papers / minutes, that due to reporting taking place at many different forums and the volume of information reported it was sometimes difficult to: • see whether the patient and donor experience reporting / escalation routes ensure that scrutiny and escalation is taking place at the appropriate forum; and • follow the flow of reporting from floor to Board. We also found that further clarity is needed in the purpose of patient and donor experience at some forums (see paragraph 2.9 for further details).	Potential risk of: • inefficiencies in reporting or key messages being missed; • issues not being appropriately escalated; and • poor patient / donor experience due to feedback not being acted upon.

Recommendations	Priority
1.1 As part of the review of quality and safety governance and reporting mechanisms, the Trust should: a. review the flow of patient and donor experience reporting 'from floor to Board' to ensure it is clear and efficient, avoiding unnecessary duplication; b. update relevant meeting terms of reference to ensure clarity over the purpose of patient and donor experience reporting at each forum; and c. ensure relevant staff are clear on the above, e.g., though publicising the new quality and safety governance and reporting mechanisms at team meetings on the intranet.	Medium (Design)

Management response	Target Date	Responsible Officer
1.1 a. A patient / Donor experience feedback procedure to be developed and published on intranet identifying reporting flow service level to Board.	31/03/2023	Deputy Director Nursing, Quality & Patient Experience
b. Review all Divisional Departmental to SLT/SMT & Quality Group Terms of References to include oversight of patient / donor CIVICA feedback (including volume feedback, outcomes, improvement actions and ongoing trend and theme monitoring and the utilisation of feedback to inform prioritisation and decision making at all levels.	31/03/2023	Divisional Director WBS & VCC
c. See 1.1 a		

Matter arising 2: Experience Feedback Reporting	Impact
We identified that: • patient and donor experience reports often contained a high level of information which may or may not be needed by that forum; and • there is some duplication in reporting to the various forums.	Potential risk of: • inefficiencies in reporting; • key messages being missed; • issues not being appropriately escalated; and • poor patient / donor experience due to feedback not being acted upon.

Recommendations	Priority
2.1 As part of the intended review of quality metrics and reporting, the Trust should: a. Review the patient and donor experience information required to achieve the objectives of each forum and tailor the reports as appropriate; and b. Ensure that reports contain succinct, concise executive summaries that clearly highlight key messages.	Medium (Design)

Management response	Target Date	Responsible Officer
2.1 a. A full review of CIVICA reports / dashboards to be undertaken to identify level of information and type of report required as a minimum at each meeting – aligning to work detailed in 1.1 a and 1.1b.	31/03/2023	Head of Nursing Professional Standards & Digital & Deputy Director Nursing, Quality & Patient Experience
All BI dashboards to include CIVICA patient / donor experience outcomes from service level to Board	30/04/2023	Head of Information
b. As outlined in 2.1.a		

Matter arising 3: Feedback to Staff	Impact
Our discussions with key staff during the audit highlighted that, whilst upwards reporting within the Trust and feedback to patients / donors is taking place, there is a need to strengthen patient and donor feedback to staff to fully ensure the process is embedded and service improvements are effectively implemented.	Potential risk of poor patient / donor experience due to feedback not being acted upon.

Recommendations	Priority
3.1 The Trust should incorporate how it effectively communicates patient and donor experience feedback to all staff as part of its review of quality and safety governance and reporting mechanisms.	Medium (Design)

Management response	Target Date	Responsible Officer
3.1 The patient / Donor experience feedback procedure (detailed under 1.1a) to include expectations of how feedback should be communicated to staff at all levels and how staff are involved in the 'so what' analysis.	31/03/2023	Deputy Director Nursing, Quality & Patient Experience

Appendix B: Improving Survey Response Rates

Considerations[3] to support improved response rates

- Use of social media channels, emails or SMS / text messages to promote surveys
- Consideration of completion rate (i.e., how many people completed the survey after starting it) alongside response rate – completion rate is a useful metric to help identify whether the survey is easy to complete and whether there are any barriers to completion
- Considering factors that affect survey completion / response rates, including:
  - survey content: question wording, question type, survey flow, survey length, etc
  - survey invitation wording: e.g., on the appointment letter or advertising posters:
    - use of positive labels (e.g., helpful, kind, generous) in communications about surveys which helps respondents to identify with the behaviour and act accordingly
    - use of enticing language, e.g., 'Want to help us improve our services? Tell us about your experience at [survey link]' or 'share your experience with us at [survey link]'
  - respondent motivation: whether the survey appeals to patients / donors, e.g.:
    - framing the survey in line with patient / donor values to encourage responses
    - further increasing awareness of the impact of survey responses so respondents know that feedback is acted upon
- Encouraging survey completion at the point of treatment / donation – this helps to increase response rates and provide a more accurate reflection of experience than surveys completed later
- Informing respondents upfront how long the survey will take;
- Giving respondents a clear idea of how much of the survey is left – using cues such as 'nearly there' or 'just a few more question to go' tends to be more effective than a progress bar;
- Reassuring respondents about confidentiality and data privacy

Target response rates

There is no set level that defines a 'good' survey response rate. However, the consensus from our review of good practice guidelines is that a response rate of 10-30% is considered good and above 50% is considered excellent. Response rates of less than 10% are considered low.

It is also important to consider the number of responses alongside the response rate. The smaller the number of responses, the higher the chances of bias in the survey results and the more challenging it is to undertake effective analysis.

Survey fatigue

Anecdotal evidence suggests there has been an increased number of online surveys due to the Covid-19 pandemic, both in and out of the workplace. The Trust should be mindful that patients / donors may be suffering from survey fatigue, i.e., a lack or loss of interest in completing surveys. This could impact the response rate and quality of feedback provided. A Userpilot article on survey fatigue quotes survey analysis by CustomerThermometer (provider of customer feedback solutions), which shows that only 9% of

[3] Source: Qualtrics (experience management company), Smart Survey (digital survey solution), Userpilot (product growth platform)

respondents complete long questionnaires and that 67% of respondents report having abandoned an ongoing survey due to survey fatigue.

Pre-response fatigue discourages potential respondents from taking the survey. This can be avoided through:

- not over-surveying patients / donors;
- keeping surveys short –; and
- providing an estimated completion time.

Mid-survey fatigue causes respondents to leave surveys incomplete. This risk may be reduced by:

- using direct questions;
- asking one question at a time;
- limiting the number of free text responses;
- using consistent response scales; and
- not asking repetitive questions.

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Digital Health & Care Record (Implementation)

Final Internal Audit Report

December 2022

Velindre University Health Trust

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 4

Review reference:	VT-2223-03
Report status:	Final
Fieldwork commencement:	8th September 2022
Fieldwork completion:	11th November 2022
Debrief meeting:	Feedback provided during fieldwork to support go-live
Draft report issued:	23rd November 2022
Management response received:	23rd December 2022
Final report issued:	23rd December 2022
Auditors:	Martyn Lewis, IT Audit Manager
Executive sign-off:	Cath O'Brien, Chief Operating Officer
Distribution:	Carl Taylor, Chief Digital Officer Rachel Hennessy, Director of Velindre Cancer Centre Suzanne Rogers, Head of Digital Programmes
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

To provide assurance that Velindre University NHS Trust (the Trust) is prepared for the November 2022 'go live' date for the Digital Health & Care Record (DHCR).

Note, that this audit work provides assurance on the process for managing the implementation of DHCR within Velindre, and not for the ongoing, successful use of the solution.

Overview

We have issued substantial assurance on this area.

The DHCR implementation was subject to a robust governance structure that ensured risks were appropriately managed.

We identified no matters for reporting in our review, although we have noted delays to the training provision.

Report Opinion

Substantial

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

Low impact on residual risk exposure

Assurance summary[1]

Objectives		Assurance
1	User Acceptance Testing	Substantial
2	Operational Impact Assessments	Substantial
3	Training	Reasonable
4	Business Continuity	Substantial
5	Readiness Assessment	Substantial
6	Go-Live Planning	Substantial

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

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Velindre University NHS Trust (the Trust or organisation) a review of the Digital Health & Care Record (DHCR) implementation, which is due to replace Canisc has been completed.

1.2 Canisc is being replaced with new and existing features being developed in user interfaces, for example Welsh Patient Administration System (WPAS) and Welsh Clinical Portal (WCP) to replace the required functionality of Canisc, to support the delivery of cancer services. Clinical information required for the care of cancer patients will be made available to clinicians regardless of the healthcare organisation in which they deliver services.

1.3 The project was originally scheduled for go-live in September 2021. However, Velindre and Digital Health & Care Wales (DHCW) revised the go-live date to November 2022. This was due to delays experienced from the increased complexity, alignment with other key local and national projects, and ongoing challenges with project and operational resources due to the impact of COVID-19.

1.4 The risks identified in the audit brief covered:

- Inappropriate access to information;
- Poor data quality; and
- Loss of functionality results in reduced patient care.

1.5 Please note that this audit work provides assurance on the process for managing the implementation of DHCR within Velindre, and not for the ongoing, successful use of the solution.

2. Detailed Audit Findings

Objective 1: User acceptance testing has appropriate coverage of the system and has been completed successfully.

2.1 There was a controlled, structured approach to testing that ensured all functionality was tested, with stakeholder involvement and any test fails being investigated and rectified.

2.2 Testing was included within the project plan and there was a schedule for testing which showed who will undertake and when testing will occur. Data migration was completed in July 2022 and user acceptance testing (UAT) was subsequently started.

2.3 Testing was done using scripts. These were developed by the workstream leads and link to the process mapping to ensure testing of all the functionality. There was a review and approval process for these to ensure they covered the full functionality to test. Scripts and testing were managed appropriately with a record of the 'current status' and result of each test.

2.4 The testing itself was undertaken by users from across the service and our review of this noted that the scripts were detailed 'walkthrough' tests of the functionality, with each test being assigned an owner and tests being subject to review.

2.5 The majority of the tests have been passed. However, there are a number that are marked either FAIL or FAIL NA with NA meaning test or script not applicable. These are subject to re-testing and raising of a defect for action where applicable.

2.6 Testing was managed and monitored at a daily UAT scrum which covered the statistics, issues, and daily plan for testing, with information on the state of testing and the current position being reported to the project board.

2.7 Following the completion of the majority of testing, a comprehensive UAT summary report was produced and presented and approved by the DHCR project board (the project board). This set out the total range of tests included, noted those tests that were outstanding with timescales for completion, and noted test failures and associated resolutions.

Conclusion:

2.8 There was a structured process for user testing. The testing included the full functionality in use within Velindre Cancer Centre (VCC), with testing being appropriately monitored. Accordingly, we have provided **substantial assurance** over this objective.

Objective 2: Operational impact assessments are completed to ensure the organisation understands any required process changes needed for the use of the new system and is ready for implementation.

2.9 Due to the historic lack of development of Canisc there are a number of workarounds embedded within its operational processes. The full functionality of the DHCR was mapped to the operational processes within VCC and gaps and required changes in working practices to fit with DHCR were documented.

2.10 The outcome of this work was a set of process maps that show that full patient pathways through the Trust. The process maps were signed off and provided to the project board, and the updated maps defined the UAT process. A presentation was given to the VCC senior leadership team (SLT) of the full end-to-end process.

2.11 There was a process for ensuring that all areas undertake operational impact assessments which identify the impacts on the business of the implementation of the DHCR.

2.12 A template was produced to provide guidance and to standardise the impact assessment process. The template clearly asked for an assessment of the current state, identified risks, noted the impact type and the number of affected people. It also identified the actions required. Our review of impact assessments has confirmed that they have followed the template provided.

2.13 The progress of the operational impact assessments was monitored by SLT and the project board, with a summary report provided which notes the assessments that have been done and where there are required actions and decisions. We note that these have been reviewed and endorsed.

2.14 We note that the changes required to operational processes are being embedded within the organisation, with DHCR programme staff having received change manager practitioner training. We also note that the subject matter experts are from the operational service and along with the workstream leads have been working closely with the rest of the service.

Conclusion:

2.15 The changes needed to operational processes following DHCR implementation have been identified and formal impact assessments produced. These changes are being embedded within the Trust and there is a structure for monitoring this. Accordingly, we have provided **substantial assurance** over this objective.

Objective 3: Training is available to users and user guides are available to ensure awareness of the new system and how to use within their roles.

2.16 The provision of training was explicitly included within the project plan, with a training plan in place which noted the scheduling and timing and with training split into different types.

2.17 There has been general awareness training provided to relevant staff. This was originally for the previous go-live date and was paused and re-started to reflect the new date. This training covered key items such as:

- Why CaNISC is being replaced;
- Overview of WPAS and WCP systems;
- Project progress to date;
- Preparations for 'Go-Live'; and
- How you can stay involved.

2.18 There was familiarisation training provided. This included role-based training and uses the DHCW on demand centre to provide training on WPAS / WCP. Once users have completed this training, they can access the WPAS sandbox to practice.

2.19 Specific, role-based training has also been provided to staff. This is tailored to VCC and covers nine WPAS and twelve WCP modules.

2.20 Training for individual staff is available via SharePoint, with each user having a training journey that sets out the progress through the 3-step training. Once the training is complete, they are certified with notification being provided to management.

2.21 We also note that user guides are in place, and these are signposted in the familiarisation and role-based training. The guides include role-based scenarios

and have been locally produced to ensure they specifically cover VCC scenarios and issues.

2.22 We note that in order to reflect service pressures, there was additional training capacity provided and Saturday and late slots were also provided in order to be flexible and accommodate staff when they can be most conveniently released.

2.23 Progress on training is reported to the project board as part of the governance process, with statistics provided on training provision.

2.24 We note that in the run up to the go-live date the reported training figures for some areas were low, with less than 50% of staff receiving training. There was clarity over the reporting of this to project board, with annual leave and sickness impacting on training delivery.

2.25 The training shortfall was acknowledged in readiness assessments and go-live decision meetings, with the training rated as amber, with extra sessions being provided to catch up.

Conclusion:

2.26 Training was included within the project plan, and a training plan developed. Training was split into three tranches, starting with general awareness, and moving to role based specific functionality training. The progress of training was monitored and reported to the project board. We note that progress slipped, however this was noted at the project board and accepted as part of the go-live decision. Due to the delays in the training provision, we have provided **reasonable assurance** over this objective.

Objective 4: business continuity plans should be in place to enable service provision in the event of a loss of system.

2.27 Business continuity plans have been considered as part of the planning for DHCR implementation, which ensures that the service areas are prepared in the event of a loss of service.

2.28 There was a governance structure in place to ensure that all departments have reviewed and updated the business continuity plans. We note that there was oversight by senior management within VCC. There was regular reporting to the project board on the status of business continuity planning and plans were presented to the project board.

2.29 We reviewed a sample of continuity plans, and we note that they have recently been reviewed and updated. They include planning for the loss of DHCR or the network and specifically include the go-live period and preparation for go-live.

2.30 The existence of the plans enables a level of patient service to continue in the event of a loss of DHCR and enables the capture of information during the down period. The plans also include preparation for the go-live period in terms of moving some key information offline to ensure availability.

Conclusion:

2.31 Business continuity has been explicitly considered within the DHCR project. All departments have reviewed and updated their continuity plans, with inclusion of continuity planning for the go-live period. Accordingly, we have provided **substantial assurance** over this objective.

Objective 5: Appropriate processes should be in place to formally assess and approve the readiness of the Trust to go live.

2.32 As the DHCR project has progressed there has been a sign off process at each stage, for example for ways of working / process maps. The stages were signed off by the SLT, workstream leads and the project board. This feeds into the general assessment readiness for go-live.

2.33 The planning for go-live included a deployment assurance matrix (DAM), which is a comprehensive collection of the key items where the Trust needs assurance that actions have been successfully completed before implementation. We note that the project team has worked with DHCW as part of this to learn lessons from implementations within other organisations.

2.34 Each item within the DAM was tracked within the spreadsheet and RAG rated to enable easy visualisation of the status of readiness. The key items included within the DAM were:

- development: enhancements are included, we note that this is signed off as complete;
- data migration: clinical validation, data quality check and data migration sign off;
- business change: ways of working, identification of changes, identification of gaps and workshops;
- testing: covers testing of all aspects within the new system;
- training: includes training planned and delivered;
- service management: includes the formulation of the service model, identification of resources and service desk training;
- hardware / infrastructure: includes a hardware survey, identification of printers and load testing;
- communications: includes communications plan with impacts and benefits of DHCR to be communicated;
- continuity; requirement to ensure all plans reviewed; and
- implementation: includes go-live plans, cutover planning, user setup and offline working.

2.35 We note that the state of readiness planning was part of the regular reporting to the project board, and the implementation plan has checkpoints to assess readiness, including for final go-live approval.

2.36 There was a formal readiness check in place with a formal readiness assessment document produced in the form of a checklist to enable final decision making. We note that this is a cut down version of the deployment assurance matrix, with the approach taken being agreed by the project board.

2.37 We note that in the run up to go-live, there were frequent meetings to enable decision points. A decision to go was made at a meeting at 16:00 on 10 November 2022, with a readiness statement updated and with each service lead presenting their status. We note that the statement at that point defined most areas as green, with some amber points relating to ways of working, SOPs, and training. The amber category relates to activities not complete but on track.

Conclusion:

2.38 Completion of each stage has been tracked and signed off through the project. There is a formal assurance matrix in place which tracks the key essential items which must be in place, and this has fed the creation of a formal readiness assessment checklist for the project board to approve. Accordingly, we have provided **substantial assurance** over this objective.

Objective 6: Go-live cutover and early life support plans are in place and ready for implementation.

2.39 We note that DHCR went live over weekend of 11-13 November 2022.

2.40 Planning for go-live included a communications plan to ensure users were informed of progress, and explicitly included support plans for staff.

2.41 The support plan set out the support arrangements for go-live. We note that there was enhanced support for go-live and the subsequent two-week period, with staff from DHCW being onsite to provide support in addition to the DHCR project team. We further note that the subject matter experts will also assist in supporting staff during and post go-live.

2.42 A plan for go-live cutover was developed, this includes key actions, with timings and individuals responsible identified. The actions are split into different themes and include:

- data migration: changing data-load scripts, moving users from old system, moving demographics, validation and escalation stages for data migration;
- database build: adding users to new database, security build, checks;
- communications: to all staff at beginning, stating Canisc is now read only, telling staff new system is now active;
- technical: renaming groups / servers etc, blocking users from adding data to Canisc;
- integration: interface adjustments, move into WPAS / WCP, RADIS;

- checkpoints: service engagement group, WPAS team, confirm data extract, BCP in place, data extracts ok; and
- testing: sanity checks, migration check, functionality test.

2.43 A dry run for go-live was scheduled and undertaken on the weekend of 21 October 2022, this used the plan previously noted. The dry run was successful with no major issues identified.

2.44 As part of the dry run a lessons learned log was maintained and populated throughout the process. Our review of this noted that lessons were clearly identified, with recommendations for improvement being clearly defined. The lessons were particularly focussed on communications, with meeting planning, timings and checkpoint content also identified.

2.45 We note that, in the event of a major issue impacting go-live, the Trust would revert to the use of Cansic. There is no formal backout / roll back plan for this. However, DHCW is closely involved in DHCR implementation and so could facilitate. We note that this point was raised with the Director of Strategic Transformation, Planning & Digital to seek assurances that Cansic could be provided, and this point was subsequently noted by the project board.

2.46 The go-live plan contained a schedule of checkpoints planned in over the implementation weekend. These were set with clear purpose, timing and identified key staff involved. It was noted at the project board that stop decisions should be made as early as possible. We note that, to better enable that, the more complex interfaces will be done first with issues being immediately escalated.

Conclusion:

2.47 A detailed plan was in place for go-live cutover. This was tested during a dry run and lessons learned identified and the plan adjusted accordingly. The go-live plan included checkpoints for decision making and enhanced early life support was planned and provided. Accordingly, we have provided **substantial assurance** over this objective.

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.

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

Decarbonisation Final Report

December 2022

Velindre University NHS Trust

NWSSP Audit and Assurance Services

Contents

1. Context 3
2. Background 3
3. Approach 4
4. Summary Observations 5
5. Conclusion 6
Appendix A: Common Management Action Plan 8

Report status:	Final
Draft report issued:	28th October 2022
Management response received:	2nd December 2022
Final report issued:	2nd December 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
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.

1. Context

1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably those arising from the 2016 Paris Accord.

1.2 The "NHS Wales Decarbonisation Strategic Delivery Plan" was published in March 2021, setting interim targets (from a 2018/19 base) of a 16% reduction by 2025 and a 34% reduction by 2030.

1.3 In October 2021 the Welsh Government set out its second carbon budget, Net Zero Wales, which confirmed:

> "Our ambition is for the public sector to be collectively net zero by 2030".
>
> *Welsh Government, October 2021*

1.4 NHS Wales is also required to comply with the Well-being of Future Generations (Wales) Act 2015. It requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities, and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

2. Background

2.1 In accordance with the "NHS Wales Decarbonisation Strategic Delivery Plan", Health Boards, Trusts and Special Health Authorities were required to develop their own Decarbonisation Action Plans (DAP), demonstrating how NHS Wales organisations would implement the Strategic Delivery Plan initiatives. The DAP's were submitted to Welsh Government in March 2022.

2.2 A peer review of DAP strategies was held on 12 July 2022 led by Welsh Government and attended by all NHS Wales organisations. The general conclusions across all plans were:

- the targets detailed within the plans showed low aspirations;
- there were concerns associated with their successful delivery, primarily due to resource availability (financial and physical); and
- there were a small number of issues associated with their compilation/format.

2.3 Specific feedback was also provided to each organisation by Welsh Government.

2.4 Also in July 2022, Audit Wales issued their review of Public Sector Readiness for Net Zero Carbon by 2030 (fieldwork conducted between November 2021 and January 2022). The review included an assessment of NHS Wales organisations and concluded that:

> "There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions".
>
> *Audit Wales, July 2022*

2.5 In September 2022, Health bodies will be required to make two separate submissions to Welsh Government, the first of these being quantitative (i.e., showing progress against the baseline $C0_2$ figures set in 2019) and the second qualitative, being a report detailing progress against the DAP.

3. Approach

3.1 Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change as outlined above. Reviews were not scheduled at Public Health Wales or Health Education and Improvement Wales for 2022/23.

3.2 Risks to be considered included:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions.
- Reputational risk by failing to meet emission targets.
- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health, and thereby, not meeting the requirements of the Well-being of Future Generations (Wales) Act (2015).

3.3 Having reviewed all DAPs, supporting information for most NHS Wales bodies and fully concluding the fieldwork at five of 11 audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees.

3.4 Fieldwork on the initial five audits concluded in August 2022.

3.5 Accordingly, the decision was taken to affirm common themes within this report, to provide an overview of the overarching position across NHS Wales. An action plan of common themes is provided at **Appendix A.**

4. Summary Observations

4.1 While there are variations between the NHS Wales bodies, broadly each is at an early stage of implementation. The following were common themes observed across those reviewed:

Governance

- Governance arrangements at a strategic level were generally good with senior leadership demonstrated.
- Recruiting to additional operational posts has proven difficult – with the limited appointments to date coming from the existing public sector staff pool. These appointments are key to being able to implement the agreed strategies (see **Management Action 1**).

Localised strategy

- All NHS Wales organisations supplied their Decarbonisation Action Plan (DAP) by 31 March 2022 detailing their response to the NHS Wales Decarbonisation Strategic Delivery Plan and the 46 associated initiatives.
- WG provided positive feedback to each organisation on their submissions but concluded overall that there were concerns associated with their successful delivery (primarily due to the availability of financial and physical resource), together with low aspirational targets detailed within the plans.
- Few of the strategies had been costed, and none had associated funding strategies – particularly noting that ring-fenced central funding for 2021/22 was £16m with no provision made in 2022/23 (see **Management Actions 2 & 3**).
- In each instance, the decarbonisation strategies were clearly part of corporate planning and included/reflected within the respective Integrated Medium-Term Plans (IMTPs).

Monitoring & reporting

- Organisations were ISO 14001 accredited ensuring that appropriate Environment Management Systems were in place to manage their environmental performance.
- Each NHS Wales organisation's performance will be assessed against baseline data prepared by the Carbon Trust. Issues have been identified with the baseline data and the disaggregation of the data for reporting purposes. Each organisation should seek assurance on the accuracy of the baseline data (see **Management Action 4**).
- Each NHS Wales organisation should ensure that appropriate engagement is established with NWSSP Procurement Services as a significant contributor to the carbon reductions outlined within respective DAPs and formalise arrangements as appropriate (see **Management Action 5**).

- Each organisation had met its obligations for national reporting to date.
- Internal reporting to date had understandably been limited, with the level of reporting increasing after Welsh Government's review of the DAPs.
- There was therefore a need to fully roll-out the structures to support appropriate monitoring and reporting within the NHS Wales organisations reviewed (see **Management Action 6**).
- It is important that the profile of decarbonisation is increased to reflect the challenge faced, for example general Terms of Reference are reviewed to reflect decarbonisation commitments, and decarbonisation is set as a standard agenda at all appropriate Executive meetings (see **Management Action 7**).
- Potential collaboration should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource (see **Management Actions 8 & 9**).

Project delivery

- The Welsh Government Estates Funding Advisory Board (EFAB) oversaw the allocation and delivery of the £16m decarbonisation funding for 2021/22 with each NHS Wales organisation successfully securing funding.
- In each instance, adequate records were retained to support the expenditure and the achievement of the original objectives; Post Project Completion Reports were produced and submitted to WG for all funded schemes.
- No ring-fenced WG capital funding was made available for 2022/23. WG offered up to £60k of revenue funding for schemes, however several NHS Wales organisations' bids could not be supported due to them being considered capital bids (see **Management Action 10**).
- NHS Wales Organisations were also self-funding initiatives from their discretionary programme. It is important that the cost benefit of these schemes is also subject to challenge and scrutiny for inclusion within the overall data (see **Management Action 11**).

5. Conclusion

5.1 In conclusion, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. The recommendations made aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.

5.2 It is recommended that an audit is scheduled for early 2023/24 with the proposed scope to include governance, strategy progress and implementation.

5.3 Additionally, as part of 2023/24 Internal Audit planning update, discussions will be held with management on the appropriateness of other areas within the decarbonisation programme including, for example:

- Procurement and supply chains.
- Application of "Best practice Pharmaceutical waste practice".
- Transport.
- Fleet and business travel.
- Staff, patient and visitor travel.
- Catering; and
- People and workforce e.g., training, policies, and working arrangements.

Appendix A: Common Management Action Plan

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agreed – Initial recruitment required to deliver plan complete Continuous review of additional skills/capabilities will be undertaken against the Decarbonisation Plan as it moves through phases	Director of Strategic Transformation, Planning & Digital. Complete Annual review
MA 2	DAPs should be fully costed to fully determine the total funding required.	Agreed Fully costed decarbonisation plan being developed	Assistant Director of Estates, Environment & Capital Development March 2023
MA 3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Agreed Trust will develop a funding strategy to deliver the requirements set out within the decarbonisation	Assistant Director of Estates, Environment &

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		plan as part of Integrated Medium Term Plan 2023 -2026. Some funding requirements will be outside the immediate control of the Trust e.g. revenue funding from LHB commissioners and/or capital from the Welsh Government	Capital Development April 2023
MA 4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agreed Initial baseline submitted The Trust will work with the Welsh Government to improve the quality of data if any issues are identified	Complete Environmental Development officer
MA 5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	Agreed The Trust will support NWSSP in developing and agreeing targeted reductions required by Velindre University NHS Trust	Assistant Director of Estates, Environment & Capital Development April 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 6	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Agreed Accountability structures are currently in place. These will be strengthened following the development of the costed Decarbonisation Plan	Assistant Director of Estates, Environment & Capital Development June 2023
MA 7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agreed It will be strengthened within the Terms of Reference of the Executive Management Board; Strategic Development Committee and Quality, Safety and Performance Committee	Director of Strategic Transformation, Planning & Digital. March 2023
MA 8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	Agreed The Trust will continue to seek opportunities to collaborate	This is an ongoing process and setting a single date is not appropriate

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 9	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Agreed The Trust will continue to seek opportunities to collaborate on training.	Environmental Development officer This is not an action that the Trust will lead on so setting a target date is not appropriate
MA10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agreed All schemes are considered via the Trusts existing governance arrangements	Complete
MA11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agreed All schemes are considered via the Trusts existing governance arrangements	Complete

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

Performance Management Framework

Final Internal Audit Report

January 2023

Velindre University NHS Trust

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 5
Appendix A: Management Action Plan 11
Appendix B: Assurance opinion and action plan risk rating 17

Review reference:	VT-2223-08
Report status:	Final
Fieldwork commencement:	28th November 2022
Fieldwork completion:	12th December 2022
Draft report issued:	23rd December 2022
Debrief meeting:	13th December 2022
Management response received:	11th January 2023
Final report issued:	11th January 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Krisztina Kozlovszky, Internal Audit Manager
Executive sign-off:	Carl James, Director of Strategic Transformation, Planning & Digital
Distribution:	Philip Hodson, Deputy Director of Planning and Performance Peter Gorin, Head of Corporate Strategic Planning & Performance
Committee:	Audit Committee Strategic Development Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance over phase 1 of evolving the Trust's Performance Management Framework (PMF) and planned actions for phase 2 and 3.

Overview

The Trust has developed a comprehensive new PMF reporting format which it continues to evolve. Phase 1 of the project has been well managed, and planned actions during phases 2 and 3 are scheduled for completion by April 2023. These actions will further enhance the robustness of the new PMF format and the related reporting mechanisms.

While we did not identify any significant matters, we wish to bring to management's attention the need to consider improving processes relating to the retention and retrieval of supporting evidence for reported PMF metrics.

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

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	PMF Project Governance	Substantial
2	PMF Design	Reasonable
3	Accuracy of Performance Metrics	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Recommendation Priority
5.1	Developing mechanisms for retention and retrieval of metric supporting evidence	3	Design	Medium

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

1. Introduction

1.1 Our review of Performance Management Framework (PMF) was undertaken in accordance with the 2022/23 Audit Plan, approved by the Audit Committee in March 2022.

1.2 The Trust is evolving the PMF in three phases:

1. Development of balanced scorecards with improved information layout, governance structures and escalation mechanisms;
2. Review of performance metrics to assess whether the Trust is capturing the right data to fully understand performance and whether targets are appropriate; and
3. Consideration of ways to automate performance reporting to ensure an efficient and sustainable process.

1.3 At the time of our review, phase 1 had recently been completed, with the new reporting dashboards being used as a pilot since August 2022, running in parallel with the Trust's existing performance reports. We were informed that, from April 2023, the Trust will cease using the existing reports.

1.4 The Trust plans to complete phases 2 and 3 during 2022/23, with a view to formally reporting through the new PMF from April 2023.

Associated risks

1.5 The key risks considered on this review were the potential for:

- slippage in the development, approval or roll out of the evolvement of the PMF;
- ineffective or inefficient performance monitoring; and
- poor performance not being promptly identified and / or appropriate, timely resolving action not being taken.

Limitation of scope

1.6 As the evolved PMF is a newly developed framework and has only operated as a pilot since August 2022, we were unable to test the operating effectiveness of the process in this review.

1.7 We have also not reviewed the Performance Accountability Framework (PAF), which is linked to the new PMF and developed in parallel, as the related work was not sufficiently progressed for us to be able to review anything at this time.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	7	8
Operating Effectiveness	-	-	1	1
Total	-	1	8	9

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

Audit objective 1: Appropriate project governance mechanisms are in place over the development of the PMF (all phases)

Project set up

2.3 Development of the PMF is being undertaken as a piece of continuous service improvement work.

2.4 The original Project Initiation Document (PID) was approved by the Trust Board on 26th November 2020. The original project timetable was set for 15 months, from November 2020 to January 2022.

2.5 Governance mechanisms in place over the project included:

- identification of a Project Manager (the Head of Corporate Strategic Planning & Performance) and Senior Responsible Officer (Director of Strategic Transformation, Planning and Digital) at the outset;
- a formal Project Group including representation from Welsh Blood Services (WBS), Velindre Cancer Centre (VCC) and Support Services; and
- formal reporting lines and regular reporting to divisional management teams, Executive Management Board (EMB) and the Trust Board / Committees.

2.6 Phase 1 of the project has been well managed and has resulted in the development of a comprehensive new PMF format. In our review of the PID, we identified areas which the Trust may wish to formally consider to further enhance the governance mechanisms in place as the project moves into phases 2 and 3. These areas are set out in matter arising 1 in Appendix A.

2.7 During our fieldwork, we identified that the Trust does not have a formal Trust-wide Project Management Office (PMO) or a Project Management Framework, although WBS has a divisional PMO (within the Innovation and Improvement Hub) and a divisional Project Management Framework. We were also informed that VCC

intends to set up a divisional PMO. This is included here for completeness but, as it does not impact upon the assurance provided in this report, no recommendation is raised.

Timely delivery of the project

2.8 The PMF project has evolved since its launch in November 2020. This evolution, alongside operational pressures arising from the Covid-19 pandemic (e.g., impacting the availability of stakeholders for engagement), meant that the Trust had to revise the project timeline in July 2021, with a further revision being made during summer 2022.

2.9 The revised timelines have been reported to the Strategic Development Committee (SDC). However, only the June 2021 revision was formally approved. Additionally, the PID was not formally revised to reflect the project's evolution and new timelines.

2.10 The launch of the new PMF is now scheduled for April 2023.

2.11 We reviewed five monthly agendas of the Project Group and related meeting minutes between July and November 2022. We confirm that project delivery was appropriately discussed at these meetings. However, lessons learnt relating to the project were not formally captured, analysed and shared.

2.12 See matter arising 1 in Appendix A.

Project reporting

2.13 Regular project status updates were provided to the Divisional Management Teams, PMF Project Group, EMB, SDC and the Trust Board.

2.14 We reviewed a sample of reports to EMB, SDC and the Trust Board. Whilst the reports were comprehensive and provided a good overview of the project status, we identified that the level of detail therein was not tailored to the audience. See matter arising 1 in Appendix A.

Conclusion:

2.15 We identified one low priority matter arising regarding project governance. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 2: The evolved PMF is adequately designed

Governance, reporting and escalation mechanisms

2.16 We were informed that a separate framework (the Performance Accountability Framework or PAF) is in development and is set to be launched at the same time as the new PMF. As we understand it, the PAF will be closely connected to the performance measures and will include references on how to identify and escalate performance related issues and whose responsibility that will be. The PAF was not sufficiently developed for us to review it formally at the time of our audit.

2.17 We understand the reporting and escalation lines will follow the divisional and corporate hierarchy (Divisional Senior Leadership teams, Executive Management Board) through to the Quality & Patient Safety Committee (QSPC) and the Board.

PMF report content, including tailoring to each audience

2.18 The aim of the new PMF is to align the Trusts' approach around the quality and safety agenda with a focus on outcomes and better use of information to support the continuous improvement of quality and performance. To achieve this, there is a standard template for the PMF report which was approved by the SDC October 2022.

2.19 The template includes a structured narrative, focused on key areas like current and past performance and action plans. Wherever possible, a Statistical Process Control (SPC) Chart is used to enable the distinction to be made between 'natural variations' in activity, and trends or performance requiring investigation.

2.20 We also note that there are hyperlinks to supplementary information at the back of the report stating how actual performance compares to previous data and the reasons behind any poor performance.

2.21 The framework uses SPC charts to provide a view on current / likely future system performance. This could be further improved with the use of predictive analytics generated through machine learning / AI, e.g., future predictions of demand / capacity and performance and layered with various scenarios (interventions) etc. This would be beneficial to the decision makers as they would be able to understand the anticipated impact of the planned actions, ensure that all related risks are mitigated within the Trust's risk appetite. See matter arising 3 in Appendix A.

2.22 The evolved Performance Management Framework adopts a 'balanced scorecard' approach aligned to the Quality Safety Framework (QSF) and Trust's strategic goals and service standards.

2.23 A hierarchy of scorecards has been developed to tailor reporting to each audience from the divisional management teams to the Board and QSPC (see figure 1 below). The QSPC will also receive reporting on any measures which are escalated to it by EMB if performance is off track.

2.24 We were informed that the metrics will be subject to regular review (e.g., at least annually) to ensure they remain appropriate, including calculation methods and targets.

2.25 We reviewed a sample of 20 measures for October 2022 and note that despite the standard template, the quality of the supporting narrative during the pilot period has been varied (e.g., some parts of the template left blank or actions to improve poor performance were not SMART). We were informed that good practice examples of concise reporting have been shared and that guidance / training is planned to support improvement. See matter arising 2 in Appendix A.

Figure 1: balanced scorecard of KPIs reported at a corporate level

Ref.	Category	Brief description	Number reported		
			EMB	QSP	Trust
1.	SAFE	Clinical and Quality Safety	29	14	4
2.	PATIENT CENTRED	Patient / Donor Staff Experience	15	5	5
3.	TIMELY	Responsive Service Delivery	15	7	4
4.	EFFICIENT	Financial & Physical Resources	23	8	7
5.	EQUITABLE	Equality & Socio-econ Impact	12	4	3
6.	EFFECTIVE	Prudent Service Delivery	19	8	4
		TOTAL number of reported measures	**113**	**46**	**27**

Key performance indicator / metric definitions and targets

2.26 In our sample of 20 metrics, we verified that each metric had a set target. We understand that, as part of the next project phase, all targets will be reviewed for appropriateness, including whether they provide sufficient challenge to the Trust.

2.27 Baseline data to reflect average performance for each metric was based on performances reported in April 2022. However, we note that in some cases, the data from April 2022 may not be truly reflective of average performance, e.g., due to the Covid-19 pandemic impact or the rise in energy costs. See matter arising 3 in Appendix A.

2.28 We were informed that there are further quality metrics, e.g., clinical measures (for example mortality, antibiotic usage etc.) in the pipeline which are under consideration for adding to the PMF.

2.29 The Trust is developing a Key Performance Indicators (KPIs) glossary of definitions and bases of calculations. Whilst the document was in draft at the time of our audit, we were able to find references to all our selected metrics therein.

2.30 We note that glossary document will also provide an audit trail to support any future changes to the measures. However, the process to update and approve the measures has not been formally documented. See matter arising 4 in Appendix A.

Statutory and legislative reporting requirements

2.31 Many of the KPIs within the PMF (particularly for VCC) are statutory or 'Tier 1' reporting requirements, mandated by Welsh Government or legislation. Therefore, these KPIs must be part of the performance monitoring measures.

2.32 We also note that Trust-wide or Support Services functions have a range of mandatory performance reporting measures in the areas of workforce (e.g., staff sickness, mandatory training, etc), health and safety (e.g., RIDDOR) and finance (e.g., financial returns, agency spending, etc). Several new Ministerial measures were announced for 2022/23, e.g., around staff wellbeing, bank and agency spending, decarbonisation etc.

2.33 The Trust has a corporate regulatory and legislative compliance function and processes within the Corporate Governance team. This was not subject to review within this audit.

2.34 We found that the current draft of the KPI glossary document is designed to have references for statutory measures. Whilst we note that this document was a work in progress at the time of our review, in our testing of 20 metrics we identified that these links have yet to be included in the glossary. See matter arising 4 in Appendix A.

Data quality assurance / confidence

2.35 The Head of Corporate Strategic Planning & Performance carries out a high-level review of the reported metrics. However, there are no formal spot checks on supporting evidence or assurances over the quality of the source data. See matter arising 5 in Appendix A.

2.36 Our review of the KPI glossary document highlighted that it is to contain a detailed guidance document for each measure, which incorporates consideration of data confidence. However, we reviewed a sample of these documents where available, identifying that the section is not robustly completed and does not address assurances over the quality of the source data. Whilst it was beyond the scope of testing for this review, we note that assurances will exist over certain data (e.g., finance through external / internal audit), but may not in other cases.

2.37 See matter arising 5 in Appendix A.

Conclusion:

2.38 We identified seven low priority matters arising regarding the new PMF design. We found that the quality of information of the reported metrics varied and there was no formal process to ensure their accuracy and the related assurance mechanism. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: Performance metrics are accurately calculated

2.39 Whilst a Records Management Policy is in place, the Trust does not have a formal process outlining the requirements for the retention of supporting documents / data specifically for the new PMF.

2.40 For our sample of 20 metrics, we reviewed the related supporting evidence and whether they were calculated in line with their definition. We identified that, for seven out of the 20 metrics, the supporting evidence provided was not direct source data (e.g., word document reports were provided).

2.41 See matter arising 5 in Appendix A.

2.42 We also identified some minor presentation issues in relation to the accuracy of the metric for the 'Trust HQ Electricity and Gas performance in kilowatt hours against target consumption budget' which had been refined promptly to make the presentation more accurate going forward. This was communicated to

management and resolved during the audit. We were informed a review of KPI presentation is planned before April 2023.

Conclusion:

2.43 We identified one medium priority matter arising regarding the lack of a formal process regarding retention of supporting evidence. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Project Governance (Operation)	Impact
Phase 1 of the PMF project has been well managed, resulting in the development of a comprehensive new PMF format. In our review of the PID, we identified the following areas which the Trust may wish to formally consider to further enhance the governance mechanisms in place as the project moves into phases 2 and 3: • formally documenting mechanisms not covered by the PID are documented, namely mitigation of risks and how / when project benefits are to be measured; • capturing revisions to the project (e.g., changes to scope or timelines) as it evolves, e.g., through revision of the PID; • documenting and sharing lessons learned; • tailoring project update reports to the audience; and • considering post project maintenance requirements. During the audit, we identified that the Trust does not have a formal Trust-wide PMO or a Project Management Framework, although WBS has a divisional PMO (within the Innovation and Improvement Hub) and a divisional Project Management Framework. We were also informed that VCC intends to set up a divisional PMO. This is included here for completeness but, as it does not impact upon the assurance provided in this report, no recommendation has been raised.	Potential risk of failure to deliver projects due to: • slippage in the development, approval or roll out of the new PMF; • underestimation of financial implications; and • inability to mitigate risks to project delivery.

Recommendations	Priority
1.1 Consider implementing the above points during the remaining stages of the PMF project, particularly regarding benefits measurement, resource and cost implications (during the project and post-project maintenance) and lessons learned (for the benefit of future projects).	Low (Operation)

Management response	Target Date	Responsible Officer
1.1 Accepted. We will implement the recommendation throughout the remaining phases of the PMF project.	Q2 2023/24	Head of Corporate Strategic Planning & Performance

Matter arising 2: Quality of report narrative and actions (Design)	Impact
We reviewed a sample of 20 measures for October 2022 and note that the standard template format was used for all of them. However, the quality of the narrative and identified actions varied between measures, e.g.: • the narrative was often not concise, although good practice examples were noted; • some sections of the template were left blank without any explanation (e.g., no action plan); and • proposed actions were not always SMART (e.g., no timescale / responsible officer). As we understand it, good practice examples have been shared across the services. We were also informed that training and guidance documents will be developed to support improved narrative.	Potential risk of: • key messages being lost in the detail; • ineffective or inefficient performance monitoring; • poor performance not being promptly identified; and • timely action not being taken.

Recommendations	Priority
2.1 Align the planned PMF training and guidance with the Trust's existing report writing training being delivered to individuals who produce reports for the Board and Committees.	Low (Design)
2.2 Divisional management (or appropriate alternative) should review PMF reports prior to submission as meeting papers to ensure: • actions in KPI reports are SMART, particularly implementation timeframes; and • the KPI report is fully completed each month, with explanations provided where elements of KPI reports are not completed.	Low (Design)

Management response	Target Date	Responsible Officer
2.1 Accepted. PMF training will be offered to all staff and stakeholders who provide input into and / or review the PMF.	Q2 2023/24	Head of Corporate Strategic Planning & Performance
2.2 PMF performance reports are reviewed and approved by the relevant Divisional and Support Service Directors / Senior Management Teams prior to submission to the EMB. They are then submitted to QSPC and the Trust Board. However, to improve the quality of explanatory narratives and SMART actions, a set of 'exemplar' KPI Supporting Data Templates has been produced which will be incorporated into the PMF training Programme (see 2.1 above).	Q2 2023/24	Director of Strategic Transformation, Planning & Digital, supported by Divisional and Support Service Directors

Matter arising 3: Metrics (Design)	Impact
Baseline performance: Baseline data to reflect average performance for each metric was based on performances reported in April 2022. However, we note that in some cases, the data from April 2022 may not be truly reflective of average performance. **Forward look position:** The use of SPC charts could be further enhanced through the use of predictive analytics generated through Machine Learning / Artificial Intelligence.	Potential risk of: • not maximising the potential of the new PMF; • inability to effectively monitor performance; and • inability to identify and address performance issues.

Recommendations	Priority
3.1 To enhance the robustness of the new PMF reporting: a. assess whether the April 2022 baseline data is appropriate for each measure and update if needed; and b. consider incorporating predictive analytics in the future using Machine Learning and Artificial Intelligence (AI) where appropriate (e.g., expectation for the year end).	Low (Design)

Management response	Target Date	Responsible Officer
3.1 Accepted. Current use of April 2022 as the default baseline will be reviewed and revised baselines will be introduced from 2023/24. In addition, we will consider incorporating predictive analysis as appropriate.	Q1 2023/24	Head of Corporate Strategic Planning & Performance

Matter arising 4: KPI definitions (Design)	Impact
We identified that: • whilst the KPI glossary document will provide an audit trail to support future changes to metrics, the process to update and approve the measures has not been formally documented; and • links to statutory reporting requirements have yet to be included in the glossary.	Potential risk of ineffective performance monitoring due to: • unauthorised or inappropriate changes to KPI definitions / calculations; • inconsistent calculation of KPIs; and • poor quality source data.

Recommendations	Priority
4.1 Formally document the process to add / remove / change KPIs (including their definition and calculation method) within the PMF.	Low (Design)
4.2 Ensure the KPI glossary has explicit links to statutory / legislative reporting measures (including definition, calculation formulae, latest source).	Low (Design)

Management response	Target Date	Responsible Officer
4.1 Accepted. A template has been developed and agreed by the PMF Project Group 10th January 2023. This will be completed and approved by Q1 2023/24	Q1 2023/24	Director of Strategic Transformation, Planning & Digital
4.2 Accepted. The PMF Project Plan requires completion of the KPI Glossary prior to PMF full 'go live' from 2023/24	Q1 2023/24	Head of Corporate Strategic Planning & Performance

Matter arising 5: Data confidence / assurance (Design)	Impact
Supporting evidence The Trust does not have a formal process outlining the requirements for the retention of supporting documents / data for the new PMF. For our sample of 20 metrics, we identified that: • for seven out of the 20 metrics, the supporting evidence provided was not direct source data (e.g., word document reports were provided); and • for one metric, the initial source data document provided did not match the metric reported due to the individual not being aware of the metric calculation definition (the subsequent report produced based on the correct definition matched the reported metric). While overall we found that all metrics in our sample were supported by the evidence provided, it took a substantial amount of time for the Trust to provide the right supporting evidence. **Data confidence** The Head of Corporate Strategic Planning & Performance carries out a high-level review of the reported metrics. However, there are no formal spot checks on supporting evidence or assurances over the quality of the source data. The glossary section considering data confidence for each metric is not robustly completed and does not address assurances over the quality of the source data. Whilst it was beyond the scope of testing for this review, we note that assurances will exist over certain data (e.g., finance through external / internal audit), but may not in other cases.	Potential risk of: • ineffective or inefficient performance monitoring • insufficient evidence to reported metrics

Recommendations	Priority
5.1 Develop and formally document a mechanism for the retention and retrieval of supporting evidence for monthly reported performance metrics (i.e., the source data and supporting calculation).	Medium (Design)
5.2 Develop and document processes for assurance over the accuracy of calculations / adherence to definition (e.g., independent spot checks)	Low (Design)
5.3 Ensure the detailed guidance for each metric within the KPI glossary robustly details assurance mechanisms over the quality of source data in the data confidence section, including considering and relying on any existing assurance mechanisms.	Low (Design)

Management response	Target Date	Responsible Officer

5.1	Accepted. VCC, WBS and Support Services, where the data is collected and analysed, will need to retain evidence supporting the monthly reported KPI metrics.	Q2 2023/24	Director of Strategic Transformation, Planning & Digital, supported by Divisional and Support Service Directors and Head of Corporate Strategic Planning & Performance
5.2	Accepted. We will develop and document processes to ensure the accuracy of the calculations.	Q2 2023/24	Head of Corporate Strategic Planning & Performance
5.3	Accepted. The KPI Glossary referred to in 4.1 & 4.2 above will include a detailed description of the calculation bases plus an assessment of the quality and level of confidence placed upon the source data.	Q1 2023/24	Head of Corporate Strategic Planning & Performance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership

4-5 Charnwood Court

Heol Billingsley

Parc Nantgarw

Cardiff

CF15 7QZ

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

New Velindre Cancer Centre Development: Contract Management

Final Internal Audit Report

January 2023

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

Executive Summary 4
1. Introduction 6
2. Detailed Audit Findings 6
Appendix A: Management Action Plan 11
Appendix B: Follow up of previously agreed management actions 15
Appendix C: Standing Orders & Standing Financial Instructions extracts 18
Appendix D: Summary of Audit findings 20
Appendix E: Assurance opinion and action plan risk rating 24

Review reference:	SSU_VEL_2223_05.2
Report status:	Final
Fieldwork commencement:	24 August 2022
Fieldwork completion:	29 November 2022
Draft report issued:	2 December 2022
Draft report meeting:	5 December 2022
Management response received:	22 December 2022 & 3 January 2023
Final report issued:	4 January 2023
Auditors:	NWSSP: Audit and Assurance – Specialist Services Unit
Executive sign-off:	Steve Ham, Chief Executive Officer
Distribution:	Carl James, Director of Strategic Transformation, Planning, Performance & Estates Matthew Bunce, Executive Director of Finance Huw Llewellyn, Director of Commercial & Strategic Partnerships David Powell, Project Director, TCS Mark Ash, Assistant Project Director (Commercials & Finance) 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 and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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

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

Executive Summary

Purpose

The audit, forming part of the 2022/23 Integrated Audit Plan, was undertaken to determine whether appropriate contract management arrangements were in place, and operating effectively, for technical and advisory services that have been procured to widen the areas of expertise available to the project; and to strengthen the support provided in the development of Project Deliverables.

Overview

Limited assurance has been determined in this area.

A number of non-compliances with Standing Orders and Standing Financial Instructions were identified, for the sample of adviser appointments reviewed, in terms of approval of contracts and variations, and implementation of appropriate contract documentation in a timely manner. In addition, the presentation by management of requests for approval, in the first instance to Project Board, has been slow.

It is recognised that both the nVCC and Enabling Works projects have been subject to challenges and pressures, with advisory support often required at short notice and to timescales outside the Trust's control, e.g., in relation to the planning and injunction processes.

However, the current governance framework does not allow for such pressures to be accommodated. Further, the current framework does not take account of the need to manage contractual changes (via compensation events) at NEC contracts.

The Trust should review the difficulties and non-compliances to date and develop a fit for purpose framework for the effective and compliant management of adviser and construction contracts going forward at both the nVCC / EW projects, and future major capital projects within the Trust.

It is acknowledged that the Executive Director of Finance has been tasked by the TCS Scrutiny Committee to review the Professional Services contractual arrangements at both the nVCC and EW projects, and assesses whether the processes undertaken for contract commitment increases complies with the Trust SOs and SFIs and in particular review any conflict between the nVCC

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	 2021/22

Assurance summary [1]

	Assurance objectives	Assurance
1	Validation of Management Action	N/A
2	Contract Arrangements (inc. Documentation)	Limited
3	Contract Fees	Limited
4	Contract Variations	Limited
5	Monitoring & Reporting	Reasonable

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

scheme of delegation contained in the 'New Velindre Cancer Centre Procurement Strategy'. The output is to be reported to Audit Committee. This work was ongoing at the time of our reporting.

Key Matters Arising		Assurance Objectives	Control Design or Operation	Recommendation Priority
1.1	Lessons-learned exercise required of the contract management practices applied to date.	1-5	Operation	High
1.2	The need to review contract management practices and develop a fit-for-purpose governance framework for the effective and compliant management of contracts going forward.	1-5	Operation	
1.3	Delegation of contingency allowances when managing NEC contacts.	4	Operation	

1. Introduction

1.1 This audit forms part of the 2022/23 Integrated Audit Plan and has sought to determine whether appropriate contract management arrangements were in place, and operating effectively, for technical and advisory services that have been procured to widen the areas of expertise available to the project; and to strengthen the support provided in the development of Project Deliverables.

1.2 The key risks considered in the review were:

- Non-compliance with defined contractual arrangements.
- Inadequate cost control arrangements applied.
- Adequate monitoring and reporting may not be demonstrated.
- Poor governance arrangements for approval of contracts / contract variations.
- Reputational risk should approvals not be provided in a timely manner.

2. Detailed Audit Findings

Validation of Management Action: Assurance that previously agreed management actions have been appropriately actioned by management.

2.1 The recommendations included in the nVCC: Contract Management report (issued February 2022: Reasonable Assurance) were followed up as part of this review. The status of the agreed management actions was as follows:

	High	Medium	Low	Total
Closed	-	-	-	**-**
Superseded	-	3	-	**3**
Outstanding	-	-	-	**-**
Total	**-**	**3**	**-**	**3**

2.2 The detail in support of the above summary is included in **Appendix B**.

2.3 Noting there was no evidence of progress towards the agreed actions. A new recommendation has been raised at this report, superseding the prior recommendations. The assurance rating will therefore be assessed within the relevant sections below.

Contract Arrangements: Assurance that all appropriate contractual arrangements were in place for the third-party providers (including contract documentation), to meet project delivery programmes.

2.4 Ten adviser appointments, from both the nVCC and Enabling Works projects, were sampled for review (see **Appendix D**). The approved financial value of these is summarised as follows:

Detail for the sampled appointments	Value	Comments
Original value of adviser work	£2,478,414	*Value, on which the Board was originally advised, based on original fee quotations / tenders, contract sums etc.*
Value of work committed as at October 2022	£2,805,943	*As per the Contracts Log*
Value of work committed with appropriate approvals & contracts in place	£1,371,528	*See Appendix D for audit findings*
Value of work committed without appropriate approvals & contracts in place	£1,434,415	*See Appendix D for audit findings (noting CM87 is included in this total)*
Current projected value of adviser work	£3,905,445	*Revised total value of work approved by the Board, in October 2022.*

2.5 The governance processes in place to obtain the required endorsements and approvals for appointments has moved slowly and delays have been observed in the raising of the initial request for endorsement to Project Board (i.e., after adviser duties had already commenced). Further delays occurred between May and October 2022, when a number of outstanding approvals were withheld whilst additional information was prepared for the Scrutiny Committee and Board to support the contract requests, noting the concerns regarding the retrospective nature of the requests for approval, and the significant increases in cost at some contracts.

2.6 These delays in seeking and granting approvals meant that some advisers have were providing support to the project for many months without payment, causing significant reputational risk to the Trust, and risking the standing down of advisers critical to the progression of the projects.

2.7 Of the ten adviser appointments reviewed, only four (CM74, CM35, CM56 & CM21) had contract documents in place at the date of fieldwork with the others awaiting Board approval. All four had been approved and signed in line with the Trust's Scheme of Reservation and Delegation of Powers. At the date of the audit fieldwork, two of these four contracts (CM35 & CM21) were awaiting new Board

approvals, noting original agreed sums had been exceeded (see **Contract Variation** section).

2.8 At six of the ten adviser appointments (CM35, CM56, CM76, , CM64, CM66 & CM67), adviser duties had commenced ahead of the required approvals and execution of contract documents (noting this issue was also identified in the 2021/22 Contract Management audit, see **Appendix B, MA1.2**).

2.9 Recognising the unique challenges faced by the projects, which in some cases have required the instruction of advisory support at short notice (to respond, for example, to planning or legal matters with deadlines outside the Trust's control), the current governance framework should be reviewed and updated to ensure it is fit for purpose to deal with these challenges going forward (**MA1**).

2.10 Noting the non-compliance with Standing Orders, and the significant reputational risks to the Trust of non-payment of advisers, **limited assurance** has been determined in this area. It is recognised that, at the time of reporting, all outstanding approvals for new contracts (e.g. CM87, see Appendix D) and contract variations had been approved by the Board, with the project team in the process of implementing the new contractual arrangements.

Contract Fees: Assurance that contract fees have been determined and approved, in accordance with the Standing Financial Instructions, in advance of work progressing.

2.11 At five of the ten adviser appointments reviewed (CM35, CM56, CM64, CM66 & CM67), work had commenced before the associated fees had been communicated and agreed.

2.12 As referenced at para. 2.9, it is recognised that the need to instruct advisory support at often short notice meant that firm quotations were not always received and agreed before work commenced. As a mitigating control, systems were in place to ensure fees incurred were monitored during these periods. The recommended review of the current governance framework should consider these challenges (see **MA1**). Whilst recognising these challenges, in a number of cases the confirmation of fees was not resolved in a timely manner.

2.13 The instruction of work without a clear indication of the potential overall cost is non-compliant with Standing Financial Instructions, and risks overspending against approved budgets. **Limited assurance** has therefore been determined in this area.

Contract Variations: Assurance that contract variations have been scrutinised through the required governance framework structure and approved in accordance with Standing Financial Instructions.

2.14 Three of the contracts reviewed (references CM74, CM35, and CM21) had exceeded the original contract award and required a variation to the existing contractual arrangements. In all three cases, the requests for approval were only reported after the original contract sums had already been exceeded.

2.15 In one instance (CM74), the variation (£14k) was managed within the project team's delegated limits.

2.16 At the other two contracts (CM21 and CM35), the need for a contract variation was reported retrospectively through the Trust's governance structure to the Scrutiny Committee and Board in May 2022 for endorsement and approval. As per para. 2.5, the requested approvals were initially withheld due to concerns over the contract management and governance processes applied (in particular, the retrospective nature of the requests and the rising costs) (see **MA1**), and eventually approved in October 2022.

2.17 At CM21, the New Engineering Contract (NEC) Professional Services contract had been utilised. NEC contracts can be varied by Compensation Events (CEs), which instruct a contractual change to the scope, time, or cost of the contract. CEs must be managed within strict contractual time frames, which do not permit time for proactive approval by the Board of the increasing contract costs as required by the current governance framework. Therefore, at this contract, the project team authorised the individual CEs (within their delegated limits), but the accumulated increase in cost (£394k) was only reported to the Board retrospectively. It should be ensured that the governance framework can accommodate contract variation by CE going forward, noting its increasing use at the projects e.g., at the Enabling Works construction contract (**MA1**).

2.18 The need for variations to original contract approvals were reported retrospectively, and appropriate consideration has not been given by the Trust to the management of contracts via CEs, therefore **limited assurance** has been determined in this area. We understand that the Director of Finance and Assistant Project Director (Commercials & Finance) are working together to consider options for an amended governance framework, which will ensure compliance with Standing Orders and the Public Contract Regulations (2015) Regulation 72, whilst permitting greater efficiency and timeliness in the management of contracts.

Monitoring & Reporting: Assurance that adequate monitoring and reporting of outputs against plans and agreed fee schedules is demonstrated in accordance with the Contract Management Procedure.

2.19 Adviser appointments were monitored by the project team via the Contracts Log, which captures key appointment information along with the current status of contract approvals and awards.

2.20 Recognising the recent challenges from the Scrutiny Committee, and concern over the retrospective nature of the requests for approval, the Contracts Log has been enhanced to record a four-month forecast spend, and flag whether the contract will need to be varied within this period based on the running rate of proposed expenditure against the original contract sum. This should support proactive reporting going forward.

2.21 A Contract Management report is a standing agenda item at the monthly Project Board meetings; with more detailed financial information (including committed against approved spend) presented on a quarterly basis.

2.22 Should the Trust decide to amend the current governance framework (see **MA1**), for example by delegating responsibility for management of contingency budgets from Board level, monitoring and reporting arrangements should clearly distinguish between expenditure against the approved contract sum, and expenditure of contingency. There should be no automatic assumption that contingency funds will be fully utilised against any particular contract, and the effectiveness of how these funds are allocated should be subject to appropriate scrutiny.

2.23 Noting the above, **reasonable assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Contract Management Governance Framework (Design)	**Impact**
A sample of 10 adviser appointments was selected for review, relating to both the nvCC and Enabling Works projects. The sample was reviewed against the requirements of the Trust's Standing Orders (SOs) and Standing Financial Instructions (SFIs) (see **Appendix C**), in respect of approvals, contract documentation, and management of contract variations. Whilst recognising the '*nVCC Delegations Framework'* document, only section 7 '*Decision Making within nVCC Competitive Dialogue process*' provides specific guidance on decision-making by the project team regarding capital costs and their respective escalation triggers, if applicable. No specific reference is made in relation to the appointment of advisers or the approval / variation of adviser contracts, however it is recognised that the document could be interpreted as providing for the same. However, noting the delegated limits within this Framework represent a change to the SOs and SFIs, this was not referenced within the document. See **Appendix D** for a summary of findings against the audit objectives. A number of weaknesses and non-compliances were identified in the processes applied. These can be summarised into the following key themes: • **Contract Management Framework:** There is no agreed framework, tailored to the nature, pressures and priorities of the project, within which to manage the instruction of adviser work (often required at short notice), and the approval of contracts and variations. Different expectations were exhibited between Project Board/Programme Board, and Scrutiny Committee/Board, noting papers were endorsed by the former but not by the latter. The delays incurred whilst securing approval placed the Trust at significant reputational risk with its advisers, with a further risk of advisers standing down having not been paid for many months. This could	Potential risk of: • Non-compliance with Trust SOs and SFIs; • Reputational risk if appointed advisers are not paid in a timely manner; • Failure to achieve value for money; • Inadequate cost control, exceeding approved funding allowances; • Acceptance of Compensation Events by default if contractual timeframes are exceeded before approvals are granted.

have been avoided if there was clarity between all parties at the outset as to the framework within which the project team were permitted to operate, and when escalation and approval was required.

- **Compliance with SOs and SFIs:** The instruction of work from advisers ahead of agreement of fees and approval/award of contracts or variations (observed at 8 of the 10 appointments) is non-compliant with Standing Orders. It was confirmed however, that no issues of non-compliance with the Public Contract Regulations (2015) Regulation 72 were identified in the decisions taken to undertake direct awards from approved frameworks, or in the variation of contracts up to a 50% cap. Advice was obtained from NWSSP Procurement Services to support the same, as required by the Standing Financial Instructions.
- **Management of Compensation Events:** The current governance framework does not support the effective management of contractual Compensation Events (CE). The CEs reviewed were approved by management to maintain contractual progress; however, this was not in compliance with Standing Orders as the management of project contingency has not been delegated from the Board. Retrospective approval has had to be sought from the Board for the cumulative contract variation.
- **Reporting:** In the reporting of the contract arrangements and variations for the various elements of legal advice and EW project management support, there was insufficient clarity as to how contract costs increased against the original approved fees and contracts.

Recommendations		Priority
1.1	The Trust should undertake a lessons-learned exercise in respect of contract management practices applied to date.	**High**

1.2	The Trust should develop a fit-for-purpose governance framework for the effective and compliant management of adviser and construction contracts at the nVCC and EW projects (and future major capital projects within the Trust), to support compliance with SOs and SFIs. The Trust may wish to consider the following in developing the framework: • Whilst recognising on some occasions advisers need to be mobilised at short notice, to meet stringent timelines outside the Trust's control (e.g., responding to planning matters), proactive reporting to the relevant forum/s should take place wherever possible, to forewarn of the coming need to instruct a new contract / vary an existing contract. Early reporting may mean full costs will not yet be known, but this would enable the Board to be sighted at the earliest opportunity and grant preliminary approval if considered appropriate, within a range of potential costs. • Robust monitoring and reporting procedures are required to support such a framework. Triggers for escalation should be built into the framework when the running rate of costs is likely to exceed the approved contract sum. Expenditure against contingency sums should be monitored separately from expenditure against the original contract sum, and clearly reported as such (noting that there should not be an automatic assumption that contingency sums will be fully expended). Reporting should be fully transparent as to the nature of increasing costs compared with the baseline position originally approved. The recommendations made in the 2021/22 Contract Management audit remain extant (see **Appendix B**) and should also be considered as part of this review.	
1.3	Where NEC contracts are applied, involving the use of compensation events to vary the contract, management of an appropriate contingency allowance (accommodated within the project budget) could be delegated to a suitable level (e.g., Chief Executive), allowing compensation events to be approved within this contingency.	

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed. The Project will contribute to the lessons learnt exercise undertaken by the Trust.	Trust deadline to be confirmed	Project Director with support of the Assistant Project Director (Commercials & Finance) and Executive Director of Finance
1.2	Agreed. The Trust has developed a contracts management framework to effectively manage the Enabling Works and nVCC contracts to effectively identify when contracts need to be varied or renewed. In addition, the Trust will ensure that Approvals for Authority to Spend on contracts will reflect accurate estimates or quotations, with an appropriate contingency sum. Once contract sums are agreed and the Approvals for Authority to Spend are checked, any further Approvals for Authority to Spend will be progressed through the Internal Governance as a matter of urgency.	Ongoing	Assistant Project Director (Commercials & Finance)
1.3	Agreed. The Project will report through the internal governance process the latest CEs position and obtain Approvals for Authority to Spend.	Ongoing	Assistant Project Director (Commercials & Finance)

Appendix B: Follow up of previously agreed management actions

Previous matter arising 1.1: Contract Documentation	
Original recommendation and management response	Original priority
The appointment process should be managed to ensure accuracy of the information reported to management i.e., contract value and timing of evaluation / acceptance. **Management response:** Noted. The Project will improve the management of the contractor appointment process by implementing a quality assurance process that signs off contract documentation.	**Medium**
Current findings	**Residual risk**
Recognising focus on the MIM priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the appointment process should now be considered in conjunction with the new recommendation made. **Conclusion:** Superseded. See **MA1, Appendix A.**	See **MA1, Appendix A**

Previous matter arising 1.2: Contract Documentation	
Original recommendation and management response	Original priority
Contract documentation should be signed in a timely manner and prior to the commencement of works. **Management response:** Noted. The Project has improved processes to improve the timeliness of signing contract documentation to ensure all is signed within 30 days.	**Medium**
Current findings	**Residual risk**
At the 10 contracts reviewed at this year's audit, contracts were only in place prior to commencement of duties in two cases. Of the eight completed after commencement, none met the 30-day timeframe as per the management response (with a number remaining outstanding at the time of fieldwork, recognising Board approvals had been required). The difficulties in achieving proactive contract execution, in some of the cases reviewed this year, are recognised. **Conclusion:** Superseded. See **MA1, Appendix A.**	See **MA1, Appendix A**

Previous matter arising 3.1: Contractor Performance and Key Performance Indicators	
Original recommendation and management response	Original priority
Reporting on contractor performance and Key Performance Indicators should be undertaken in line with expectation. **Management response:** Noted. The Project will ensure that balanced scorecards for appropriate contractors will be reported to Project Board on a quarterly basis.	**Medium**
Current findings	**Residual risk**
Recognising focus on the MIM priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the expectations for reporting should now be considered in conjunction with the new recommendation made. **Conclusion:** Superseded. See **MA1, Appendix A.**	See **MA1, Appendix A.**

Appendix C: Standing Orders & Standing Financial Instructions extracts

Standing Orders: Schedule 1 - Scheme of Reservation & Delegation of Powers

Section 1 - schedule of matters reserved to the board
Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions.

Section 5 - Financial Limits
Trust Board - no limit
Chief Executive - up to £100k
Further delegated financial limits which are less than £100k will be agreed by the Chief Executive and the Executive Management Board.

Standing Financial Instructions: Contract Variations

11.17.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g., scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Trust budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Trusts compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Appendix D: Summary of Audit findings

Table 1: Sampled appointments with contracts in place

Contract Ref	Project	Description	Current projection of total value of contract (as per Contracts Log, October 2022)	Original contract value	Value of work committed to October 2022 (as per Contracts Log)	Variation to original approved value	Appropriate approvals granted before work commenced? (inc. compliance with delegated limits)	Fees agreed before work commenced?	Contract in place before work commenced?	Total value of work committed without approval and / or contract
CM74	EW	Technical Project Manager (40 days)	£43,085	£28,896	£43,085	£14,189	Y	Y	Y	-
CM35	nVCC	Legal-Competitive Dialogue	£1,153,000 [1]	£539,977	£1,100,000	£560,023	Y	**N** [2]	**N**	£560,023
CM56	nVCC	S73 Phases 1 and 2	£39,294	£39,662	£39,294	**-**	**N**	**N**	**N**	£39,294
CM21	EW	Advisory Support	£788,466	£788,466	£788,466	-	Y	Y	Y	-
Total			**£2,023,845**	**£1,397,001**	**£1,970,845**	**£574,212**				**£599,317**
CM87 [3]	*EW*	*Advisory Support*	*£500,000*	*£500,000*	*£130,135*	-	*N*	*Y*	*N*	*£130,135*

[1] *Further to the original contract award of £539,977, additional ad hoc services were required in the sum of £229k (which were included in the original contract but not let as part of the original award), bringing the total contract value to £769k. At July 2022, a total expenditure against this contract of £1.1m was reported. The contract therefore required variation, to the maximum permitted value of 50% of the original contract value; taking the total value to £1.153m. The addition of the ad-hoc services and the contract variation was retrospectively approved by the Board in October 2022.*

[2] *Whilst the Trust Board approved the procurement of the legal advisers via direct award from a framework in November 2020, fees were not confirmed / agreed or the contract executed until after advisory duties had already commenced and financial commitments had been made (circa £34k). Following full expenditure against the original contract sum of £539,977, further commitments (£560k) were made ahead of Board approvals.*

[3] *From review of CM21, management advised that CM87 is a continuation of the advisory support to be. In October 2022, the Board approved the raising of a new contract, valued at £500k, to cover the increase in cost from the original contract value (£788,466). Whilst noting only £130,135 had been logged on the Contract Log as committed against this new contract, Compensation Events (CEs) totalling £322k were originally instructed by the project team, utilising project contingency funds (without the required Board approval in place). At October 2022, where the work instructed under these CEs had not yet been delivered, the original CEs were closed off and outstanding requirements transferred to the new £500k contract.*

Table 2: Sampled appointments with no contracts in place

Contract Ref	Project	Description	Current projection of total value of contract (as per Contracts Log, October 2022)	Original forecast for commitment to spend	Value of work committed to October 2022 (as per Contracts Log)	Appropriate approvals granted before work commenced? (inc. compliance with delegated limits)	Fees agreed before work commenced?	Contract in place before work commenced?	Total value of work committed without approval and / or contract
CM76	EW	Technical Project Manager (160 days)	£115,600	£115,600	£40,460	**N**	Y	**N**	£40,460
CM63	nVCC	MIM Financial Support	£60,000	£60,000	£0	Not yet approved	Y	-	-
CM64	EW	Legal - Litigation	£500,000	£500,000	£450,000	**N** [3]	**N**	**N**	£450,000 [2]
CM65	nVCC	Legal - Planning Matters	£50,000	£50,000	£0	Not yet approved	Y	-	-
CM66	nVCC	Legal - Preferred bidder to financial close	£500,000 [1]	£200,000	£58,798	**N**	**N**	**N**	£58,798
CM67	nVCC	S73 Phase 3	£156,000	£155,813	£155,705	**N**	**N**	**N**	£155,705
Totals			**£1,381,600**	**£1,081,413**	**£704,963**				**£704,963**

[1] *Whilst the 'preferred bidder to financial close' work was originally quoted and approved at £200k, and awarded within the CM35 contract (£539,977), the contract value was subsequently consumed by Competitive Dialogue requirements, leaving no remaining contract value for the financial close element. Additionally, forecast costs for the financial close element have now risen to £500k. The Board approved the raising of a new contract, for £500k, in October 2022. The reporting of the change in cost for this work, against original approvals, does not appear to have been sufficiently explained in the Board reports evidenced.*

[2] *It is recognised that, whilst the contract had not been implemented, the Board was fully informed of the ongoing costs associated with the litigation process.*

Appendix E: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

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

NHS WALES
Velindre University NHS Trust

Counter Fraud Progress Report
09/09/2022 – 28/12/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. Introduction
2. Progress

Staffing

Activity -

Infrastructure/Annual Plan

FPN/IBURN

Alerts/Bulletins

Awareness sessions

Referrals/Enquiries

Investigations

Other

3. Appendices (Supplied Seperately)

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Velindre NHS Trust in relation to the third period of reporting for the year 2022-2023. The report covers the period from 9th September 2022 to the 28th December 2022.

The report's format has been adopted in order to update the Audit Committee about counter fraud referrals, investigations, activity and operational issues.

At 28th December 2022, 68 days of Counter Fraud work have been completed against the agreed 110 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness training, policy review, and, preparing for international Fraud Awareness week.

This report builds upon the previous counter fraud progress reports submitted at the previous audit committee meetings.

The breakdown of these days is as follows: (P=Period) () = Running Total

TYPE	Days P1	Days P2	Days P3	Days P4
Proactive	15	15 (30)	25 (55)	
Reactive	9	6 (15)	0 (15)	

2. Progress

Staffing

For the duration of this reporting period the team has been understaffed by 25%. The recruitment campaign that was carried out has seen a conditional offer made to the successful candidate. It is anticipated that this person will commence in their new role in the team on 3rd January 2023. The successful applicant will be joining from their current role at the counter fraud service wales and will bring with them a wealth of experience of the NHS and Counter fraud within it. They are an accredited Counter Fraud Specialist (ACFS).

Activity

Infrastructure/Annual Plan

During this reporting period, work has continued in developing the infrastructure that will allow successful compliance with the Counter Fraud Plan for 2022-2023. In this period the below activity has taken place in relation to this area of work -

a. The maintenance of a comprehensive activity database which is already assisting in maintaining a detailed and accurate record of work undertaken.
b. Review of the Counter Fraud Bribery and Corruption Policy – Velindre NHS Trust have their own Counter Fraud Bribery and Corruption Policy. This has now been reviewed and amended and has been forwarded for review at Executive Board Management panel.
c. Maintenance of Counter Fraud digital presence – Fully functional, modern, Counter Fraud Intranet site has now been further updated and maintained. This is hosted by the Cardiff and Vale University Health Board Share point site but is available to all members of Velindre staff via the link below. This link is publicised and signposted via the Velindre intranet site and through ongoing publications and messaging such newsletters bulletins and surveys.

(Link to the site for reference : Counter Fraud - Home (sharepoint.com))

d. Counter Fraud e-Learning arrangements – the Counter Fraud learning site on the All Wales Learning @ Wales Platform has been completed. It awaits the new All Wales eLearning package to be finalised and distributed by the Counter Fraud Service Wales. And as such is not yet live. An update from the Counter Fraud Service Wales anticipates this package will go live in April 2023.
e. New awareness materials have been produced in relation to general fraud awareness training and mandate fraud awareness training and these have been launched during the course of international fraud awareness week in October on the Fraud Team intranet site.

Fraud Prevention Notices and IBURN notices

(These notices are issued nationally by the NHS Counter Fraud Authority and require action by Local Counter Fraud Teams)

During this reporting period two fraud prevention notices issued by the NHS Counter Fraud Authority.

(1) This FPN was issued in relation to Mandate fraud and foreign payments following a successful fraud being perpetrated in NHS England. The methodology involved the impersonation of the Chief Finance Officer via email requesting staff to make a payment to a foreign supplier. There have been no issues internally and the organisation's financial staffing cohort alerted to the MO being used to ensure vigilance. FPN inclusive of advice and mitigating actions issued to relevant staffing cohorts within the distribution list.

(2) This FPN was issued to raise awareness as to the possible fraud risks in relation to fraudulent attempts for payment of office supplies/consumables concentrating mainly on printer toners and printer drums. This type of fraud appears to be prevalent in the primary care domain

i.e. GP practices. Information passed to Primary Care team in order for cascading to GP practices. Liaison made with NHSWSSP accounts payable team and assurance provided that the risk to the organisation is extremely low. FPN, along with advice and mitigating actions forwarded to the relevant staffing cohorts in line with the distribution list restrictions.

One (1) IBURN notice has been issued in relation to Cyber related mandate fraud. Enquiries made with NWSSP to ensure that the rogue companies haven't had any involvement in NHS Wales. Assurance provided that there have been no issues. Information cascaded to finance teams as a reminder for vigilance.

Local Alerts/Bulletins

During this reporting period no local intelligence bulletins have been issued

Awareness Sessions

During this reporting period two further awareness sessions have been delivered to Velindre staff. One general fraud awareness session and one Mandate Fraud specific session. (During the course of International Fraud Awareness week)

Referrals/Enquiries

During this reporting period no referrals have been received in relation to Velindre NHS Trust.

Investigations

NA

Other

Fraud Awareness Week

International fraud awareness week took place between 14th November and 18th November. A number of digital support materials were issued and made available to all staff within the organisation via emails shots, notices and via the intranet site. This included a new SWAY newsletter which can be found at this link Sway (office.com)

A 'Pop up' stall was arranged to be held at Velindre HQ offices and at the Welsh Blood service at Llantrisant.

Awareness sessions were also delivered to staff at Velindre HQ in relation to general fraud awareness and mandate fraud awareness.

Fraud Risk Profile

A fraud risk profile has now been developed for the organisation. This profile aims to assist in achieving compliance with the Government Functional Standard GovS 013: Counter Fraud NHS requirement 3 – Risk Assessment. This profile is included at **Appendix 1.** The profile lists the inherent risks to NHS organisations provided by the NHS Counter Fraud Authority that are relevant to Velindre UNHST. These areas will now be subject to fraud risk assessment work by the counter fraud team. This profile will be added to as necessary when further risks are identified as a result of investigation or information received from other sources. The first risk assessment into staff expenses fraud has been completed and forwarded to the organisation for review and inclusion on the local risk register in order to comply with the Velindre UNHST Risk Management Policy. This assessment is included at **Appendix 2.**

This work will be ongoing as time and resource allows.

Counter Fraud Arrangements NHS Wales

A report has been produced in relation to the current and future NHS Wales Counter Fraud provision. This report has been shared among Directors of Finance and at the Counter Fraud steering group at their most recent meetings. Local Counter Fraud Managers and teams have not been involved in this consultation. The report has been commissioned by NHS Wales Shared Services Partnership and has been produced by the Head of the Counter Fraud Service Wales. The report is focussed on the current situation and presents different options for the future of the provision. The options for the future of the service have been described as follows:

Option 1

No change – continue with the current three tier service provided via CFS Wales, LCFS and NHSCFA.

Option 2

Hybrid system – all health bodies have the option to opt into a NWSSP led

service. LCFS services provided by NWSSP would retain a local presence at the health bodies they represent, maintaining a strong operational relationship with the relevant Finance Directors. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.

Option 3

Centralised Model – CFS Wales and all LCFSs move across to an NHS Wales Shared Service Model which retains a strong local presence at the relevant health bodies, similar to the current NWSSP procurement provision. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.

It is understood that these options will now be further explored within a working group.

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ann Marie Stockdale, Head of Outpatient, Medical Records and Private Patient Services
PRESENTED BY	Lisa Miller, Head of Operational Services and Delivery Ann Marie Stockdale, Head of Outpatient, Medical Records and Private Patient Services
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

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

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Team have completed submission of July 2022 invoices. Work on August 2022 and September 2022 invoicing is underway and will be completed by mid January 2023. Delays due to resourcing issues within the Team, and implementation of Healthcode billing system as recurrent solution.

2.2 The reduction in the invoicing timeline has been maintained. The aim is reduce this further until a position of one month in hand is achieved.

2.3 Healthcode was implemented on the 15th September 2022 which will require Insurance Companies to adhere to a payment timeline of 30 days for all electronic billing. Invoices raised before this time have a 90 day payment timeline.

2.4 A final report detailing the position against aged debt has been drafted and will be submitted to the Private Patient Management Group, and subsequently the Executive Director of Finance.

2.5 An external company (Liaison) has been appointment through the procurement route to support delivery of key objectives, including debt recovery. Liaison have been on site and working closely with the Private Patient Team.

2.6 As an audit action, financial key performance indicators have been developed for consideration and agreement. These are as follows:-

Key Performance Indicators (Targets to be agreed)	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022
% Debts Payable by Insurance Companies	94.3%	96.8%	93.4%	97.4%	96.6%
% Debts Not Payable by Insurance Companies	5.7%	3.1%	6.6%	2.6%	3.4%

% Debts aged 30 days or less	0.0%	47.0%	43.4%	12.5%	25.2%
% Debts aged 31-180 days	38.2%	17.1%	20.1%	51.1%	36.3%
% Debts aged 181-365 days	28.2%	16.5%	13.8%	12.0%	11.1%
% Debts aged 1 year +	33.6%	19.3%	22.7%	24.4%	27.2%

Following feedback from the Audit Committee, an additional indicator has been added. The indicator calculation is derived from the total private patient value divided by the amount of income raised in the last twelve months (rolling year) times 365 days. The position is as follows:

Key Performance Indicator	**31/07/2022**	**31/08/2022**	**30/09/2022**	**31/10/2022**	**30/11/2022**
Days Sales Outstanding	79	122	52	128	117

Key Performance Indicators (Targets to be agreed)	**31/07/2022**	**31/08/2022**	**30/09/2022**	**31/10/2022**	**30/11/2022**
Debts recovered in month compared with total debt end of month	6.8%	0.1%	180.5%	-46%	34.9%

2.7 The full report (Appendix 1) continues to demonstrate a significant shift in debt between months particularly by insurance companies. It is anticipated that this position will shift over the forthcoming months with the introduction of electronic billing in parallel to the team now fully established.

2.8 The present percentage of debts less than 180 days is 61.5%, which when compared to average of Apr-Sep 2021 (Audited Period of Debts as Reference Point of Base for Improvement) of 45%, reflects a highly significant shift towards “recent” rather than “aged” debt, improving the likelihood of receipt and demonstrable benefit of processes embedded. This is influenced by the high proportion and value of invoices raised during recent months, reflective of the factors raised earlier within this paper.

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

Debt Due Less Than 180 Days - Proportion	17%	49%	35%	51%	57%	61%	45%

2.9 The Private Patient Team have commenced focus on recovery of debt greater than 180 days and a targeted reduction of the total "Days Sales Outstanding". The contracted in support via LIASON will further support this work.

2.10 Additional financial support is being targeted in partnership with LIASON, to advance the targeted improvements in terms of maximizing commercial and contract management, processing and business support.

3.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

4.1 The Committee is asked to REVIEW and APPROVE the financial key performance indicators.

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

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Appendix 1 – Aged Debt Report

Spreadsheet attached.

PP Aged Debt Position December 2

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

Key Performance Indicators (Targets to be agreed)	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022
% Debts Payable by Insurance Companies	94.3%	96.8%	93.4%	97.4%	96.6%
% Debts Not Payable by Insurance Companies	5.7%	3.1%	6.6%	2.6%	3.4%
% Debts aged 30 days or less	0.0%	47.0%	43.4%	12.5%	25.2%
% Debts aged 31-180 days	38.2%	17.1%	20.1%	51.1%	36.3%
% Debts aged 181-365 days	28.2%	16.5%	13.8%	12.0%	11.1%
% Debts aged 1 year +	33.6%	19.3%	22.7%	24.4%	27.2%
Days sales outstanding	79	122	52	128	117

Movement between Months (brackets indicate increase in debts)

Key Performance Indicators (Targets to be agreed)	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022
Debts recovered in month compared with total debt end of month	7.9%	17.2%	63.3%	20.1%	25.0%	6.8%	0.1%	180.5%	-46.6%	34.9%

All debts	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	0	429,597	167,379	118,239	217,211
31-60 days	48,263	0	58,168	160,372	33,900
61-90 days	80,645	48,263	0	241,246	131,489
91-180 days	55,854	107,641	19,360	79,954	146,922
181-365 days	136,686	150,957	53,004	113,282	95,449
1 year +	162,844	176,682	87,363	229,765	234,267
Total	**484,293**	**913,140**	**385,275**	**942,858**	**861,497**

All debts	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	31/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	85,827	(281,159)	388,750	(162,309)	99,441	63,800	(429,597)	262,218	49,140	(98,972)
31-60 days	(107,005)	61,982	(51,437)	141,081	(89,007)	41,071	48,263	(58,168)	(102,204)	126,472
61-90 days	(3,159)	(3,184)	(14,554)	24,688	36,048	(80,317)	32,382	48,263	(241,246)	109,757
91-180 days	(13,390)	33,850	9,167	(26,020)	22,938	25,477	(51,787)	88,281	(60,594)	(66,968)
181-365 days	(20,339)	(50,686)	(11,389)	9,058	(5,223)	4,528	(14,270)	97,953	(60,278)	17,833
1 year +	(348)	245	18,480	(32,394)	1,290	(21,642)	(13,838)	89,319	(142,402)	(4,502)
Total	**(58,415)**	**(238,952)**	**339,017**	**(45,896)**	**65,488**	**32,918**	**(428,847)**	**527,866**	**(557,584)**	**83,620**

Insured	31/07/2022	31/08/2022	30/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	0	427,667	166,301	118,239	213,176
31-60 days	48,263	0	58,168	159,294	33,900
61-90 days	80,645	48,263	0	241,246	130,411
91-180 days	50,733	106,410	19,359	79,954	146,922
181-365 days	131,137	141,686	45,403	108,338	92,573
1 year +	146,149	159,817	70,644	211,157	215,484
Total	**456,927**	**883,844**	**359,875**	**918,230**	**832,468**

Insured	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	31/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	88,509	(277,733)	380,725	(163,241)	99,441	63,800	(427,667)	261,366	48,062	(94,937)
31-60 days	(107,920)	66,353	(56,365)	141,409	(89,335)	41,071	48,263	(58,168)	(101,126)	125,394
61-90 days	(2,007)	(4,486)	(10,664)	20,798	36,376	(80,645)	32,382	48,263	(241,246)	110,835
91-180 days	(15,502)	33,890	4,783	(22,340)	23,353	25,805	(55,677)	87,051	(60,595)	(66,968)
181-365 days	(20,169)	(50,686)	(6,497)	8,942	(4,775)	4,528	(10,550)	96,283	(62,935)	15,765
1 year +	(348)	(622)	18,505	(32,263)	2,145	(21,642)	(13,668)	89,173	(140,513)	(4,327)
Total	(57,437)	(233,285)	330,487	(46,695)	67,206	32,918	(426,917)	523,969	(558,353)	85,762

Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)					
Within maturity (0-30 days)	0	1,193	0	0	4035
31-60 days	0	0	1,078	1,078	0
61-90 days	0	0	0	0	1,078
91-180 days	5,121	1,231	0	0	0
181-365 days	5,550	9,270	7,601	4,943	5,131
1 year +	16,695	16,865	16,718	18,607	18,782
Total	**27,366**	**28,559**	**25,397**	**24,629**	**29,028**

	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	31/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	(2,682)	(3,426)	8,025	932	0	0	(1,193)	1,193	0	(4,035)
31-60 days	915	(4,371)	4,928	(328)	328	0	0	(1,078)	0	1,078
61-90 days	(1,152)	1,302	(3,890)	3,890	(328)	328	0	0	0	(1,078)
91-180 days	2,112	(40)	4,384	(3,680)	(415)	(328)	3,890	1,231	0	0
181-365 days	(170)	0	(4,892)	116	(448)	0	(3,720)	1,669	2,658	(188)
1 year +	0	867	(25)	(131)	(855)	0	(170)	147	(1,889)	(175)
Total	(977)	(5,668)	8,530	799	(1,718)	0	(1,193)	3,162	769	(4,398)

Self payer					
Within maturity (0-30 days)	0	1,930	446	0	4,035
31-60 days	0	0	0	446	0
61-90 days	0	0	0	0	446
91-180 days	903	903	0	0	0
181-365 days	580	410	1,203	1,053	903
1 year +	1,086	1,256	1,110	1,491	1,666
Total	**2,569**	**4,499**	**2,759**	**2,990**	**7,051**

Self payer	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	31/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	0	(809)	809	0	0	0	(1,930)	1,484	446	(4,035)
31-60 days	380	0	0	0	0	0	0	0	(446)	446
61-90 days	(60)	210	0	0	0	0	0	0	0	(446)
91-180 days	(150)	(40)	90	210	(753)	0	0	903	0	0
181-365 days	(170)	0	(260)	(40)	(110)	0	170	(793)	150	150
1 year +	0	867	(25)	25	(855)	0	(170)	146	(381)	(175)
Total	0	228	614	195	(1,718)	0	(1,930)	1,740	(231)	(4,060)

Top Up					
Within maturity (0-30 days)	0	0	632	0	0
31-60 days	0	0	0	632	0
61-90 days	0	0	0	0	632
91-180 days	4,218	328	0	0	0
181-365 days	4,970	8,860	6,398	3,890	4,228
1 year +	15,609	15,609	15,609	17,116	17,116
Total	24,797	24,797	22,639	21,639	21,977

Top Up	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	31/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	(5,531)	(2,617)	7,216	932	0	0	0	(632)	632	0
31-60 days	338	(4,928)	4,928	(328)	328	0	0	0	(632)	632
61-90 days	(338)	338	(3,890)	3,890	(328)	328	0	0	0	(632)
91-180 days	2,262	0	4,294	(3,890)	338	(328)	3,890	328	0	0
181-365 days	0	0	(4,632)	156	(338)	0	(3,890)	2,462	2,508	(338)
1 year +	0	0	0	(156)	0	0	0	(0)	(1,507)	0
Total	(3,269)	(7,207)	7,916	604	(0)	0	(0)	2,158	1,001	(338)

Overseas					
Within maturity (0-30 days)	0	0	0	0	0
31-60 days	0	0	0	0	0
61-90 days	0	0	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	0	0	0	0	0

Overseas	28/02/2022	31/03/2022	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	31/09/2022	31/10/2022	30/11/2022
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0	0	0
31-60 days	197	557	0	0	0	0	0	0	0	0
61-90 days	(754)	754	0	0	0	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0	0	0
Total	2,292	1,311	0	0	0	0	0	0	0	0

AUDIT COMMITTEE

TECHNICAL UPDATE

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Claire Bowden, Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
FRAB	Financial Reporting Advisory Board
IFRS	International Financial Reporting Standard(s)
TAG	Technical Accounting Group

1. SITUATION/BACKGROUND

1.1 This report has been prepared to provide the Committee with an update on the new International Financial Reporting Standard (IFRS) 16 for leases that has previously been advised will affect the financial statements prepared for 2022/2023 and future years.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

IFRS 16 – Leases

2.1 This IFRS replaces the current leases standard: most notably largely removing the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months unless the underlying asset is of low value. This will lead to some operating leases being added to the Statement of Financial Position as an asset, with a corresponding liability for future rentals.

2.2 This IFRS was originally expected to be applied to the 2019/2020 financial statements, however, in November 2018, the Financial Reporting Advisory Board (FRAB) made the decision to defer implementation of this standard to 1st April 2020.

2.3 The Committee were advised in October 2020 that implementation had been deferred again until 1st April 2021. A further decision was then made to defer implementation until 1st April 2022, and the Committee were informed of this in January 2021.

2.4 The Finance team have continued to work with the Welsh Government, Estates & Procurement staff, and the All Wales Capital TAG group to ensure implementation of the standard from the 2022/2023 financial year, and appropriate recognition in this and future year's annual financial statements.

3. IMPACT ASSESSMENT

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

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As they can be quantified at this stage, they have been included in section 2.

4. RECOMMENDATION

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

AUDIT COMMITTEE

AUDIT COMMITTEE ANNUAL REPORT 2022

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Martin Veale JP, Audit Committee Chair Claire Bowden, Head of Financial Operations
PRESENTED BY	Martin Veale JP, Audit Committee Chair Claire Bowden, Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Trust's Standing Orders require each sub-committee of the Board to submit an annual review setting out its activities during the year and detailing the results of a review of its performance.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report provides the Committee with a summary of the work undertaken during the period 1st January – 31st December 2022.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the Trust's activities / functions.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Committee are asked to **APPROVE** the report prior to submission to the Trust Board for noting.

AUDIT COMMITTEE

ANNUAL REPORT 2022

Audit Committee
Annual Report 2022

1. Foreword

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee. It outlines the coverage and results of the Committee's work for the year ending 31 December 2022.

During the year, I was supported by Independent Members, Vicky Morris and Gareth Jones, who continued to provide their considerable knowledge and wide-ranging experience to the Committee. I would like to take this opportunity to put on record my sincere thanks for the significant contribution made by both during the year.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NHS Wales Shared Services Partnership, Local Counter Fraud Services and by Audit Wales.

Meetings have been well attended and have continued to be held online. The meetings have been characterised by constructive dialogue and challenge, and the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Trust, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Martin Veale JP
Chair of the Velindre University NHS Trust Audit Committee
14 December 2022

2. Introduction

This report summarises the key areas of business activity undertaken by the Committee between January and December 2022 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

This report reflects the Committee's key role in the development and monitoring of the governance and assurance framework within which the Trust operates.

3. Role and Responsibilities

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

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

The Trust operates a separate Audit Committee to provide assurance on the work of the NHS Shared Services Partnership (NWSSP). Whilst the same Independent Members sit on both committees, they are entirely separate, and the NWSSP Audit Committee produces its own Annual Report.

4. Agenda Planning Process

The Chair of the Committee, in conjunction with the Trust's Executive Director of Finance and Director of Corporate Governance, draws up the agenda for Committee meetings, which is based upon an agreed annual programme of work and clearly linked to the Committee's Terms of Reference.

The Trust Governance team aim to disseminate the agenda and papers to Committee members at least five working days before the date of the meeting.

5. Operating Arrangements

The Committee's Terms of Reference are reviewed annually, with the next review being considered at the January 2023 Audit Committee. A copy of the Terms of Reference extant at the point of writing this report is attached at the end.

The Audit Committee Cycle of Business for June 2022 to June 2023 was noted in July 2022 and will next be updated and presented in April 2023. The agenda of each meeting, however, is sufficiently flexible to allow the committee to consider any emerging issues.

6. Membership, Frequency and Attendance

The Terms of Reference of the Committee state that the Committee should consist of a minimum of three Independent members of the Board. One of these members must also be a member of the Quality & Safety Committee.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. During 2022 this option was not exercised.

During the year the Committee met on five occasions with attendance as follows:

Name	Audit Committee
Mr Martin Veale JP (Independent Member) Chair	4 out of 5
Mr Gareth Jones (Independent Member)	4 out of 5
Mrs Vicky Morris (Independent Member)	5 out of 5

During the year, the meetings were supported by the following:

- Mr Matthew Bunce, Executive Director of Finance
- Ms Claire Bowden, Head of Financial Operations
- Mr Chris Moreton, Deputy Director of Finance
- Mrs Lauren Fear, Director of Corporate Governance
- Mrs Emma Stephens, Head of Corporate Governance

- Mr Steve Wyndham, Audit Wales
- Mrs Kate Febry, Audit Wales

- Mr Simon Cookson, Internal Audit
- Mrs Emma Rees, Internal Audit

- Mr Gareth Lavington, Lead Local Counter Fraud Specialist

7. Audit Committee Activity 2022

The Audit Committee fulfilled its planned work for 2022 covering a wide range of activity. This work can be summarised under the following headings:

7.1 External Audit

- The Committee approved the Audit Wales plan for 2022 in May 2022. Updates from representatives from Audit Wales were given at each meeting.
- Audit Wales documentation was provided to the Committee during the year in relation to the:
  - Annual Audit Plan 2022;
  - Financial Audit 2021/2022;
  - Structured Assessment 2021 (phase 2): Corporate Governance & Financial Management Arrangements.
- Audit Wales provided the Committee with a report entitled "Taking Care of the Carers" that related to how NHS bodies supported the wellbeing of their staff during the COVID-19 pandemic, with a focus on safeguarding staff at higher risk from COVID-19.
- Audit Wales also shared with the Committee other relevant publications that were of relevance to the Trust, including one entitled "Public Sector Readiness for Net Zero Carbon by 2030".
- An external audit was also undertaken to evaluate the Trust's conformity with the ISO14001:2015 standard which relates to its environmental management system. This was reported to the Audit Committee in May 2022, with confirmation that the Trust had successfully obtained recertification.

7.2 Internal Audit

- The Committee received regular progress reports from the Internal Audit team during the calendar year following agreement of an Internal Audit Plan for 2022/2023 in May 2022.
- During the year the Committee considered 17 reports completed by Internal Audit: their assurance ratings are shown below, with a full list of the reports shown in appendix 1.

Rating	**Number**
Substantial	4
Reasonable	10
Limited	0
Advisory	*3*
	17

- Internal Audit's annual assurance opinion for 2021/2022 was reported to the Committee in June 2022. It stated that "the Final Opinion provides the Board with **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact** on residual risk exposure until resolved".

7.3 Annual Accounts, Annual Governance Statement & Accountability Report

- The Committee meeting in June 2022 received the audited 2021/2022 Annual Accounts, Annual Governance Statement, Letter of Representation and the Trust's response to Audit Wales regarding governance arrangements.
    - The Trust's Annual Accounts were subject to a Qualified Audit Opinion by Audit Wales in respect of the regularity of expenditure as, following a Ministerial Direction, the accounts included expenditure and funding in relation to clinicians' pension tax liabilities.
    - The Committee endorsed and recommended the approval of the Trust's Annual Accounts and other documents to the Trust Board.
- A report detailing lessons learned following the production and external audit of the 2020/2021 Charitable Funds accounts was presented to the Committee in May 2022.

7.4 Counter Fraud

- The Committee received the Counter Fraud Annual Report for 2020/2021 in January 2022; and the Annual Report for 2021/2022 in July 2022.
- The Committee received the Annual Workplan for 2022/2023 in May 2022, and updates from the Counter Fraud Specialist or Lead at each meeting.

7.5 Internal Assurance & Risk Management Monitoring

- The Committee received details of the changes to the Trust Board standing orders for the updated Terms of Reference and Operating arrangements for the Charitable Funds Committee, the Strategic Development Committee, the Quality, Safety & Performance Committee, and the Audit Committee; and endorsed them for Trust Board approval.
- The Committee received a report in relation to an external review commissioned on the Private Patient service, together with subsequent regular updates in relation to the recommendations and agreed actions arising from it, including action to recover income due to it on a timely basis.
- The Committee were provided with an update on the development of the Trust Assurance Framework, together with the ongoing work to support its continued development, articulation and operationalisation with the Trust.
- A Committee self-assessment questionnaire was issued in November 2021 for completion by Members and attendees, with findings reported in May 2022. The next self-assessment questionnaire will be issued in December 2022 / January 2023.
- Procurement Compliance was reported regularly to the Committee.

- Declarations of Interests, Gifts, Sponsorship, Hospitality & Honoraria were presented in the May and October 2022 meetings.
- The Trust Risk Register was presented at the January, May and October 2022 meetings for review by the Committee, noting that more detailed reviews took place in the relevant Committee and Divisional meetings. A Risk Management Policy was drafted and endorsed by the Audit Committee in July 2022 for Trust Board approval.
- The Audit Action plan, which tracks the implementation of the recommendations of audit, was reviewed by the Committee at each meeting. At the July 2022 meeting, the Committee approved a procedure for the management of internal and external audit recommendations, management responses and actions, which is now in place.
- The Committee also received and reviewed the legislative and regulatory compliance register at their July 2022 meeting.

8. Reporting the Committee's Work

The Chair of the Audit Committee reports to the Board on the key issues discussed at each meeting by way of a written Highlight Report. These reports are supported by the more detailed Committee minutes. Committee papers and committee minutes are routinely published on the Trust's website.

9. Conclusions and Way Forward

The work of the Audit Committee in 2022 has been varied and wide-ranging. The Committee's programme of work will continue to be reviewed to ensure that its contribution to governance, risk management, financial management, counter fraud and internal control is maximised.

This report demonstrates that the Audit Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of control in place and that where necessary has recommended improvements to controls.

Appendix 1

Levels of Assurance Assigned by Internal Audit

Substantial Assurance	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk exposure.**
Reasonable Assurance	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited Assurance	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

List of Internal Audits Undertaken and Assurance Ratings

Velindre University NHS Trust

Internal Audit Assignment	Assurance Rating 2022
Use of Digital Technology – Fit for the Future ***Advisory***	N/A
Board Committee Effectiveness	Reasonable
Trust Assurance Framework	Reasonable
New Velindre Cancer Centre Development: MIM Governance	Substantial
New Velindre Cancer Centre Development: Contract Management	Reasonable
Financial Systems	Reasonable
Scrutiny of Expenditure over Chief Executive's Limit	Reasonable
DBS Checks	Reasonable
Charitable Funds	Reasonable
Wellbeing of Future Generations Act ***Advisory***	N/A
Follow Up: Previous Recommendations	Reasonable
New Velindre Cancer Centre Development: Financial Reporting	Substantial
New Velindre Cancer Centre Development: MIM Procurement	Substantial
Staff Wellbeing ***Advisory***	N/A
Finance & Service Sustainability: Budgetary Control & Savings Plans	Reasonable

Research and Development	Substantial
New Velindre Cancer Centre Development: Enabling Works	Reasonable
SUMMARY (excluding advisory reports)	14
Substantial	4
Reasonable	10
Limited	0
Total	14

Audit Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

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

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

2. PURPOSE

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

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

  - the organisation's ability to achieve its objectives,

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

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

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

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

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

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

- The Schedule of Losses and Compensation;

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

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

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

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

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

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

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

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

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

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

3.4 This will be evidenced through the Committee's use of effective governance and assurance

arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

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

- The reliability and integrity of these assurances.

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

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

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

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

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

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

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

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

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

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

Authority

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

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

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

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

Access

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

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

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

Sub Committees

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

4. MEMBERSHIP

Members

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

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external'

members from outside the organisation to provide specialist skills, knowledge and expertise.

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

Attendees

4.2 In attendance:

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

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

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

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

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

10 CHAIR'S ACTION ON URGENT MATTERS

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

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

AUDIT COMMITTEE

REVIEW OF AUDIT COMMITTEE TERMS OF REFERENCE

DATE OF MEETING	12/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer / Committee Secretariat
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**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In accordance with the Audit Committee Cycle of Business, the latest version of the Audit Committee Terms of Reference have been brought to the Audit Committee for review. There have been no recommended changes, but the Committee is invited should they wish to suggest any minor changes they may feel appropriate which can then be actioned accordingly.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Audit Committee Terms of Reference has had no changes since the previous version but today is opened to the Audit Committee members for any comments or recommended changes.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 the Audit Committee is asked to:

- REVIEW the Audit Committee Terms of Reference and feedback any comments or recommended changes during the meeting.
- APPROVE the Audit Committee Terms of Reference, including any agreed suggested changes, subject to these being applied.

Audit Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

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

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

2. PURPOSE

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

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

    - the organisation's ability to achieve its objectives,

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

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

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

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

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

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

- The Schedule of Losses and Compensation;

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

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

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

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

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

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

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

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

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

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

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

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

- The reliability and integrity of these assurances.

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

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

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

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

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

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

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

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

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

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

Authority

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

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

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

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

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

Access

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

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

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

Sub Committees

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

4. MEMBERSHIP

Members

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

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

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

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

assurance arrangements.

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

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

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

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

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

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

10 CHAIR'S ACTION ON URGENT MATTERS

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

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