Public Audit Committee

Tue 19 December 2023, 10:00 - 12:30

Microsoft Teams

Agenda

10:00 - 10:00
0 min

1.0.0 STANDARD BUSINESS

Led by Gareth Jones, Acting Chair of the Audit Committee

1.1.0 Apologies

Led by Gareth Jones, Acting Chair of the Audit Committee

1.2.0 In Attendance

Led by Gareth Jones, Acting Chair of the Audit Committee

1.3.0 Declarations of Interest

Led by Gareth Jones, Acting Chair of the Audit Committee

1.4.0 Draft Minutes from the Public Part A Audit Committee meeting held on 19 October 2023

Led by Gareth Jones, Acting Chair of the Audit Committee

- 1.4.0 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 19 OCTOBER 2023 -LF(GJ).pdf (9 pages)

1.5.0 Action Log Public Part A Audit Committee

Led by Gareth Jones, Acting Chair of the Audit Committee

- 1.5.0 Public Audit Committee Action Log updates for December 2023 Committee.pdf (7 pages)

10:00 - 10:00
0 min

2.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

2.1.0 Trust Risk Register

Led by Carl James, Director of Strategic Transformation, Planning & Digital

- 2.1.0a TRUST RISK REGISTER -AUDIT COMMITTEE - 19.12.2023 -v final.pdf (12 pages)
- 2.1.0b Audit Risk Report - 15.12.2023.pdf (2 pages)

2.2.0 Trust Assurance Framework

Led by Carl James, Director of Strategic Transformation, Planning & Digital

- 2.2.0a TAF Paper -AUDIT COMMITTEE - 19.12.2023 - vfinal.pdf (9 pages)
- 2.2.0b TAF DASHBOARD 2.0 - TB Nov final.pdf (24 pages)

2.3.0 Review of Audit Action Tracker – Review of Overdue and Completed outstanding Recommendations / Actions from Internal & External Audit

Led by Chris Moreton, Deputy Director of Finance

- 2.3.0a Audit Action Tracker Cover Paper 19 December 2023 Audit Committee updated after EMB.pdf (13 pages)
- 2.3.0b Appendix 1 - Red Overdue Recommendations Actions Audit Committee 19 December 2023.pdf (2 pages)
- 2.3.0c Appendix 2 Audit Action Tracker - Updated November 2023 - 19 December 2023 Audit Committee - Overdue Red

and Complete Green.pdf (10 pages)

2.4.0 Clinical Audit Report (Oral Update)

Led by Chris Moreton, Deputy Director of Finance

10:00 - 10:00
0 min

3.0.0 EXTERNAL AUDIT

Led by Darren Griffiths (Audit Wales)

3.1.0 Audit Position Update

Led by Darren Griffiths (Audit Wales)

- 3.1.0 VUNHST Audit Cmt 202312 Audit Update.pdf (10 pages)

10:00 - 10:00
0 min

4.0.0 INTERNAL AUDIT

Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)

4.1.0 2023/24 Internal Audit Progress Update

Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)

- 4.1.0a VUNHST AC cover paper 19 December 2023.pdf (6 pages)
- 4.1.0b Velindre University NHS Trust December 2023 AC Progress Report.pdf (6 pages)

4.2.0 Business Continuity Audit Report

Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)

- 4.2.0a VT 2324 Dec 2023 Audit Committee Business Continuity IA Report Cover Paper.pdf (5 pages)
- 4.2.0b VT2324-07 - Business Continuity Final Report.pdf (16 pages)

4.3.0 Recruitment & Retention Audit Report

Led by Stephen Chaney, Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)

- 4.3.0a VT 2324 Dec 2023 Audit Committee Recruitment and Retention IA Report Cover Paper.pdf (5 pages)
- 4.3.0b VT2324-04 Recruitment and Retention Final Internal Audit Report.pdf (14 pages)

4.4.0 nVCC Approvals Audit Report

Led by Huw Richards, Head of our Capital & Estates Team (Audit and Assurance Services)

- 4.4.0a VT nVCC Commercial Approval Points Cover Paper.pdf (5 pages)
- 4.4.0b VEL SSU 2223 01 nVCC Commercial Approval Points Final Report 041223.pdf (16 pages)

4.5.0 nVCC Planning Audit Report

Led by Huw Richards, Head of our Capital & Estates Team (Audit and Assurance Services)

- 4.5.0a VT nVCC Planning Permissions Cover Paper.pdf (5 pages)
- 4.5.0b VEL SSU 2223 04 Planning Final Report 041223.pdf (13 pages)

10:00 - 10:00
0 min

5.0.0 COUNTER FRAUD

5.1.0 Counter Fraud Progress Report Quarter 3 23/24

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 5.1.0a Board Committee Report Cover Sheet PUBLIC.pdf (7 pages)

5.1.0b VELINDRE Q3 COUNTER FRAUD PROGRESS REPORT - PUBLIC ddrraafftt.pdf (6 pages)

10:00 - 10:00
0 min

6.0.0 FINANCE

6.1.0 Private Patient Service Review - Actions Update Report (Oral Update)

Led by Chris Moreton, Deputy Director of Finance

6.2.0 Private Patient Service Debt Position (Oral Update)

Led by Chris Moreton, Deputy Director of Finance

6.3.0 Losses and Special Payments Report

Led by Tracy Hughes, Head of Financial Operations

6.3.0 AC Losses and write offs paper Dec 2023.pdf (3 pages)

6.4.0 Receipt of Finance Technical Updates

Led by Tracy Hughes, Head of Financial Operations

There are no Technical Updates

10:00 - 10:00
0 min

7.0.0 CONSENT AGENDA

7.1.0 For Approval

7.1.1 Capital Management Procedure

Led by Chris Moreton, Deputy Director of Finance

7.1.1a FP 01 Capital Management Procedure Cover Paper - AC 19.12.2023.pdf (6 pages)
7.1.1b Appendix 1 - FP 01 Velindre Capital Management Procedure review AC 19.12.2023.pdf (42 pages)
7.1.1c Appendix 2 - FP 01 Velindre Capital Management Procedure review (tracked Changes) AC 19.12.2023.pdf (42 pages)

7.2.0 For Noting

Led by Gareth Jones, Acting Chair of the Audit Committee

7.2.1 Procurement Compliance Report

Led by Chris Moreton, Deputy Director of Finance

7.2.1 Procurement Report to Nov 23 - 19 Dec 23 Audit Committee Final.pdf (26 pages)

10:00 - 10:00
0 min

8.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

10:00 - 10:00
0 min

9.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

10:00 - 10:00
0 min

10.0.0 ANY OTHER BUSINESS

By prior approval of the Acting Chair of the Audit Committee

10:00 - 10:00
0 min

11.0.0 DATE AND TIME OF THE NEXT MEETING

Tuesday 12 March 2023 at 10:00AM

10:00 - 10:00
0 min

12.0.0 CLOSE

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

MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
THURSDAY 19 OCTOBER 2023 AT 10:00AM

PRESENT:	
Gareth Jones	Acting Chair and Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Lauren Fear	Director of Corporate Governance & Chief of Staff
Simon Cookson	Director of Audit & Assurance (NWSSP - Audit and Assurance Services)
Melanie Goodman	Audit Manager (NWSSP - Audit and Assurance Services)
Martyn Lewis	ICT Audit Manager (NWSSP - Audit and Assurance Services)
Katrina Febry	Audit Wales
David Burridge	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
Jessica Corrigan	Business Support Officer

1.0.0	**Standard Business** Led by Gareth Jones, Acting Chair, and Independent Member	**Action**
	Introduction Led by Gareth Jones, Acting Chair and Independent Member	
1.1.0	**Apologies** Led by Gareth Jones Apologies were received from: • Martin Veale, Chair of Audit Committee and Independent Member • Steve Ham, Chief Executive Officer • Cath O'Brien, Chief Operating Officer • Emma Rees, Deputy Head of Internal Audit • Steve Wyndham, Audit Wales	
1.2.0	**In Attendance** Led by Gareth Jones Gareth Jones welcomed attendees from Audit Wales and Internal Audit Services to the Audit Committee Meeting and informed that David Osbourne would be joining for the Private Patient item.	
1.3.0	**Declarations of Interest** Led by Gareth Jones No declarations of interest were declared.	
1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 26 July 2023** Led by Gareth Jones ****ACTION: Change wording - Item 2.2.0 Audit Position Update to read "**_ACTION: Katrina Febry informed the Committee she needed to re-submit the Audit Update Papers because she had omitted one piece of work which was the Workforce Planning Review"._** ****ACTION: Private Patient – _Liaison_ to be put in italics or speech brackets as it's a title.** ****ACTION: Item 5.1.0 Actions Update Report - Page 6 – To add wording following the section – _"David Osborne highlighted that in terms of the greater than six-month debt position, which is £600,000, a minimum of £200,000-£300,000 will be in the unapplied."_ - _"These are not outstanding debts as the Trust has been paid but the cash is sitting in the unapplied receipt account and is not allocated against the private patient debts."_** ****ACTION: Item 3.2.0A Velindre University NHS Trust Final Accounts 2022-23 – _"Welsh Risk Pool provisions have been corrected to £4.587 million from £14.587million."_ wording to be changed to _"Welsh Risk Pool provisions have been reduced by £4.587 million to £4 billion"._**	**AH** **AH** **AH** **AH**

	The AUDIT Committee **AGREED** the minutes of the meeting held on the 26 July 2023 subject to the action amendments above.	
1.5.0	**Action Log** Led by Gareth Jones **01/2023 8.1.0 Private Patient Service Debt Position –** September 2023 meeting with BI happened. There is a full programme of work and Private Patients was not prioritised. The Committee agreed this action could be closed and picked up as a general action in the Private Patients Paper. The Executive Management Board reviewed the complete BI work programme for the next couple of years and its prioritisation, alongside the team's capacity. Private Patient Key Performance Indicators should be picked up in the work on the Performance Management Framework (PMF) and quality indicators. **07/23 1.5.0 Action Log – Trust Assurance Framework -** Wording on action log to be changed to ***"Lauren Fear advised no timescale exists for the use of BI in the context of the Trust Assurance Framework".*** Subject to the change the Committee agreed the action could be closed. **07/2023 2.2.0 Audit Position Update -** The Committee agreed could be closed but wording on action log to be amended as per amendment in the 26 July 2023 minutes above. **07/2023 10.1.0 - Private Patient Service Debt Position -** Ensuring Insurance companies include a unique reference/identifier for each private patient in their invoicing. The Audit Committee agreed the action could be closed and picked up in the Private Patient Report. ****ACTION: The Private Patient paper states there wasn't any capacity within the Corporate Finance Debtors Team to support the Private Patient Debtors Team. It was confirmed this is inaccurate and will be amended as they are progressing work to review the unallocated cash.** **11.3.3 Trust Priorities –** The Audit Committee agreed this action could be closed as the recommendation / agreed management actions are part of the normal IM&T process. ****ACTION: Action log to be amended to reflect discussions and circulated to the Committee.** The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions.	**DO** **AH**
2.0.0	**PRIVATE PATIENT SERVICE REVIEW** Led by Matthew Bunce, Executive Director of Finance	
2.1.0	**Actions Update Report** Led by Matthew Bunce, Executive Director of Finance This report was postponed until item 7.0.0. Going forward the two items will be combined. Gareth Jones invited David Osborne to take the Committee through this item and item 7.1.0. David Osborne took the Committee through the report and highlighted the following: • Business Intelligence (BI) Support issues – There is ongoing system development with a work around solution in place. • Healthcare at Home Contract – A draft agreement is in place and currently ratifying that internally. There is a meeting arranged for 24 October 2023 to conclude. David Osborne informed the Committee that the action plan includes extensions due to the entirety of the contract with *Liaison.* Had a formal meeting with *Liaison* within the last week and are currently reviewing the outputs requested. There will be a defined product of all activities undertaken. The Private Patient Team is now up to full compliment. The Committee understood that the report also goes to Quality, Safety & Performance Committee so the Audit Committee is only looking at the financial commercial aspects of the improvements. The Committee acknowledged the aged debt position which achieved a reduction from £1million to £250,000.	

	The Committee highlighted in relation to the BI Support issues, the fact it is being escalated needs to be reflected in any narrative discussion about the Risk Register and our delivery against our corporate objectives. The AUDIT Committee **NOTED** the report.	
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 took the Committee through the report. Vicky Morris raised concern that the risks that have not progressed in terms of mitigation of those risks and include no narrative on what has changed since the last Audit Committee for assurance. Gareth Jones stated that it would have been helpful for Audit Committee to see the updated version discussed at the recent Executive Management Board to see the progress. The Audit Committee recognised the progress that had been made with risk mitigation but stressed the need to see the progress in between. The narrative of the paper needs to be made clear for high level risks about the mitigation actions that have been taken. Lauren Fear assured the Committee that discussion has taken place with Steve Ham about putting in place an additional process over the next couple of weeks and will be arranging to sit with Executive Management Board colleagues to go through their risks. Following this assurance, the Committee noted this is being escalated and managed appropriately. Vicky Morris questioned whether the level of assurance around management of the risk register should be at level two and whether it more at a level one, particularly the summary statements of actions for symptomatic issues/notified outcomes, as currently the outcomes are not shown. Gareth Jones suggested that on the basis of the assurance that came out of the Board meetings in September 2023 and the assurance that Lauren Fear has provided in relation to Executive Management Board, it be left as a level two but with a strong message that unless things improve by the next Audit Committee the Committee will be looking at reducing these to a one. The Committee agreed with this approach and the need for the concerns raised to be escalated in the Highlight Report. Vicky Morris highlighted a key discussion in QSP Committee was about the various risks that sit at a high level regarding legacy systems moving from one system to another and stressed the importance of those type of discussions being summarised at Audit Committee as that would then go onto the TAF discussion about delivery of strategic objectives. There are a range of risks that are of a concern that relate to legacy systems /IT systems and there is a need to recognise this as an Audit Committee. Lauren Fear agreed that the paper should tell the whole story. The AUDIT Committee **NOTED** the risks level 20, 16 and 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper.	
3.2.0	**Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear took the Committee through the report. Lauren Fear confirmed that work on completing the template is underway for the November cycle but would consider whether we wanted to meet again as a Board to update the refreshed risk or whether the Board was content to do that via a Chair's Action and see the template come through in November 2023 completed. The Committee raised concerns about the join up between a Trust Board discussion about strategic objectives for this current year from the Integrated Medium-Term Plan (IMTP) and the agreement of risks against that. The lack of discussion in the last few months highlighted concerns about how the	

	Trust Assurance Framework (TAF) would be delivered and managed proactively without a TAF to be confident about our delivery of our strategic objectives. The Committee felt there is a need to review the strategic risks and objectives to see whether the risks reflect their impact, which may affect the Trust's ability to achieve those objectives. The Audit Committee agreed this needs to be taken to the November 2023 Trust Board and following that the Audit Committee can review the TAF and can be informed by the Board discussion. Vicky Morris sought assurance that Executive colleagues would be in a position to progress the work that needs to be undertaken for delivery of strategic objectives and the management of risks. Matthew Bunce assured that fundamentally the risks of this organisation have not changed over five years and agreed with the need for the Audit Committee to see the latest version of the risks and how they link to the Ten-Year Plan, and the strategic aims which show the individual IMTP objectives and strategies. Gareth Jones commented that from an objective perspective Audit Committee has not seen anything that has happened and agreed strategic risks have not changed significantly but need to see all in one place and the Committee needs to review TAF regularly. ****ACTION: Recommendation for the November 2023 Trust Board to have a formal discussion on the updated strategic risks which will reflect the discussion had in the September Trust Board. Need to link the strategic risks back to the strategic objectives in the Ten-Year Plan and then need to have an appropriate Trust Assurance Framework to review in the November 2023 Trust Board meeting.**	**LF**
3.3.0	**Governance Assurance & Risk Governance, Assurance & Risk Programme of Work** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear took the Committee through the report on the programme of work introduced across the organisation for assurance and strategic development, recognising that the Board and Executive Teams were not fulfilling obligations to their full potential so the governance was re-structured to support in doing this. The Trust has gone from having Excel Spreadsheets in a myriad of various places that did not join up to an agreed risk strategy/risk appetite which reflects into reporting one risk system. The paper outlines the engagement across the work and the elements of this, involving significant engagement of staff. Vicky Morris struggled to understand some of the references, in particular the points that Executive Management Board were asked to consider and felt it was hard to discuss these from a detailed point of view and would be helpful if these could be outlined as there's not enough information provided. Also in terms of G1.1.2 it was hard to understand what had been involved without going back and forth to the appendices. Lauren Fear explained that one of projects was around how to create key performance indicators for governance effectiveness both at Board, Committees' and Executive Management level. One other project around the updated governance manual pulls all governance process aspects together for Board and Committees. Additionally, reporting on milestones is contained within that manual for any of the processes and the management of each of the processes is also going to be reported within that project. It has been suggested that we get reporting of governance processes clear and transparent over the next 6 months and then we can consider early next financial year what additional key performance indicators could then start to be reported on. Gareth Jones raised the point that several actions particularly around structure are due to be completed by October 2023 and questioned if that target date was achievable, especially in relation to G2.2 Meetings Standard minutes format, which needs a standard meeting content. Lauren Fear confirmed there will be meetings internally to go through all of these and assured she was confident on October 2023 target dates but possibly not for G2.2. Training on minutes has been completed but it requires Executive Leads, with the Independent Member and Chair to have time to check on what the principles now say, so this will take a few weeks.	

	****ACTION: Change March 2023 to March 2024 in the report where applicable.** The Committee agreed it is about how you translate the education and training piece; in relation to minutes, we have a transcript and there is need for the Executive and Business Support Officer/Meeting Secretariat to collectively move to a position where we start from the transcript but try to tease out the key points. The Committee agreed minute writing is a skill and does require an understanding and knowledge of the points being discussed in the meeting to capture salient points in the minutes and this is a process where people will improve in time. The AUDIT Committee were pleased to **NOTE** the progress that has been made to date and are looking forward toward further developments and improvements.	**LF**
3.4.0	**Review of Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce took the Audit Committee through the report. Matthew Bunce provided an updated on the overdue / red actions that he is responsible for as Executive Lead on Appendix 1 and highlighted below: • Financial Systems -2021/2022 Audit Report – The Financial Control Procedure is a standard procedure that exists around Capital which needed updating to reflect new governance structures and this was updated but needs to go through the new Strategic Capital Board process. Assured the Committee this would be completed by 31 December 2023. The Committee stressed the need to check the process of where this goes once complete and that Audit Committee check/sign it off. Subject to that the Audit Committee were content with the requested extension date. • Charitable Funds 2021/22 – See Agenda Item 8.1.1. ****ACTION: Matthew Bunce assured the Committee that at every Executive Management Board he stresses the need to set realistic actions and realistic and fair target dates. Matthew Bunce agreed to reinforce the message with each of the Executives on each of the red actions and raise this again in Executive Management Board.** **Matthew Bunce highlighted that in the Audit Action Tracker Procedure there is a section that states that when actions are closed there should be a summary of the key things that have been done. Matthew Bunce has had sessions with the two Divisions recently reminding them of the procedure and process and will highlight that also again to Executive colleagues.** ****ACTION: Gareth Jones and Vicky Morris requested assurance be provided for the overdue actions. To have assurance as a Committee there is a need to see the steps that are in place in order to deliver that action, not just on the table/ action tracker but also as an appendix to clearly see there is a pathway to delivery by the requested extension date.** **External Audit action in relation to BI has no requested extension date, so an update needs to be provided on progress and when this is expected to be complete. Matthew Bunce will ask each Executive Director to give specific actions on the red/overdue recommendations in Appendix 1, which will then be shared with Gareth Jones and Vicky Morris.** ****ACTION: For future Audit Committees a separate annex is to be included to pick up overdue / actions to be assured things are being addressed.** The Committee agreed in future Executives will be given a final warning that unless sufficient assurance is provided attendance will be required at Audit Committee to explain why actions have not been progressed. The Committee were pleased with how the report had progressed. The AUDIT Committee **AGREED** the requested extension dates and **AGREED** to formally closing the 26 green/complete actions and these being changed to blue status.	**MB** **MB** **MB**

4.0.0	**EXTERNAL AUDIT** Led by Katrina Febry (Audit Wales)	
4.1.0	**Audit Position Update** Led by Katrina Febry (Audit Wales) Katrina Febry took the Committee through the report which covers the progress that has been made against audit plans. David Burridge informed the Committee of the plan to do work for the Charity accounts in December 2023 as the Charity Commission deadline is the end of January 2024. David Burridge informed the Committee the deadline should be achievable. Katrina Febry highlighted the following key points on the Performance Audit Update: • 2022 - Workforce Planning Review is complete. • 2023 – Structured Assessment Review is nearly complete and should be sent to the Trust for clearance by the middle of November 2023. • Will keep the Trust informed of the timing of the Operational Governance, Workforce Planning and the Quality Governance Follow Up work, which will take place in 2024. Katrina Febry explained that Audit Wales are considering a change in the 2023 work programme; the attached paper suggested a deep dive into digital arrangements which was a piece of work planning for whole of Wales, but in Health Boards they are now considering whether it should be replaced with a review on financial stability arrangements. If it is decided to progress that piece of work early next year with a view to report the end of the financial year, that would move the digital piece of work to the 2024/5 programme. Gareth Jones questioned if this would even be considered for Velindre given the predicted break-even position in the IMTP and expressed it is not ideal to postpone digital for further 12 months. Matthew Bunce highlighted that Internal Audit were looking at financial sustainability and stressed the need to look at whole of Wales sustainability and not just look at individual organisations in the system. This needs to touch on work with Welsh Government and Value Sustainability Board, the drive in fundamental change to roll out efficiencies. Katrina Febry agreed to look at the programme in its entirety and see whether it may be possible to progress the digital work early in the 2024/5 programme. In response to a question on capacity to complete all work as stated, Katrina Febry assured that it was agreed with Executive Management Board that the timing of each piece of work will be looked at, taking on board what capacity the Trust and individuals have and that Audit Wales will also be working with Internal Audit where there are any areas of work that complement each other. ****ACTION: 2022 audit plan operational Governance Executive Lead is to be confirmed with Cath O'Brien whether this would be her or the Divisional Directors.**	**LF**
4.2.0	**Audit Wales - Financial Accounts Memorandum Report** Led by Dave Burridge (Audit Wales) David Burridge took the Audit Committee through the report. This report contains the issues raised from the Audit Accounts report that was presented at the July 2023 Audit Committee and comprises of three recommendations: one high and two medium priority. Gareth Jones queried Matter Arising one, 'The majority of declaration of the interest returns were completed in January or February rather than at year end' where acceptance by management was 'Partial'. Gareth Jones questioned what happens in the case where the recommendation has been partially accepted by management. David Burridge explained that this particular one was partial as have not quite done what was requested and partial acceptance has been agreed.	

	Gareth Jones raised that in relation to Matter Arising three, Welsh Government is not prepared to accept the different way of categorising these amounts and questioned what happens if the Trust cannot get Welsh Government to change its mind. David Burridge clarified that was not a question of getting Welsh Government to change their mind, the issue was this year the Trust tried to make it easier and changed the way they disclosed these items in the accounts and the Welsh Government objected to that so they want Velindre to do the accounts as per the previous year. Audit Wales recommendation was to make an appropriate audit trail of what has been done, not to make it simpler. The AUDIT Committee **NOTED** the report.	
4.3.0	**Audit Wales – Workforce Planning Report** Led by Katrina Febry (Audit Wales) Katrina Febry took the Committee through the report which consisted of six recommendations: two high priority and four medium priority. Katrina Febry drew the Committee's attention to recommendation six, monitoring effective delivery of the people strategy. This report covers how the impact of actions taken is articulated to give members the assurance. This report will be shared with Quality, Safety and Performance Committee to consider the recommendations, actions and the outcomes through QSP. The AUDIT Committee **NOTED** the report.	
5.0.0	**INTERNAL AUDIT** Led by Simon Cookson, Director of Audit & Assurance, NWSSP (Audit and Assurance Services	
5.1.0	**2023/24 Internal Audit Progress Update** Led by Simon Cookson, Director of Audit & Assurance, NWSSP (Audit and Assurance Services Simon Cookson explained to the Committee that Internal Audit had hoped to have four Audit Reports to be presented at this Audit Committee meeting but there is only one at agenda item 8.2.3. The other three reports are out in draft but delayed due to Internal Audit sickness and awaiting Trust responses. Simon Cookson assured the Committee there is nothing significant in the draft reports for the Committee to be concerned about. Simon Cookson took the Committee through the report and highlighted that of the 18 audits, they are expecting to drop by one; there was some work scheduled around the enabling works on the cancer centre which were going to be undertaken in two pieces, which has now been changed to one. Vicky Morris queried the management responses being 12 working days overdue and questioned how that has been managed. Simon Cookson responded to say meetings have been arranged on those reviews and Internal Audit is hoping to close off those reports in the next couple of weeks. Gareth Jones commented that the implication from the update suggest that the delay is due to the lack of management responses from the Trust, and do not reference any potential impact of delays from Internal Audit, and suggested where appropriate, could a more balanced account of why delays are there. Simon Cookson agreed to reflect this going forward. Matthew Bunce assured the Committee that all Executives now have access to the Key Performance Indicator dashboard and 24/25 plan based around the Trust Assurance Framework. The AUDIT Committee **NOTED** the report. Agenda item 8.3.3 was taken at this point of the meeting and then Martyn Lewis left the meeting.	
6.0.0	**COUNTER FRAUD**	
6.1.0	**Counter Fraud Progress Report Quarter 2 23/24** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington took the Committee through the report and highlighted: • Progressed quite well with the National Fraud Initiative. • Now 11 members of staff in Velindre on eLearning. All Wales figures now at 4,590 (4,100 of those work for organisations where they mandate that training). • There were Three Fraud risks which were not too much of an issue in the Trust.	

	The Committee questioned who considers this paper before it goes to Audit Committee and has this been to Executive Team before consideration here. There was a question whether future reports should be endorsed at Executive Management Board before coming to Audit Committee. The Committee were informed there is now a refresh on corporate induction which is a half day face to face. Every time an induction takes place Workforce are going to be provide a list of new employees to Gareth Lavington and Ian Bevan to provide sessions for new starters outside of that on Counter Fraud and Information Governance. Not currently mandated but liaising with Workforce on this. The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	
	Simon Cookson let the meeting at 12:55PM.	
7.0.0	**FINANCE**	
7.1.0	**Private Patient Service Debt Position** Led by David Osborne Head of Finance Business Partnering David Osborne took the Committee through the report. David Osborne recognised the need to transact these to reduce the aged debt greater than six months, so the reports and the Key Performance Indicators are showing this and therefore can conclude the activity. ****ACTION: Gareth Jones questioned if the Key Performance Indicators targets to be agreed were actuals now of where the Trust is and are they Key Performance Indicators as such, as there is an interest specifically on how quickly we issue the invoices in respect of the treatments that's covered by them and there is no target for those two measurables.** **David Osborne agreed that it is a profile of debt as opposed to a Key Performance Indicator and agreed to take that back to the improvement group to do a true performance Key Performance Indicator review rather than a profile statement.** The AUDIT Committee NOTED the report. Not approving or noting the Key Performance Indicators as these are being taken away and will be brought back to Committee at a later date.	**DO**
7.2.0	**Losses and Special Payments Report** Led by Tracy Hughes, Head of Financial Operations Gareth Jones welcomed Tracy Hughes to the meeting. Tracy Hughes took the Committee through the report. The AUDIT Committee **NOTED** the report.	
7.3.0	**Receipt of Finance Technical Updates** Led by Tracy Hughes, Head of Financial Operations There were no Technical Updates to be presented at this Committee meeting.	
8.0.0	**CONSENT AGENDA** Led by Gareth Jones, Acting Chair of the Audit Committee	
8.1.0	**ENDORSE FOR APPROVAL** Led by Gareth Jones, Acting Chair of the Audit Committee	
8.1.1	**Revision to Standing Orders / Standing Financial Instructions** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Committee agreed to this item could be taken out of consent as per discussion in Agenda item 3.4.0. Discussion and action added below from above agenda item. ****ACTION: Charitable Funds 2021/22 – The Delegated Financial Limits Paper has been to Charitable Funds Committee twice. The Charitable Funds Committee have now agreed to the delegated limits of Chief Executive Officer and the Executive Director of Finance limit rising from £5,000-£25,000. Matthew Bunce explained that in the Scheme of Delegation of Standing Orders and Standing Financial Instructions there is a table which still has £5,000 listed so this will need to go to Board to sign off and would then go to Audit Committee for endorsement of the amendment of the standing orders and Standing Financial Instructions.**	

	The Audit Committee agreed this would be an addendum to the report in agenda item 8.1.1 Variation to Standing Orders Velindre University NHS Trust; to be taken at this Committee as a verbal amendment to be added in as a written form for the November Trust Board. ****ACTION: Schedule 1 – Model Scheme of Reservation and Delegation document, Page six - Name to be completed in section *"Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify [Trust to insert details]"*.** ****ACTION: Vicky Morris raised the question of whether the Integrated Quality and Safety Group should be included in the diagrams as there is inconsistency between PowerPoints and the narrative.** **Lauren Fear clarified that this is not part of Committee structure. Lauren Fear will pick this up with Vicky Morris outside of the meeting to ensure all feedback is incorporated.** The AUDIT Committee **ENDORSED FOR APPROVAL** subject to the actions above being completed.	**LF** **LF** **LF**
8.3.0	**FOR NOTING** Led by Gareth Jones, Acting Chair of the Audit Committee	
8.3.1	**Procurement Compliance Report** Led by Matthew Bunce, Executive Director of Finance The AUDIT Committee **NOTED** the report.	
8.3.2	**Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The AUDIT Committee **NOTED** the Declarations of Interests, Gifts, Sponsorship, Hospitality and Honoria received for the period 31/05/2023 – 06/10/2023.	
8.3.3	**Digital Strategy & Transformation Programme Audit Report** Led by Martyn Lewis, ICT Audit Manager, NWSSP (Audit and Assurance Services) Martyn Lewis took the Committee through the reasonable assurance report with the objective to provide assurance of the implementation of the digital strategy and transformation programme. Gareth Jones questioned if the 31 October 2023 target dates were achievable. Lauren Fear confirmed that the publication of all the destination 2033 materials and the enabling strategies were on schedule for end of next week. Gareth Jones questioned why in Matter Arising two it states there is no Director of Digital on the Trust Board as it's within Carl James' title. Martyn Lewis confirmed this is a note for consideration to have a specific Digital Director on Boards in other organisations. The AUDIT Committee **NOTED** the report.	
9.0.0	**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 30 November 2023, with the risk position escalated.	
10.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	None.	
11.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
12.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 19 December 2023 at 10:00am.	
13.0.0	**CLOSE**	
	The meeting CLOSED at 1:25pm.	

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 19 October 2023 Meeting			
10/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 26 July 2023.** **Change wording - Item 2.2.0 Audit Position Update to read "**ACTION: Katrina Febry informed the Committee she needed to re-submit the Audit Update Papers because she had omitted one piece of work which was the Workforce Planning Review".**	**ACTION: Alison Hedges**	**CLOSED** **October 2023:** The wording has been amended in the July 2023 Audit Committee minutes.	**AH**
10/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 26 July 2023.** **Private Patient – *Liaison* to be put in italics or speech brackets as it's a title.**	**ACTION: Alison Hedges**	**CLOSED** **October 2023:** The word *Liaison* throughout the July 2023 minutes has been changed to italics. This will be applied to any future minutes.	**AH**
10/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 26 July 2023.** **Item 5.1.0 Actions Update Report - Page 6 – To add wording following the section – *"David Osborne highlighted that in terms of the greater than six-month debt position, which is £600,000, a minimum of £200,000-£300,000 will be in the unapplied."* - *"These are not outstanding debts as the Trust has been paid but the cash is sitting in the unapplied receipt account and is not allocated against the private patient debts."***	**ACTION: Alison Hedges**	**CLOSED** **October 2023:** The additional wording has been added to the July 2023 minutes.	**AH**

10/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 26 July 2023.** **Item 3.2.0A Velindre University NHS Trust Final Accounts 2022-23 – *"Welsh Risk Pool provisions have been corrected to £4.587 million from £14.587million."* wording to be changed to *"Welsh Risk Pool provisions have been reduced by £4.587 million to £4 billion".***	**ACTION: Alison Hedges**	**CLOSED** **October 2023:** The wording has been amended in the July 2023 minutes.	**AH**
10/2023 1.5.0	**Action Log.** **07/2023 10.1.0 - Private Patient Service Debt Position - The Private Patient paper states there wasn't any capacity within the Corporate Finance Debtors Team to support the Private Patient Debtors Team. It was confirmed this is inaccurate and will be amended as they are progressing work to review the unallocated cash.**	**ACTION: David Osborne**	**OPEN**	**DO**
10/2023 1.5.0	**Action Log.** **Action log to be amended to reflect discussions and circulated to the Committee.**	**ACTION: Alison Hedges**	**CLOSED** **October 2023:** The Action log was amended and circulated to the Audit Committee 27 October 2023.	**AH**
10/2023 3.2.0	**Trust Assurance Framework.** **Recommendation for the November 2023 Trust Board to have a formal discussion on the updated strategic risks which will reflect the discussion had in the September Trust Board. Need to link the strategic risks back to the strategic objectives in the Ten-Year Plan and then need to have an appropriate Trust Assurance Framework to review in the November 2023 Trust Board meeting.**	**ACTION: Lauren Fear**	**CLOSED** **November 2023:** On Trust Board agenda for November.	**LF**

10/2023 3.3.0	**Governance Assurance & Risk Governance, Assurance & Risk Programme of Work.** **Change March 2023 to March 2024 in the report where applicable.**	**ACTION: Lauren Fear**	**CLOSED** **November 2023:** Updated in report.	**LF**
10/2023 3.4.0	**Review of Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit.** **Matthew Bunce assured the Committee that at every Executive Management Board he stresses the need to set realistic actions and realistic and fair target dates. Matthew Bunce agreed to reinforce the message with each of the Executives on each of the red actions and raise this again in Executive Management Board.** **Matthew Bunce highlighted that in the Audit Action Tracker Procedure there is a section that states that when actions are closed there should be a summary of the key things that have been done. Matthew Bunce has had sessions with the two Divisions recently reminding them of the procedure and process and will highlight that also again to Executive colleagues.**	**ACTION: Matthew Bunce**	**CLOSED** **December 2023:** Matthew Bunce has reinforced the message on setting realistic target dates at Executive Management Board.	**MB**

10/2023 3.4.0	**Review of Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit.** **Gareth Jones and Vicky Morris requested assurance be provided for the overdue actions. To have assurance as a Committee there is a need to see the steps that are in place in order to deliver that action, not just on the table/ action tracker but also as an appendix to clearly see there is a pathway to delivery by the requested extension date.** **External Audit action in relation to BI has no requested extension date, so an update needs to be provided on progress and when this is expected to be complete. Matthew Bunce will ask each Executive Director to give specific actions on the red/overdue recommendations in Appendix 1, which will then be shared with Gareth Jones and Vicky Morris.**	**ACTION: Matthew Bunce**	**CLOSED** **November 2023:** A summary of specific actions that are in place for the Audit recommendations to be completed by the agreed extension date was circulated to Gareth Jones and Vicky Morris 29/11/2023.	**MB**
10/2023 3.4.0	**Review of Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit.** **For future Audit Committees a separate annex is to be included to pick up overdue / actions to be assured things are being addressed.**	**ACTION: Matthew Bunce**	**CLOSED** **December 2023** Already have an annex that summarises the overdue actions. The Director of Finance has reminded all Executive Directors and Divisional SMT/SLTs of the importance of including in the tracker an explanation as to why an extension to the completion date is required and a summary of the actions completed to support the request for an action to be closed.	**MB**

10/2023 4.1.0	**EXTERNAL AUDIT - Audit Position Update.** **Katrina Febry agreed to look at the programme in its entirety and see whether it may be possible to progress the digital work early in the 2024/5 programme.**	**ACTION: Katrina Febry**	**CLOSED.** **Update November 2023:** I have considered the Velindre Audit Plan for 2023 but have to consider that alongside the Audit Plan for other health organisations. We feel it important for Audit Wales to be able to comment on the arrangements in health organisations to achieve financial efficiencies, given the current financial climate. Therefore, I can confirm that we will be switching our digital arrangements review will be postpone to our 2024 Audit Plan. We will commence work on financial efficiencies early in 2024. (Please note our audit year is different to the financial year).	**KF**
10/2023 4.1.0	**EXTERNAL AUDIT - Audit Position Update.** **2022 audit plan operational Governance Executive Lead is to be confirmed with Cath O'Brien whether this would be her or the Divisional Directors.**	**ACTION: Lauren Fear**	**CLOSED** **November 2023:** LF confirmed to KF it will be Divisional Directors.	**LF**

10/2023 7.1.0	**FINANCE - Private Patient Service Debt Position.** **Gareth Jones questioned if the Key Performance Indicators targets to be agreed were actuals now of where the Trust is and are they Key Performance Indicators as such, as there is an interest specifically on how quickly we issue the invoices in respect of the treatments that's covered by them and there is no target for those two measurables.** **David Osborne agreed that it is a profile of debt as opposed to a Key Performance Indicator and agreed to take that back to the improvement group to do a true performance Key Performance Indicator review rather than a profile statement.**	**ACTION: David Osborne**	**OPEN**	**DO**
10/2023 8.1.1	**Revision to Standing Orders / Standing Financial Instructions.** **Charitable Funds 2021/22 – The Delegated Financial Limits Paper has been to Charitable Funds Committee twice. The Charitable Funds Committee have now agreed to the delegated limits of Chief Executive Officer and the Executive Director of Finance limit rising from £5,000-£25,000. Matthew Bunce explained that in the Scheme of Delegation of Standing Orders and Standing Financial Instructions there is a table which still has £5,000 listed so this will need to go to Board to sign off and would then go to Audit Committee for endorsement of the amendment of the standing orders and Standing Financial Instructions.**	**ACTION: Lauren Fear**	**CLOSED** **November 2023:** The amendment to the CEO and Director of Finance Delegated Financial Limits for Charitable Funds has been made to the Scheme of Delegation within the Standing Orders and Standing Financial Instructions. This revision has been included with other revisions to the Standing Orders and Standing Financial instructions for Approval at the November Trust Board.	**LF**

	The Audit Committee agreed this would be an addendum to the report in agenda item 8.1.1 Variation to Standing Orders Velindre University NHS Trust; to be taken at this Committee as a verbal amendment to be added in as a written form for the November Trust Board.			
10/2023 8.1.1	**Revision to Standing Orders / Standing Financial Instructions.** **Schedule 1 – Model Scheme of Reservation and Delegation document, Page six - Name to be completed in section *"Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify [Trust to insert details]"*.**	**ACTION: Lauren Fear**	**CLOSED** **November 2023:** This has been updated and has been included with other revisions to the Standing Orders and Standing Financial instructions for Approval at the November Trust Board	**LF**
10/2023 8.1.1	**Revision to Standing Orders / Standing Financial Instructions.** **Vicky Morris raised the question of whether the Integrated Quality and Safety Group should be included in the diagrams as there is inconsistency between PowerPoints and the narrative.** **Lauren Fear clarified that this is not part of Committee structure. Lauren Fear will pick this up with Vicky Morris outside of the meeting to ensure all feedback is incorporated.**	**ACTION: Lauren Fear**	**OPEN**	**LF**

AUDIT COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	19.12.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	LAUREN FEAR, DIRECTOR OF GOVERNANCE AND CHIEF OF STAFF
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	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.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to: • **NOTE** the risks of 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board	04.12.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust Board in November considered the October version of the Risk Register. The Trust Board also noted the development activities listed in section 4. Executive Management Board reviewed the November version, and following further scrutiny with VCS Senior Leadership Team, the updates are summarised in this cover paper and reflected in the appendix.	

Please complete this section if you have indicated that the report purpose is for ASSURANCE.

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR			2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.				

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

The report is to inform the Audit Committee of the status of risks reportable to Board, in line with the renewed risk appetite levels. In addition, the report will update on progress against the Risk Framework.

2. BACKGROUND

The risks currently held on Datix for the Trust are to be considered by the Audit Committee.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 7 risks to report to Board and Committee on Datix 14, this includes 4 risks with a current score over 15 and 3 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

Changes during reporting since Trust Board – 30 November 2023:

Risks which have closed/ no longer at Board risk appetite reporting levels:

- **3184 – Reduction in score from 16 to 8**
  There is a risk to VCC as a result of no Lead Digital Pharmacist in post resulting in multiple risks for VCC and the Trust.

  December reporting update: Funding has been secured and appointment offered, therefore likelihood reduced to 2, impact remaining 4, with a score now of 8 until appointee in post.

- **3222 – Risk Closed**
  There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.

  December reporting update: *Appointment made and in post as at 4th December.*

- **3215 – Risk Closed**
  There is a risk that clinical instruction or information may not be received or acted on by primary or secondary care medical colleagues for patient

management due to clinical correspondence not being signed off via the Document Management System (DMS).

December reporting update: Review of letters complete. Escalation process in place. Harm review completed and no harm identified.

Risks which Executive Management Board accept as appropriate that score not changed during this reporting period:

- **3153 – Risk score currently remains at 15, expected reduction in January as a result of actions taken**
  There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm.

  December reporting update: Meeting held - Digital / Physics liaison meeting on 06/12/23 for discussion to ensure all parties fully understand the risk. Actions agreed and will be implemented by end December - this would then reduce the risk for January reporting if implemented as planned. No performance issues had been raised with the Digital Service Desk since the risk was originally raised.

- **3001 – Risk score stable, as a result of action being taken and external environment continuing to be challenging**

  There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.

- **3230 – Risk score remains at 12, expected reduction in January as a result of actions taken**

  There is a risk to patient safety regarding the referral of patients into VCC, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care.

December reporting update: New short-term central management of new patient referrals agreed and will be implemented by end January 2024.

- **2465 – Good progress made and risk score will start to reduce as actions implemented during 2024**

  There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.

  December reporting update: Audit complete and received at Senior Leadership Team in December - Operational services to oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft IMTP 2046-27.

- **3227 – Risk expected to decrease in next reporting period**

  new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.

  December reporting update: This risk is expected to decrease in score in next reporting period due to good progress made to Financial Close requirements.

Risks which Executive Management Board comment on risk scores

- **Risks 2187 and 2515 – Executive Management Board have requested further review at January Executive Management Board**

  2187 - There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.

  2515 - There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.

4. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle

Matters 1 – 7 were reported to the Trust Board on 30th November.

Matters 8 and 9 were recommended from the Trust Risk Group and supported by Executive Management Board.

	Matter raised through recent governance cycle	**Action Taken/ In plan**	**Timeframe**
1	Risk scores and target risk scores	Following Executive Management Board review and Divisional Leadership Team work, a number of scores were challenged and are being reassessed through the December-January cycle	December-January reporting cycle
2	Digital Risks	Separate paper to be brought back on the enterprise digital risk landscape to the next Committee meeting.	January Quality, Safety & Performance Committee
3	Administration systems and processes	This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored	December-January reporting cycle
4	15 level risks are related to workforce issues in Velindre Cancer Services – triangulated to TAF 03	Workforce Risk 03 will include this in next review	December-January reporting cycle
5	Formatting of report to be clear on active risk management in the period	New updates from Datix are included in this cover paper as well as in a separate column in the Risk Register appendix	Addressed in this paper
6	Datix information for risk 2515 required updating	Updated since November Quality, Safety & Performance Committee	Addressed in this paper

7a	Assurance level considerations by Audit Committee	Active risk management has resulted in a number of scores being reduced however not yet evidence of impact of actions on remaining risks – This will be further addressed and challenged in next period and explicit comment from the Executive Management Board (EMB) will be included for the next report – to demonstrate why EMB is comfortable with the current risk score or if not, what action is being taken.	December-January reporting cycle
7b	Assurance level considerations by Audit Committee	In addition, any decrease in scores which result is no longer being currently reported at Trust Board level will be summarised for the next report in a separate table in the cover paper also.	Current risks have been reviewed against the previous report. There are no risks which have reduced to a level below that reportable to Trust Board.
Recommendations from Trust Risk Group			
8	Review of risk domains – particular concern wrt Clinical safety being clearly part of Quality domain on Datix	Review of Policy by Trust Risk Team, including this. Data pull for Quality and Safety domains during December – (to report on in January) –	March (for Trust Board approval) January

		to review categorisation	
9	When risks first loaded onto Datix, inherent risks reported above risk appetite levels – for assurance on effectiveness of controls	Actioned from January reporting cycle	January reporting cycle

Next Steps in Engagement and Embedding

- As of 28th November 2023 an Introduction to Risk training has a completion rate of 76% across VCS, WBS and Corporate.
- As we approach the six month initial completion deadline (end November) work is being undertaken with managers to ensure completion of level one training, as well as sharing the training through Trust wide communications.

Row Labels	Completed	Not completed	Grand Total
120 Corporate Division	**166**	**48**	**214**
NHS|MAND|Risk Awareness - 2 Years|	166	48	214
120 Research, Development and Innovation Division	**50**	**8**	**58**
NHS|MAND|Risk Awareness - 2 Years|	50	8	58
120 Transforming Cancer Services Division	**13**	**10**	**23**
NHS|MAND|Risk Awareness - 2 Years|	13	10	23
120 Velindre Cancer Centre	**628**	**259**	**887**
NHS|MAND|Risk Awareness - 2 Years|	628	259	887
120 Welsh Blood Service	**384**	**64**	**448**
NHS|MAND|Risk Awareness - 2 Years|	384	64	448
Grand Total	**1241**	**389**	**1630**

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐	

. A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item. There are no direct well-being goal implications or impact in the current risks in this paper.

	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

	Click or tap here to enter text.

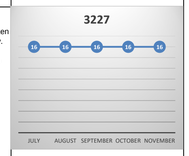
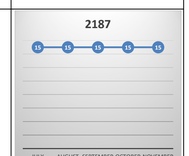
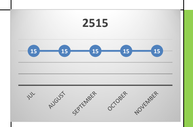
6. RISKS

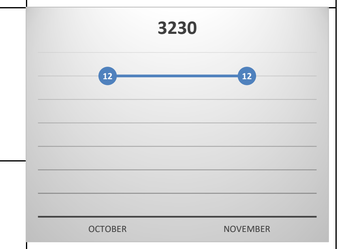
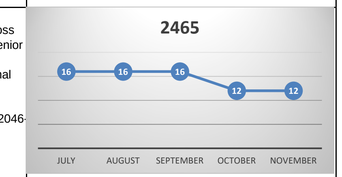
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require further work.
BY WHEN?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1

Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.	7	Improvements sustained over time - BAU
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.	6	Outcomes realised in full
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.	5	Majority of actions implemented; outcomes not realised as intended
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.	4	Increased extent of impact from actions
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.	3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.	2	Symptomatic issues being addressed
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.	1	Actions for symptomatic issues, no defined outcomes
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.	0	Enthusiasm, no robust plan

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update	Risk Type	Opened	Division	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	ACTION Due date	ACTION Description	Risk Trend Graph
3153	There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm.	There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm. We use a package called ProSoma (which is a Medical Device) for creating target volumes and treatment plans as part of the Radiotherapy pre-treatment process. The manufacturer has supplied lists of folders to exclude from real time anti-virus scanning to avoid interfering with the correct operation of the software. Digital have implemented real time scanning of these folders contrary to the advice of the manufacturers and Medical Physics Experts in Radiotherapy.	- Advised Digital of the manufacturer requirements and the radiation risks to patients from realtime scanning. -Regular 'liaison' meetings between RT Physics and digital are in place to ensure any future system upgrades are planned in line with manufacturer recommendations and ensure the risk to immediate patient safety / the radiation risks are considered in addition to the risk of cyber attack. There is still significant risk from Prosoma radiation incidents.	18/10 Update: Kept risk at 15 until Digital confirm that realtime antivirus scanning of these folders has ceased. Will update risk as soon as have confirmation. It is Physics understanding that realtime scanning of these folders is still happening, risk to remain at 15. Some incidents have been reported whereby saving of patient scans and delineated tumour volumes has not been possible, thus impacting the patient pathway. The full detail of these incidents are to be submitted as Datix incidents to enable appropriate investigation.	Safety	12/07/2023	Velindre Cancer Centre	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Rare - Would only occur/reoccur in very exceptional circumstances, considered a very remote probability that it could happen / happen again.	1- Negligible	1	30/11/2023		Actions being taken as per progress column. 6/12 update - Meeting held - Digital / Physics liaison meeting on 06/12/23 for discussion to ensure all parties fully understand the risk. Actions agreed and will be implemented by end December - this would then reduce the risk for January reporting if implemented as planned. No performance issues had been raised with the Digital Service Desk since the risk was originally raised.	
3227	new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	changes during the design development process lead to a design which costs more overall, increasing project costs.	1.Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial boot camp is scheduled for w/c 09/10/23 to try to finalise commercial position on various issues Ongoing 2. See comments against Action 1. Ongoing	Risk increase is due to Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury.	Financial Sustainability	16/10/2023	Transforming Cancer Services	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	31/10/2023	14/12/2023	Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial boot camp is scheduled for 10/10/23 to try to finalise commercial position on various issues Ongoing	
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. 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..RTDS data submissions v..Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi..Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii..MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	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. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service.	A comprehensive 5 year workforce plan is underway to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC. This includes recruiting to the 13.5 posts within the satellite centre business case and additional posts for the IRS commissioning schedule at nVCC. Financial support of the workforce plan will be required to enable the target risk rating to be achieved. A process of continual prioritisation of business critical tasks is in place and it is ensured that detailed project and resource plans are kept up to date. Every occurrence when developmental / IRS work is put on hold to meet urgent radiotherapy treatment planning demand is being logged.	Safety	14/09/2020	Velindre Cancer Centre	Expected - Will occur/reoccur and likely to be frequent.	5 - Critical	25	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Unlikely - Not expected to occur/reoccur but there is some possibility.	5 - Critical	10	29/12/2023	31/10/2023	5 year workforce plan	
																		30/11/2023	Readvertise post that did not recruit	
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training. Theatre: One member of the team is currently on long term sick. Return to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.	Service provision across all specialities is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. A locum Consultant Clinical Oncologist was appointed in Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team. A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service. Future Planning: An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due September 2023	Options appraisal to be delayed due high current service demand. The current on resources to support the shift to a paperless radiotherapy service required for the satellite centre (due for completion by May 2024) and ongoing IRS demands. Options appraisal review delayed until early 2024.	Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	Probable - Will probably occur/reoccur but will not be a persistent issue.	5 - Critical	20	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Unlikely - Not expected to occur/reoccur but there is some possibility.	5 - Critical	10	30/12/2023	30/09/2023	Brachy Workforce	
																		31/07/2023	Insufficient brachy MPE	

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update Since Last Governance Cycle	Risk Type	Opened	Division	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	ACTION Due date	ACTION Description	Risk Trend Graph
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	Meeting took place to review the risk with the senior WOD SLT and Exec Director. Confirmation was received that the Healthy and Engaged Workforce Steering Group is the meeting to oversee this risk and to review on a quarterly basis	Safety	09/12/2022	Corporate Services	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	31/12/2023	31/03/2024	Healthy and Engaged Steering Group to agree arrangements to monitor and evaluate wellbeing interventions	
																		22/12/2023	The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. Plans in those areas of work already in place need to be aligned to this risk or new plans developed. The work plan derived from this should sit under the 'Building Our Future Together' Portfolio.	
																		31/04/2024	Divisions/Departments should have proactive stress risk assessments	
3230	There is a risk to patient safety regarding the referral of patients into VCC, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	Multiple methods for the communication of new patient referrals to Velindre Cancer Centre	Monitoring the receipt of paper and electronic communications specific to new patient referrals to ensure timely actions to be taken.	Standard referral form in draft. Links with the Digital Team established to look at e-form solutions. Central e-mail box set up in readiness. Meeting with DHCW to be scheduled to review the e-referral solution (Hospital to Hospital). Demonstration Recording shared for background/further information to support discussion.	Safety	19/10/2023	Velindre Cancer Centre	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very	4 - Major	4	45260	31/01/2024	Short term central management of new patient referrals	
																		31/12/2024	Electronic Solution (Long Term)	
2465	There is a risk to patient safety caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	In interim work has commenced to move to centralised email boxes by SST for clinical issues. Communication to highlight all urgent request should not use email as means of communication, clarified with key areas eg. SACT, Med sec roles and responsibilities and to not send emails 'just in case'.	Safety	05/11/2021	Velindre Cancer Centre	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	29/12/2023	09/10/2023	IB to undertake an audit into the use of email within the medical directorate across VCC. Audit complete and received at Senior Leadership Team in December - Operational services to oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft IMTP 2046-27.	

AUDIT COMMITTEE

Trust Assurance Framework

DATE OF MEETING	19.12.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and this paper provides an update to the Audit Committee, following Trust Board in November 2023.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to **NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Shape	13.11.2023
Quality, Safety and Performance Committee	16.11.2023
Trust Board	30.11.2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Trust Assurance Framework was discussed at the Trust Board on 30th November. This paper for Audit Committee governance mirrors that version. Executive Management Board (Shape) is on 18th December when the final two risks are being finalised for January reporting and also further updates on the other TAF risks will be agreed.

The three key points highlighted to the Quality, Safety and Performance Committee in November were:

- Of the refreshed Trust Assurance Framework risks, six of the eight are included in Appendix 1 on the new format. The remaining two were amended later in the review cycle and are being worked on at pace by Executive leads.

- The Chair of Quality, Safety and Performance Committee has raised some matters prior to the meeting, including the need to ensure that there was alignment to the Integrated Medium Term Plan goals and then triangulation against the progress on these goals is an important element of first line of defence assurance.

- It is important to note that embedding of the Trust Assurance Framework, as a valuable management tool, through the Divisional leadership teams and senior management across the organisation remains a priority for the next phase of the Governance, Assurance & Risk development.

During the meeting, further matters were raised:

- Specific feedback on individual risks was discussed, including: TAF 01: *"There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources."* requiring greater clarity on Velindre Cancer Services vs Welsh Blood Service references; TAF 02 required further detail and completion; *TAF 03 "There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives."* requires articulation to the Trust Risk

Register (as also referenced in the Trust Risk Register Cover paper for Trust Board today). Any additional specific feedback on individual risks will be addressed in the December-January reporting cycles also.

- During reflections on triangulation at the end of the Committee meeting, it was agreed that increased service pressures across many aspects of performance were impacting on the risk of delivery of service. This was to be considered in the context of *TAF 01: "There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources."*

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	***Report for Noting***

APPENDICES	
1	Summary of Strategic Risk Refresh outcomes
2	New Trust Assurance Framework

1. SITUATION

A review of the Trust Assurance Framework (TAF) and Strategic Risks have been undertaken, following collaboration with the divisional Senior Leadership/Management Teams, Committee members, Executives and Independent members.

The new Strategic Risks are included in this paper for information, following a review process through divisional Senior Leadership Teams, Executive Management Board and committees.

The revised Trust Assurance Framework is appended for six of the eight of the strategic risks. These risks were considered at Executive Management Board on 13th November. The remaining two are:

TAF 07 - There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regime, staffing challenges, and lack of consistent quality, outcome and mortality metrics.

TAF 08 - There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.

2. BACKGROUND

The Trust Assurance Framework (TAF) was established in 2020, detailing ten strategic risks. A dashboard was developed to record the TAF and support ongoing management by Executive Leads.

The Trust Assurance Framework template was reviewed, updated and discussed with Independent Members who sit on the Audit Committee who reviewed the template. The template was endorsed by the Executive Management Board ahead of Audit Committee approval in April 2023.

The Strategic Risk Refresh started with divisional teams, Velindre Cancer Service (VCS) Senior Leadership Team, also attended by some Executive colleagues, and Welsh Blood Service (WBS) with a core group of attendees. These sessions were an opportunity to review the current risks, their appropriateness from a service perspective and to gather suggestions of key areas for inclusion in the refresh. Similar discussions took place in the Executive Management Board and Strategic Development Committee.

The National Risk Register was published in August 2023, a review of which was undertaken and key areas highlighted of relevance to Trust have been considered as part of the Strategic Risk Refresh.

As background, it is important to note that Strategic Development Committee, Quality, Safety & Performance Committee and Trust Board have all expressed concern over recent months that during this review period, a Trust Assurance Framework was not operational for six months. Overarching lessons learnt from this has been discussed in various Committees and Trust Board, and is broadly two-fold:

- The refresh of strategic risks will take place annually going forwards, in line with the Integrated Medium Term Plan review. The Trust Assurance Framework guidelines are being updated to reflect this.

- During all subsequent reviews, the existing risks will be reported on until the refresh has taken place.

3. ASSESSMENT

3.1 Following the Strategic Risk Refresh the outcome has been shared with the Trust Board is included in Appendix 1.

The refreshed Strategic Risks have been populated on to the new Trust Assurance Framework Dashboard, which has previously been reviewed by this Committee and approved by the Audit Committee. The new template links with strategic frameworks, includes an area for reference to operational risk related to the strategic risk and have SMART action plans, alongside the core information around key controls, sources of assurance and gaps in controls.

3.2 Summary of Actions Taken/ In Plan from Strategic Development Committee, Quality Safety & Performance and Audit Committee:

	Matter raised through recent governance cycle	**Action Taken/ In plan**	**Timeframe**
1	Populate refreshed TAF on Bower BI template	Work completed in background on Power BI and refreshed information to be populated from next reporting cycle.	December-January reporting cycle
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	December-January reporting cycle
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Good progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the Planning team to map and then populate with Executive leads at next review.	December-January reporting cycle
4	Deep dive of two risks at Quality, Safety &	Following reporting of refresh framework of strategic risks, this will	December-January reporting cycle

	Performance Committee going forwards	recommence from the next reporting cycle.	
	Feedback on specific risks from Quality, Safety & Performance Committee – including triangulation of key themes	Addressed in next Strategic Risk review and update.	December- January reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may including further Board development time etc.	December- April, in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee are asked to:

- Consider and **NOTE** the Strategic Risk Refresh, as detailed in Appendix 1 of this report.
- **NOTE** the next steps, both in respect of governance and operationalisation, as detailed in section 3.2 of this report.
- **NOTE** the Trust Assurance Document.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** All Strategic Risks are related.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). All domains are relevant to this work, as the strategic risks span all areas of the Trust

	business and are imperative to quality and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

RISK ID		RISK TITLE		STRATEGIC GOAL		RISK SCORE TREND	
RISK LEADS				RISK THEME			

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING		Overall Trend in Assurance	

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
	Trust Risk Register associated risk on Datix. (see section 4)			X								

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control

RISK ID	01	RISK TITLE	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	
RISK LEADS	Cath O'Brien	Rachel Hennessey	Alan Prosser	RISK THEME	Service Capacity		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING	PE	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between 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 to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
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 arrangements. Weekly meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plan please in time for Board.	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and WBMDR.	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government EPRR for Health, Local Resilience Forum - SCG.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB Review.	PA	QSP committee and Board and external stakeholders if required.	PA

C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			**E**	Horizon scanning and representation at key forums including UK Forum, JPAC, SaBTO Regular liaison with Blood Policy and Tissue, Cells and Organs team in Welsh Government. NICE Guidelines re Cancer drugs	**Not Assessed**	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	**Not Assessed**	QSP, SDC	**Not Assessed**
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	**Not Assessed**	Performance Report - SLT, EMB, QSP and Board	**Not Assessed**	Welsh Government Quality, Planning and Delivery Review	**Not Assessed**
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	**Not Assessed**	Performance Report - SLT, EMB, QSP and Board	**Not Assessed**	Welsh Government Quality, Planning and Delivery Review	**Not Assessed**

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**
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 require digital systems to be in place which are out of WBS control. Projects are progressing externally.		A1.1
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 inappropriate use of blood, which impacts demand.		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3184	There is a risk to VCC as a result of no Lead Digital Pharmacist in post resulting in multiple risks for VCC and the trust. These include for example lack of Medicines management clinical leadership for the implementation and ongoing use of general medicines EMPA, update of current chemocare and implementation of new all wales SACT EMPA. Implementation of pharmacy robot nVCC.	20	Risk Increasing
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Stable/No Movement
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	15	Risk Decreasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	**IA**	Jul-25	National oversight group is currently discussing with CAV in light of new supplier for All Wales LIMS soplution.	14.11.23	No current funding route idetified within LIMS and may be identified as a core recommendation through Infected Blood Inquiry (IBI).	
A1.1	Working with DCHW to support the Blood Transfution Model of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	**IA**		Discussions ongoing about funding solutions	14.11.23		

A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	**PA**		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including - preoptimisation of anaemia patients - Intraoperative cell salvage (ICS) - Quality insights QS138 Audit (NICE standard, ongoing audit tool to monitor patient blood management quality standards) - Appropriate use of OD neg red cells - Appropriate use of platelets	14.11.23	All Wales programmes which will ensure equity of care for patients.	

SECTION 1

RISK ID	02	**RISK TITLE**	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	**STRATEGIC GOAL**	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	**Carl James**	**Jacinta Abraham**	**Nicola Williams**	**RISK THEME**	Partnership Alignment		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	**LIKELIHOOD**	**IMPACT**	**TOTAL**	**12**	**CURRENT RISK**	**LIKELIHOOD**	**IMPACT**	**TOTAL**	**8**	**TARGET RISK**	**LIKELIHOOD**	**IMPACT**	**TOTAL**	**6**
	3	4				2	4				2	3		

SECTION 3

Overall Level of Effectiveness: **7 Levels of Assurance(see definitions tab)**	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL HAVE A GRAPH

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management framework implemented March 2023	IA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national arrangements in place for blood and cancer services; will be enhanced by creation of Executive Function in Welsh Government in April 2023	PA	Strategic Development Committee/ Quality Safety and Performance Committeee; introduction of Executive Function in WG will support effective system comnmissioning; Executive Function in WG from Aoril 2023 will enhance arrangments	PA	Regulatory scope re MHRA tbc; clear stanadards for services understood and suppported by commissioning arrangements across NHS Wales	PA
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	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	IA	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		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**	
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		Need to enusre the gaps in assurance are refelcted in the action plan

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite			
DATIX RISK REF	**RISK TITLE**	**CURRENT RISK RATING**	**RISK TREND**
	There are currently no associated operational risks according to the risk appetite to include		

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control	
1.4	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James		Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase	Progress update needed Action Plan needs strengthening to indicate how gaps in assurance are being managed Assurance level needs to be included progress update needs to be included
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce		Programme outputs to be confirmed	Programme established and staff on-boarded	09/11/2023	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase	
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)		tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase	

SECTION 1

RISK ID	03	**RISK TITLE**	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 -Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Workforce Supply and Shape		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	
	4	4		16		4	3		12		2	3		6

SECTION 3

Overall Level of Effectiveness: (7 Levels of Assurance(see definitions tab))	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL INCLUDE A GRAPH

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E
C3	Workforce planning - skills development	Susan Thomas	X			PE
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE
C9	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

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 People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
Provide operational managers with skills and capabilities to undertake effective	IA	Joint finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	IA
Evaluation sheets	IA	Joint finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	IA
Staff Meeting to feedback on implementation plan	IA	Joint finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	IA
Recruitment and retention reports via Board	PA				
Reports via Trust Committee cycle on updates	PA				
Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	IA
Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA		

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**
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	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite					
DATIX RISK REF	**RISK TITLE**	**INTIAL RISK RATING**	**CURRENT RISK RATING**	**TARGET RISK RATING**	**RISK TREND**
	There are currently no associated operational risks according to the risk appetite to include				

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	**IA**	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	8.11.23	Plan is moniitoted via Health and Engaged Steering group and plan in palce to March 2024	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	**IA**	Mar-23	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	8.11.23	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	**IA**	Mar-24	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB			
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	**IA**	Dec-23	A plan to implement the People Strategy will be presented to EMB in December.			
1.5	Development of a Strategic workforce plan	Susan Thomas	**IA**	Mar-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy			
1.6	Development of a Trust Retention Plan	Susan Thomas	**IA**	Feb-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly			
1.7	Review Exit Interview Process	Susan Thomas	**IA**	Jan-24	Task and Finish group to consider Exit interview process			

SECTION 1

RISK ID	04	**RISK TITLE**	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**STRATEGIC GOAL**	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	9	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	4
	3	4				3	3				2	2		

SECTION 3

Overall Level of Effectiveness: (7 Levels of Assurance(see definitions tab))	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL INCLUDE A GRAPH

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 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
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
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE
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
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Working group led by CJ		Trust Board reporting on strategy and controls via cycles of business		To be completed as per compliance/ reg tracker updates	
Education and training steering group		Trust Board reporting on strategy and controls via cycles of business		To be completed as per compliance/ reg tracker updates	
Education and training steering group					
Healthy and Engaged Steering Group and Education and Training Steering Group					
Healthy and Engaged Steering Group					
Health and Wellbeing Steering Group					
Executive Management Board					
PMF Workling Group					
SLT Meetings					
SLT Meetings and Educationa and Training Steering Group					

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**
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	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include				

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		Mar-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message.	09/11/2023		
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey will be distilled to further develop our work programme	09/11/2023		
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		Jan-24	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in	09/11/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	09/11/2023		

SECTION 1

RISK ID	05	**RISK TITLE**	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**STRATEGIC GOAL**	5 - A sustainable organisation that plays it part in creating a better future for people across the globe	**RISK SCORE TREND**	
RISK LEADS	Carl James			**RISK THEME**	Digital Transformation		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	9
	4	4				3	4				3	3		

SECTION 3

Overall Level of Effectiveness: (7 Levels of Assurance(see definitions tab))	RATING	PE	Overall Trend in Assurance	
				THIS WILL BE A GRAPH

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital Officer		X		E	Trust Digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	Not Assessed
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	IA	Wales Audit Office	Not Assessed
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	Feedback and progress working with universitues	IA	Wales Audit Office	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	Not Assessed
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office/ Centre for Digital Public Services	PA
C7	Digital inclusiion in wider community	Chief Digital Officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audti Office	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

Assurance ratings need to be added for all the sources of assurance. Ref the definitions tab

C11	Trust digital Governance	Carl James		X		PE	Trust Digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	IA
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/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
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme established/ Architectural Review Board	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audti Office	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
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.		
Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Stable/ No Movement

SMART ACTION PLAN

Action Ref	Action Plan	Ownder	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control	
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer		Nov-22	Digital Programme has now been established from Oct '23	Nov-23	As the Programme continues to develop the overall level of risk should reduce	The level of asurance should increase.	Dates need to be reviewed and updated progress notes need to be added any gaps in assurance need to be reference with an action plan
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer		Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The Digital Strategy has now been published and a draft insfrastructure strategy (reference architecture) is available.	Nov-23	As the Programme continues to develop the overall level of risk should reduce	The level of asurance should increase.	

SECTION 1

RISK ID	06	**RISK TITLE**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Lauren Fear			**RISK THEME**	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	
	4	4		16		3	4		12		2	4		8

SECTION 3

Overall Level of Effectiveness: **Refer to 7 Levels of Assurance (see definitions tab)**	**RATING**	E	**Overall Trend in Assurance** Refer to 7 Levels of Assurance (see definitions tab)	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS

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
							SOURCES OF ASSURANCE					
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	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	6	Aiudit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	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	6	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	6	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	6

C5	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	4		
C6	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.	5			Audit Wales review of Quality Governance Arrangements	5
C7	Qulaity 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.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
None	Third line of defence in respect of C5 - Board Development Programme: No course of action is proposed.	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include		

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
C5	Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	6	Complete	Supported by the development priorities identified through an externally facilitated programme of Board development underway.			
	Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	6	Complete	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.			
	Develop and iplement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Dec-23	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			
	Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	4	Mar-23	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.			
	Refresh of Trust Assurance Framework risks	Lauren Fear	3	Dec-23	Project TAF 2.0 withint he GAR Programme has started, risks are reveiwed on a monthly basis and reported through governance routes accordingly			
	Revised reporting mechanism to be developed	Lauren Fear	3	Mar-23	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			

	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Mar-23	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			

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce

05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance

09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

DEFINITIONS

CONTROL EFFECTIVENESS

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

ASSURANCE RATING		
Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA

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

LEVELS OF ASSURANCE DESCRIPTORS

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

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

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

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

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

RISK SCORE

LIKELIHOOD MATRIX

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

RISK RATING MATRIX - IMPACT X LIKELIHOOD

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

IMPACT MATRIX

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
01	Compliance *Statutory duty/ inspections*	No or minimal impact or breach of guidance/statutory duty	Minor breach of guidance/statutory duty Reduced performance rating if unresolved Verbal reports from Regulator	One breach guidance/statutory duty Challenging recommendations Observation reports from regulator	Multiple breaches in statutory duty Enforcement action Improvement notices	Multiple breeches in statutory duty Prosecution Severely critical report
02	Environmental *Environmental impact*	No or minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
03	Financial Sustainability *Including claims*	Insignificant cost increase Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim(s) less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million	Loss of >1 per cent of budget Claim(s) >£1million
04	*Information Governance* General Data Protection *Regulation (GDPR)*	Minimal privacy impact requiring no or minimal intervention	Minor impact on an individual's privacy	Moderate privacy impact requiring professional intervention Possible ICO reportable breach Could result in an event which impacts on a moderate (less than 100) number of patients/donors	Major breach leading to possible larger scale privacy breaches Likely ICO reportable breach if IG standard not adhered to Could result in an event which impacts on a major (between 100 and 1000) number of patients/donors	Serious breaches and non-compliance Definite ICO report required if breach occurs Could result in an event which impacts on a major (more than 1000) number of patients/donors
05	Partnerships Relationships with internal and external stakeholders and in working with system partners	No or minimal issues in establishing and maintaining effective relationships with internal and external stakeholders No or minimal misalignment of operational actions or strategic approach with system partners	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders Minor misalignment of operational actions or strategic approach with system partners	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders Moderate misalignment of operational actions or strategic approach with system partners	Major issues in establishing and maintaining effective relationships with internal and external stakeholders Major misalignment of operational actions or strategic approach with system partners	Failure to establish and maintain effective relationships with internal and external stakeholders Severe misalignment of operational actions or strategic approach with system partners

		Minimal issues with collaborative working initiatives within our cancer and blood and transplant systems	Minor issues with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues with collaborative working initiatives within our cancer and blood and transplant systems	Severe issues with collaborative working initiatives within our cancer and blood and transplant systems

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
06	Performance and Service Sustainability *Business objectives/projects* *Service/business interruption*	Failure to achieve minor objective No or minimal service issue **Programme/ projects** Insignificant cost increase Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective. Minor impact on service. **Programme/ projects** 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives. Moderate impact on service. **Programme/ projects** 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives. Major impact on service. **Programme/ projects** 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives Service failure **Programme/ projects** >50 per cent over project budget More than 100 per cent schedule slippage against timescales
07	Quality *Quality/complaints/ audit / GxP*	Peripheral element of treatment or service suboptimal Informal complaint/enquiry Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal Formal complaint (stage 1) Local Resolution Single failure to meet internal standards Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g., reassurance.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Multiple failures to meet internal standards Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced. Short term harm, donor/patient/staff requiring treatment from medical practioner.	Non-compliance with national standards with significant risk to patients or donors if unresolved Multiple complaints/ independent review Multiple failures to meet national standards Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ /staff admission to hospital required, or increased stay in hospital >3days.	Non-compliance with national standards with severe risk to patients or donors if unresolved Inquest/ombudsman inquiry Gross failure to meet national standards Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused. (SABRE)
08	Reputational *Adverse publicity/ reputation*	Potential for public concern	Local media coverage Minor reduction in public confidence	Local media coverage Moderate reduction in public confidence	National media Coverage with <3 days service well below reasonable public expectation Major reduction in public confidence	National media Coverage with >3 days service well below reasonable public expectation. Gross loss of public confidence
09	Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
		has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	Safety *Impact on safety of patients, staff or public (physical or psychological harm)*	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14	Major injury leading to long-term incapacity /disability Requiring time off work for >14	Incident leading to death Multiple permanent injuries or irreversible health effects

			Increase in length of hospital stay by 1-3 days	days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	Workforce and OD *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

AUDIT COMMITTEE

AUDIT REPORT OVERDUE AND COMPLETED RECOMMENDATIONS ACTIONS

DATE OF MEETING	19/12/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Matthew Bunce, Executive Director of Finance
PRESENTED BY	Chris Moreton, Deputy Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	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.
RECOMMENDATION / ACTIONS	**RECOMMENDATION** • The Audit 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. • The Audit Committee are asked to **APPROVE** 14 (61%) Internal Audit Report actions and 3 (25%) External Audit Report actions have been completed since the October '23 Audit Committee **(Green Status)**. If agreed these actions will be formally Closed **(Blue Status).** • 2 (9%) Internal Audit Report actions and 1 (8%) External Audit Report action have passed the agreed implementation date **(Red Status)**. The Audit Committee is asked to **APPROVE** the extension dates identified.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run - The Audit Action Tracker was taken to Executive Management Board on 30 October with the 'October 2023 updates' . This 'November 2023 Updates' Report was taken to 04 December 2023 meeting to provide an update to the Executive Management Board on reported progress against audit report recommendations and identified management actions. The Executive Management Board **ENDORSED** for Committee APPROVAL the Recommendations / Actions provided in the report.	04/12/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix 1	Red Overdue Recommendations Actions Audit Committee 19 December 2023
Appendix 2	Audit Action Tracker – Updated November 2023 – 19 December 2023 Audit Committee - Overdue Red and Complete Green

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 Following the October '23 Audit Committee during October '23 and November '23 further updates from Action owners on implementation progress were sought. The latest responses have been added to the 'November 2023 Update' columns 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 Tracker.

1.3 This report focuses on the status of the red/overdue and green/complete actions and Audit Committee is requested to consider the contents of the report and the attached action plan.

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Context

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

2.1.2 To aid forward planning, the following timetable was shared with Executive / Director Leads which provided the deadlines for responses on all Tracker updates until February 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	20 November 2023	04 December 2023	19 December 2023
December	18 December 2023	02 January 2024	
January	18 January 2024	01 February 2024	
February	16 February 2024	29 February 2024	12 March 2024

2.1.3 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 One Internal audit report was added to the Audit Action Tracker following the October '23 Audit Committee which included 5 Matters' arising with 5 recommendations, all of which were medium priority. In response to these Internal Audit recommendations management identified 6 actions. The report added was:

- Digital Strategy & Transformation Programme - Final Internal Audit Report

2.2.2 Work undertaken by Management / Officer leads to complete actions since the October '23 Audit Committee has resulted in 14 Internal Audit actions being completed.

2.2.3 The table below provides a summary of the movement in total internal audit actions from October '23 Audit Committee to 19 December '23 Audit Committee.

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
October '23 Audit Committee					
Total Outstanding Actions	42	0	20	22	0
Less: Completed Actions (Green) – Agreed by Audit Committee to close (Changed to Blue)	(25)	(0)	(13)	(12)	0
Following October '23 Audit Committee					
Total Outstanding Actions	17	0	7	10	**0**
Add: Total Actions from new reports presented by Internal Audit to October '23 Committee	6	0	6	0	**0**
Total Outstanding Actions	**23**	**0**	**13**	**10**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 30 October '23 (Update October 2023)	**2**	**0**	**0**	**2**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 04 December '23 (Update November 2023)	**12**	**0**	**8**	**4**	**0**
Total Completed Actions (Green) - propose close (Blue) @ December '23 Audit Committee	**14**	**0**	**8**	**6**	**0**
Total Outstanding Actions @ 04 December '23 (excludes completed actions)	**9**	**0**	**5**	**4**	**0**

2.2.4 The tables below provide a summary of the audit action status position.

November '23 – Internal Audit

Priority	2022/23	2023/24	Total
No. of Audit Reports	21	7	**28**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	6	17	**23**

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 October 2023	Action complete November 2023	Closed
High	0						10
Medium	13			5		8	108
Low	10	2		2	2	4	71
N/A (Advisory Audit)	0						10
Total Open Actions	**23**	**2**	**0**	**7**	2	12	199
% Open Actions	**100%**	**9%**	**0%**	**30%**	**9%**	**52%**	**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 October 2023	Action complete November 2023	Closed
Executive Director of Finance	2			2			64
Director of Strategic Transformation, Planning & Digital	13			3	1	9	30
Director of Governance & Chief of Staff	2					2	20
Director of Nursing, AHPs & Health Science	0						8
Director of OD and Workforce	0						8
Chief Operating Officer	1			1			29
TCS nVCC Project Director	0						19
Executive Director of Finance and Chief Operating Officer	0						2
Chief Operating Officer and Director of Governance & Chief of Staff	0						10
Executive Medical Director	3			1	1	1	9
Director of Strategic Transformation, Planning & Digital and Executive Director of Finance	2	2					0
Total	**23**	**2**	**0**	**7**	**2**	**12**	**199**

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

Priority	2022/23	2023/24	Total
High			
Medium			
Low		2	2
N/A (Advisory Audit)			
Total	0	2	2

2.2.5 There are 2 actions (9%) for which the implementation date has passed and management action is not complete (Red).

2.2.6 There are 14 actions (61%) since the October '23 Audit Committee that have been completed.

2.2.7 There are 7 actions (30%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.2.8 There are no actions identified as not on target to be completed by agreed implementation date (Amber).

2.3 External Audit Actions Analysis

2.3.1 Two External audit reports were added to the Audit Action Tracker following the October '23 Audit Committee which included 9 recommendations, 3 of which were high priority and 6 were medium priority. In response to these External Audit recommendations management identified 9 actions. The reports added were:

- Review of Workforce Planning Arrangements -Velindre University NHS Trust
- Audit of Accounts Report Addendum – Velindre University NHS Trust

2.3.2 Management / Officer leads have completed 3 actions (25%) since the October '23 Audit Committee.

2.3.3 The tables below provide a summary of the audit action status position.

November '23 – External Audit

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

Priority	2023/24	Total
No. of Audit Reports	3	**3**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	12	**12**

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 October 2023	Action complete November 2023	Closed
High	6	1		2		3	9
Medium	6		1	5			3
Low	0						2
N/A (Advisory Audit)	0						35
Total	**12**	**1**	**1**	**7**	0	3	**49**
%	**100%**	**8%**	**8%**	**59%**	**0%**	**25%**	**N/A**

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implement-ation on 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 October 2023	Action complete November 2023	Closed
Executive Director of Finance	3			3			10
Director of Strategic Transformation , Planning &	3	1		1		1	4
Director of Governance & Chief of Staff	0						20
Director of Nursing, AHPs & Health Science	0						2
Director of OD and Workforce	6		1	3		2	9
Chief Operating Officer	0						2
Director Corporate Governance & Chief of Staff & Executive Director Nursing, AHP and Health Science.	0						2
Total	**12**	**1**	**1**	**7**	**0**	**3**	**49**

2.3.4 There is 1 action (8%) for which the implementation date has passed and management action is not complete (Red).

2.3.5 There are 3 actions (25%) since the October '23 Audit Committee that have been completed.

2.3.6 There are 7 actions (59%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.3.7 There is 1 action (8%) that is not on target for completion (Orange).

2.4 Summary of the position as of 19 December 2023:

- 14 (61%) Internal Audit Report actions and 3 (25%) External Report actions that have been completed **(Green Status)** and will be requested to be changed to closed **(Blue Status)** at the December '23 Audit Committee.

- 7 (30%) Internal Audit Report actions and 7 (59%) External Audit Report actions are on target for completion by the agreed date **(Yellow Status).**

- 1 (8%) External Report action is not on target for completion by the agreed date (**Orange Status**).

- 2 (9%) Internal Report actions and 1 (8%) External Audit Report action have passed their agreed implementation date (**Red Status**).

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	Choose an item

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *There are no specific quality and safety implications related to the activity outlined in this report.* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required *Not applicable*
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item** If more than one Well-being Goal applies please list below: The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated If more than one wellbeing goal applies please list below:

	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Not applicable for this report **Source of Funding**: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not applicable Equality Impact Assessments would be undertaken where any of the actions proposed in response to a recommendation require that, for example where a new policy is developed or existing policy changed, a change to a service provision etc.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

Appendix 1. Overdue /Red Actions / Recommendations

Internal Audit.

Capital Systems Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where leadworks	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Airising 1: Governance - Capital Procedures (Operation)** 1.1 FP01 Capital Management Procedure should be reviewed and updated.	Low	1.1 Accepted: The Capital Management Procedure will be updated and will be submitted for approval following Trust governance requirements.	Carl James, Director of Strategic Transformation, Planning & Digital / Matthew Bunce, Executive Director of Finance	Steve Colliandris, Head of Financial Planning & Reporting	30 November 2023	Overdue	Capital management procedure is still under review following the formation of the Strategic Capital Board. At present is on course to be completed within the agreed implementation date. A meeting of key personnel met at the Start of Sep with a further meeting scheduled for wc18th September to update and review the procedure following significant changes following the Establishment of SCB.	The procedure has been updated to reflect the changes required following the formation of the Strategic Capital Board. The procedure will be going to the Capital Planning Group on the 10th October for comment / review before following the required governance route prior to being submitted to Audit Committee in December. **Request one month extension to end of December to allow for governance approval route.**	Procedure has been updated and is currently going through the correct governance route. The procedure is still expected to be approved by Audit committee on the 19th Dec. The full timing and governance route is provided below Capital Planning Group - 14th Nov Strategic Capital Board - 16th Nov EMB - 04th Dec Audit Committee - 19th Dec	31-Dec-23	1	1	

Trust Priorities - Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 26 July 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Enhancements to the prioritisation process (Design).** 1.1 The Trust could further enhance the benefits of the Prioritisation Framework by using it in discussions with external stakeholders (e.g., Welsh Government, commissioners, Llais, etc.) during the annual planning process.	Low	1.1 Agreed - The Trust is currently developing its engagement plan of the development of our plan during 2023/24. This will include a process for clearly articulating our key organisational priorities (output of the prioritisation framework) to both our internal and external stakeholders.	Carl James, Director of Strategic Transformation, Planning & Digital / Matthew Bunce, Executive Director of Finance	Philip Hodson, Deputy Director of Planning & Performance	29/09/2023	Overdue	A meeting has been arranged for 27.09.2023 to develop the next IMTP 2024/2025 to 2026-2027 with Executive Team, Service Planning Leads and Enabling Leads. The key organisational priorities will be incorporated within the discussions to develop the plan.	Meeting on 27/09/2023, where organisational priorities were discussed, it was agreed that there would be a follow-up meeting on 26th October 2023 with Executive Team, Service Planning Leads and Enabling Leads. It was agreed that organisational priorities would be agreed during this meeting.	It is now assumed that the submission date for the IMTP is 28th March 2024 and NOT the 31st January 2024. Therefore it has been agreed that the Trust should use this extension to allow for further engagement with the Executive Management Board, including individual meetings with each Executive Director, the Strategic Development Committee and with the Trust Board. As a result an agreed set of priorities will now be finalised by 22nd December 2023.	Revised implementation date of 22nd December 2023.	3	1	

External Audit.

External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 25 April 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed implementation Date	Status		Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 5	**Improving reporting on the benefits arising from digital investments** Whilst there is good reporting on pr ogress in delivering key digital projects and programmes, the reports do not provide an assessments of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	High	The further development of digital benefits will be undertaken in sever al ways: (i) a range of key performance indicators that are reported to the Executive Management Board	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Outstan			Digital measures continue to be included in the Performance Management Framework (PMF). The QSP Digital report format has been updated to show more clearly the impact being delivered by the Digital team and has been through two QSP reporting cycles. Reporting arrangements (including benefits) have been agreed with both the Velindre Futures and Welsh Blood Service Futures programmes and are in operation and a new Business Change Manager role has been appointed using 12month fix DHCW funding towork on benefits realisation. Now that the Digital Strategy has been published a new set of measur es (e.g. on Digital Inclusion) have been defined to show progress towar ds the strategy and will be available for inclusion in the PMF from Jan '24. The Trust approach to creating dashboards for Quality and Safety and the Performance Management Framework has been agreed and the priority measures will be available from April '24, these measures include Digital measur es. Activities on this will close in April '24, although we will continually work on measures and the dashboards.	Requested extension date - 31 April 2024.			

Audit Action Plan

Priority	
Low	< 3 months *
Medium	< 1 month *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Patient and Donor Experience | **Assurance Rating: Reasonable** | **Date Received at Audit Committee: 12 January 2023**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Meeting Structure** 1.1 As part of the review of quality and safety governance and reporting mechanisms, the Trust should 1.1a. review the flow of patient and donor experience reporting from floor to Board to ensure it is clear and efficient, avoiding unnecessary duplication;	Medium	a. A patient / Donor experience feedback procedure to be developed and published on intranet identifying reporting flow service level to Board.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	~~Nigel Downes,~~ Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extendion Request Agreed April 2023 Audit Committee: 30 May 2023	Action Closed					2		Aug-23
	1.1b update relevant meeting terms of reference to ensure clarity over the purpose of patient and donor experience reporting at each forum; and	Medium	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.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Divisional Director WBS & VCC Alan Prosser, Director of WBS & Rachel Hennessy/Paul Wilkins Director of VCC	31/03/2023	Action Closed				n/a	n/a	n/a	March/April 2023
	1.1c 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 theintranet.	Medium	See 1.1 a	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	~~Nigel Downes,~~ Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extendion Request Agreed April 2023 Audit Committee: 30 May 2023	Action Closed					2		Aug-23
Matters Arising 2	**Experience Feedback Reporting** 2.1 As part of the intended review of quality metrics and reporting, the Trust should: 2.1a. Review the patient and donor experience information required to achieve the objectives of each forum and tailor the reports as appropriate; and	Medium	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.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Viv Cooper (VCC) & Zoe Gibson (WBS), Head of Nursing Professional Standards & Digital & Nigel Downes, Deputy Director Nursing, Quality & Patient Experience	31/03/2023	Action Closed				n/a	n/a	n/a	March/April 2023
	2.1a	Medium	All BI dashboards to include CIVICA patient / donor experience outcomes from service level to Board	~~Nicola Williams, Director of Nursing, AHP's & Medical Scientists~~ Carl James, Director of Strategic Transformation, Planning & Digital - TBC	Emma Powell, Head of Information	30/04/2023 Extension Request Agreed July Audit Committee end July 2023. Extension request agreed in October 2023 Audit Committee 31st October 2023	Complete	Currently still waiting and chasing Civica. No further update.	Data feed into the warehouse has been resolved. Awaiting specification for the measures needed within the dashboard. Discussions at Executive Directors on 10 October 2023 regarding ability to fund non-recurrent capacity to expedite quality metrics / dashboard work (agreed in principle). Discussions regarding specification will be undertaken with cancer and blood services during October to enable potential procurement of additional capacity to undertake work in2023/2024.	Further Update November 2023: **Complete.** The plan for initial development of the PMF and QAS dashboards was approved at the Trust Integrated Quality and Safety Group last week for an April '24 delivery. Update November 2023 The Civica feed to the Trust data warehouse has now been resolved and the data is available to support the required measures. There is one Civica patient experience measure to include in the Q&S and PMF dashboards % of Patients Who Rate Experience at VCC as excellent (PREMS) which is already available in the current PMF. The plan to develop the BI dashboards for Q&S and PMF is being agreed in November at which stage this actionwillbeclosed.		6	2	Nov-23
	2.1b. Ensure that reports contain succinct, concise executive summaries that clearly highlight key messages.	Medium	b. As outlined in 2.1.a	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Emma Powell, Head of Information	30/04/2023	Action Closed				n/a	n/a		March/April 2023
Matters Arising 3	**Feedback to Staff** 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 reportingmechanisms.	Medium	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.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	~~Nigel Downes,~~ Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extension Request Agreed April 2023 Audit Committee: 30 May 2023	Action Closed					2		Aug-23

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 UNHSTrust

Performance Management Framework					Assurance Rating: Reasonable			Date Received at Audit Committee: 12 January 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Matter arising 1: Project Governance (Operation)** 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	1.1 Accepted. We will implement the recommendation throughout the remaining phases of the PMF project.	Carl James, Director of Strategic Transformation, Planning & Digital	Peter Gorin, Head of Corporate Strategic Planning &Performance	Q2 2023/24	Action Closed	n/a	n/a	n/a				Jul-23
Matter Arising 2	**Matter arising 2: Quality of report narrative and actions (Design)** 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	2.1 Accepted. PMF training will be offered to all staff and stakeholders who provide input into and / or review the PMF.	Carl James, Director of Strategic Transformation, Planning & Digital	Peter Gorin, Head of Corporate Strategic Planning &Performance	Q2 2023/24	Action Closed	n/a	n/a	n/a				Jul-23
Matter Arising 2	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	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).	Carl James, Director of Strategic Transformation, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital, supported by Divisional and Support Service Directors - Alan Prosser, Director of WBS. Rachel Hennesy, Interim Director of VCC / Paul Wilkins, Director of VCC	Q2 2023/24	Action Closed	n/a	n/a	n/a				Jul-23
Matter Arising 3	**Matter arising 3: Metrics (Design)** 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	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.	Carl James, Director of Strategic Transformation, Planning & Digital	Peter Gorin, Head of Corporate Strategic Planning &Performance	Q1 2023/24	Action Closed	n/a	n/a	n/a				Jul-23
Matter Arising 4	**Matter arising 4: KPI definitions (Design)** 4.1 Formally document the process to add / remove / change KPIs (including their definition and calculation method) within the PMF.	Low	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	Carl James, Director of Strategic Transformation, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital	Q1 2023/24	Action Closed	n/a	n/a	n/a				Jul-23
Matter Arising 4	Ensure the KPI glossary has explicit links to statutory / legislative reporting measures (including definition, calculation formulae, latest source).	Low	4.2 Accepted. The PMF Project Plan requires completion of the KPI Glossary prior to PMF full 'go live' from 2023/24	Carl James, Director of Strategic Transformation, Planning & Digital	Peter Gorin, Head of Corporate Strategic Planning & Performance	Q1 2023/24	Action Closed	n/a	n/a	n/a				Jul-23
Matter Arising 5	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	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.	Carl James, Director of Strategic Transformation, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital, supported by Divisional and Support Service Directors - Alan Prosser, Director of WBS. Rachel Hennesy, Interim Director of VCC / Paul Wilkins, Director of VCC and Peter Gorin, Head of Corporate Strategic Planning & Performance	Q2 2023/24	Complete	Next meeting of PMF Subgroup 10/10/23 looking to review final version of Glossary of KPI Terms, Definitions and Calculation Bases guidance document developed which sets out KPI definition; numerator/denominator/data source/ person accountable for assuring it and responsible for maintaining supporting evidence over the accuracy of reported performance against individual KPIs	As the next meeting of PMF Subgroup is on 10/10/23. (before action tracker return deadline) next update will report progress. We will be looking to review final version of Glossary of KPI Terms, Definitions and Calculation Bases guidance document developed which sets out KPI definition; numerator/denominator/data source/ person accountable for assuring it and responsible for maintaining supporting evidence over the accuracy of reported performance against individual KPIs.	**Complete.** Glossary document complete with current KPIs (numerator/denominator; data source; etc.). The Glossary of KPIs Definitions and Calculation bases will continue to evolve and be updated for new WBS and Estates measures plus new Clinical, Workforce and Equity KPIs as they are introduced to the PMF Performance Reports in the future.				Nov-23
Matter Arising 5	5.2 Develop and document processes to assure over the accuracy of calculations / adherence to definition (e.g., independent spot checks)	Low	5.2 Accepted. We will develop and document processes to ensure the accuracy of the calculations.	Carl James, Director of Strategic Transformation, Planning & Digital	Peter Gorin, Head of Corporate Strategic Planning & Performance	Q2 2023/24	Complete	Next meeting of PMF Subgroup 10/10/23 looking to review final version of Glossary of KPI Terms, Definitions and Calculation Bases guidance document developed which sets out KPI definition; numerator/denominator/data source/ person accountable for assuring it. Consider requesting Internal Audit to carry out spot checks on a soample of KPIs. This document also includes escalation parameters and an audit trail of KPI changes and reason	**Complete.** Glossary document complete. The Trusts audit plan will pick up accuracy checks as part of routine audit process on the Trusts' audit programme	n/a				Oct-23
Matter Arising 5	Ensure the detailed guidance for each metric within the KPI glossary explicitly details assurance mechanisms over the quality of source data in the data confidence section, including considering and relying on any existing assurance mechanisms.	Low	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.	Carl James, Director of Strategic Transformation, Planning & Digital	Peter Gorin, Head of Corporate Strategic Planning & Performance	Q1 2023/24	Action Closed	n/a	n/a	n/a				Jul-23

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

External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 25 April 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 1	**Improving administrative governance arrangements** We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: - missing committee meeting papers. - the Register for Gifts, Hospitality and Sponsorship and the Declaration of Interest Register; and	High	Tracking has been implemented to ensure the completeness and timely publication of committee agenda bundles and other key governance papers as part of the weekly Corporate Governance Team meeting.	Lauren Fear - Director of Corporate Governance and Chief of Staff	Kay Barrow, Corporate Governance Manager	22nd March 2023	Action Closed				n/a	n/a	n/a	May-23
Recommendation 1	**Improving administrative governance arrangements** We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: - the ten year strategy and enabling strategies. The Trust should establish a clear and robust process to ensure it publishes key papers and documents on its website in a timely and ongoing basis	High	10-year strategy: An engagement and communications plan has been developed to the support the launch of the Trust 10-year strategy in May 2023. This will include publishing the strategy on the Trust website	Carl James - Executive Director of Strategic Transformation, Planning and Digital	Carl James - Executive Director of Strategic Transformation, Planning and Digital	31st May, 2023 Extension request agreed in October 2023 Audit Committee 31 October 2023	Complete	Final documents received and are undergoing Welsh translation - launch planned for October 2023	Translated versions expected on 18th October and launch will occur in October 2023	**Complete.** The ten Year Strategy and Enabling Strategies have been published on the Trust Website. The Destination 2033 was launched in November 2023. **Complete.** The Trust has established a clear and robust process to ensure it publishes key papers and documents on its website in a timely manner. This is included in the Corporate Governance Manual and ensures this aspect is explicitly captured as a key responsibility for the role of the Meeting Secretariat.		5	1	Nov-23
Recommendation 2	**Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies** The Quality, Safety, Performance Committee has not received the log which tracks recommendations relating to the quality and safety of services made by external inspection and regulatory bodies since early in 2020. The Trust should immediately reinstate the tracker to enable the committee to oversee, scrutinise, and challenge the progress it is making in addressing both quality and safety recommendations and any relating to performance	High	The Quality & Safety Extract of the Trust Wide Legislative & Regulatory Compliance Register will be received at each meeting of the QSP Committee - together with the associated Improvement Plan using the 7 levels of assurance template. Note: The Trust wide Legislation & Regulatory Compliance Register is already established and received in full by the Trust Audit Committee.	Nicola Williams Executive Director of Nursing, AHP &Health Science	Zoe Gibson, Head of Quality & Safety and Emma Stephens, Head of Corporate Governance	Mar-23	Action Closed				n/a	n/a	n/a	May-23
Recommendation 3	**Establishing measurable outcomes for strategic priorities** The Trust has translated its strategic priorities into specific objectives and actions in the 2022-25 IMTP (including timescales for delivery). The Trust should seek to articulate the intended outcomes for each strategic objective/action in future IMTPs, including what success would look like	High	The Trust IMTP 2022-2026 sets out a range of specific objectives related to their delivery which are timebound. Further work will be undertaken to: (i) improve the SMART elements of the objectives (ii) align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase2)	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	30th March, 2023	Action Closed				n/a	n/a	n/a	May-23
		High	(ii) align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Dec-23	Action Closed				n/a	n/a	n/a	May-23
Recommendation 4	**Enhancing reporting on 2022-25 IMTP Delivery** The Trust's arrangements for reporting delivery of the 2022-25 IMTP are reasonable, but it needs to better describe the impact the actions are making. The Trust should report on the impact of actions delivered to date to allow the Board to better understand the extent that delivery of the IMTP is making a difference and determine any actions that need to be rolled forward to the 2023-26 IMTP	High	The Trust IMTP for 2023-2026 will outline the impact/benefits of actions we are taking as outlined in our IMTP. The process for developing the IMTP has included an assessment of actions which should be rolled forward to 2023-2026. In respect of reporting, we will ensure that progress update are provided to: - Senior Leadership Team at their monthly meetings - Executive Management Board at their monthly meetings - Quality, Safety and Performance Committee at their bi-monthly meetings - Trust Board at their bi-monthly meetings	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Action Closed				n/a	n/a	n/a	Jun-23
Recommendation 5	**Improving reporting on the benefits arising from digital investments** Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessments of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	High	The further development of digital benefits will be undertaken in several ways: (i) a range of key performance indicators that are reported to the Executive Management Board	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Overdue	BI prioritisation plan agreed at EMB in July 2023. Initial measures for digital services in place. Plans in place to develop a range of new measures across the whole Trust (frontline and support services) over the next 3 - 5 years. A further discussion with the Audit Committee would be welcomed to determine how to best close this action/demonstrate delivery of the recommendation given the long term / constant evolution of output/outcomes measures across the organisation.		Digital measures continue to be included in the Performance Management Framework (PMF). The QSP Digital report format has been updated to show more clearly the impact being delivered by the Digital team and has been through two QSP reporting cycles. Reporting arrangements (including benefits) have been agreed with both the Velindre Futures and Welsh Blood Service Futures programmes and are in operation and a new Business Change Manager role has been appointed using 12 months DHCW funding to work on benefits realisation. Now that the Digital Strategy has been published a new set of measures (e.g. on Digital Inclusion) have been defined to show progress towards the strategy and will be available for inclusion in the PMF from Jan '24. The Trust approach to creating dashboards for Quality and Safety and the Performance Management Framework has been agreed and the priority measures will be available from April '24, these measures include Digital measures. Activities on this will close in April '24, although we will continually work on measures and the dashboards.	Requested extension date - 31 April 2024.			
Recommendation 5		High	(ii) improving the clarity of benefits in projects/business cases on a case-by-case basis	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Not time bound - as related to each business case	Action Closed				n/a	n/a	n/a	Jun-23
Recommendation 5		High	(iii) implementing the measures set out within the digital strategy and key service plans (e.g., quality metrics) which will demonstrate the impact of digital services on service quality and outcomes and including an overall % spent on digital technology	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Feb-24	On Target	BI prioritisation plan agreed at EMB in July 2023. Initial measures for digital services in place. Plans in place to develop a range of new measures across the whole Trust (frontline and support services) over the next 3 - 5 years. A further discussion with the Audit Committee would be welcomed to determine how to best close this action/demonstrate delivery of the recommendation given the long term / constant evolution of output/outcomes measures across the organisation.	BI prioritisation plan agreed at EMB in July 2023. Initial measures for digital services in place. Plans in place to develop a range of new measures across the whole Trust (frontline and support services) over the next 3 - 5 years. A further discussion with the Audit Committee would be welcomed to determine how to best close this action/demonstrate delivery of the recommendation given the long term / constant evolution of output/outcomes measures across the organisation.					

Audit Action Plan

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

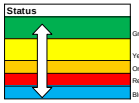
* Unless a more appropriate timescale is identified/agreed

Velindre UNHS Trust

Clinical Audit (Velindre Cancer Centre) Final Internal Audit Report | **Assurance Rating: Reasonable** | **Date Received at Audit Committee: 25 April 2023**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Arising 1: Clinical Audit Actions** 1.1 a. The clinical audit action plan should be updated in a timely manner. We understand the implementation of AMaT will support this, as the Clinical Leads will be responsible for inputting and updating action plans.	Medium	1.1a The Clinical Audit Team is currently piloting AMaT with the anticipation to roll the system out across all audits in the team. A review of audit systems in the organisation is being undertaken to ensure no duplication of systems and explore how AMaT can support other areas of the Trust.	Jacinta Abraham, Medical Director	Nicola Hughes, Medical Directorate Manager	Jun-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 1	1.1 b. Where clinical audits lead to clear actions, Clinical Leads should ensure actions noted within the clinical audit action plan are SMART. The use of AMaT will provide the foundation for standardisation and should assist with creating SMART actions. The Clinical Audit Team should undertake spot checks on the actions to verify this.	Medium	1.1b Once the SMART action guide (see 1.1c below) has been produced, the Clinical Audit Team will undertake spot checks on actions to ensure they are SMART.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Apr-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 1	1.1 c. Guidance and training on developing SMART actions should be provided to Clinical Leads.	Medium	1.1c Produce a SMART action training guide for all audit leads to follow.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Apr-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 1	1.2 a. The clinical audit action plan should identify whether a re-audit is required, along with the reason and timescales therefor.	Medium	1.2a Where re-audit is required, this is included in the action plan, a section will be added to document the reason for re-audit. Timescales are usually recorded. Not all audits require re-audit this is identified via the recommendation or documented on the proforma. Ensure where re-audits are required that all documentation reflects this clearly.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Mar-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	May-23
Matters Arising 1	1.2 b. The Trust should develop a process for independently verifying implementation of actions and benefits realisation where re-audit is not planned. This could be undertaken on a spot-check / sample basis and could be done by the Clinical Audit Team or, to create resilience, by a clinician who was not involved in the original audit.	Medium	1.2b Formalise the current process to evidence actions and benefits have been undertaken or realised.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jun-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 2	**Matter Arising 2: Clinical Audit Best Practice** 2.1 The Trust should consider the above points and the wider HIQP clinical audit best practice guidance as it continues to develop its clinical audit activities, and reviews quality governance mechanisms as part of the Quality & Safety Framework Implementation Plan.	Low	2.1 All best practice identified in this report to be reviewed and applied where possible to improve the effectiveness of clinical audits.	Jacinta Abraham, Medical Director	Catherine Pembroke, Medical Clinical Audit Lead (Oncology Consultant)	Jul-23	Complete		**Complete.** Best practice principles identified in the report have been reviewed. using AMat for all clinical trials will support a rolling clinical audit programme that covers the different stages of individual projects. A new report is being developed from AMaT identifying new audits and progress of open audits which will be subitted to VCCQSMG bi-monthly along with best practice guidance if clinical audit is best suited to develop improvements. . Working towards a QI hub, however this will take time to implement and embed. Current practice to continue with with best practice principles in mind with agreed governance route for approval nd submission to QSMG.	n/a	n/a	n/a	n/a		Oct-23
Matters Arising 3	**Matter Arising 3: Centralised Clinical Audit Function** 3.1 The Trust should consider joining the divisional clinical audit teams into a centralised Trust clinical audit team.	Low	3.1 Discuss the options regarding feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation.	Jacinta Abraham, Medical Director	Jacinta Abraham, Medical Director	01/07/2023 Extension request agreed in October 2023 Audit Committee 31 December 2023	On Target		Discussions have taken place, WBS are reviewing with a view to recruit a post where clinical audit is identified in the JD, and will work along side the VCC clinical audit team. This will support Trust working,process and governance alignment. Extension is required for WBS to identify what role will include Clinical Audit.	JD completed and currently going through Job Matching Panel. Further discussions between VCC/WBS to be implemented.	Requested Extension to January 2024 in October 2023 Update.	6		
Matters Arising 4	**Matter Arising 4: Robustness of SST Minutes** 4.1 The Trust should ensure that SST meeting minutes clearly demonstrate discussions around clinical audit (plan progress, audit findings, learning, action implementation, etc).	Medium	4.1 Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jul-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 4		Medium	4.1 Review of SST meetings to establish how discussions are documented with progress of clinical audits	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jul-23	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 5	**Matter Arising 5: Clinical Audit Reporting and Oversight Mechanisms** 5.1a As part of the review of quality and safety governance and reporting mechanisms, the Trust should address the above points to further enhance the efficiency and effectiveness of the scrutiny and oversight of clinical audit activities from 'floor to Board.	Low	5.1a The new Trust Integrated Quality and Safety Governance group will help with the triangulation of clinical audit outcomes across the Trust and ensure escalation to the Quality and Safety committee as appropriate. VCC will develop a process map to evidence the report structures within VCC for clinical audit. Reporting requirements are being reviewed in line with the quality hubs.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Dec-23	Complete		Process and governance map of current reporting structure has been developed for VCC and will be submitted for comment to VCCQSMG.	**Complete.** To be Noted at the next VCCQSMG meeting.	n/a	n/a	n/a		Nov-23
Matters Arising 5	5.1 b The Trust should ensure that the agreed clinical audit reporting mechanisms are clearly communicated to relevant staff and adhered to at all levels of the Trust.	Low	5.1b **VCC**: Current process map of the VCC governance and reporting mechanism to be added to the clinical audit intranet page.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	May 2023	Action Closed	n/a	n/a	n/a	n/a	1	1	Jul-23
		Low	5.1b **WBS**: We have strengthened the reporting of Clinical Audit within the WBS by making it an integral part of the Welsh Blood Service Clinical Governance Groups, reporting to the Regulatory Assurance and Governance Group (RAGG). We have recently added a separate report including national comparative audits.	Jacinta Abraham, Medical Director	Edwin Massey, Deputy Medical Director WBS	Completed	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	May-23

Audit Action Plan



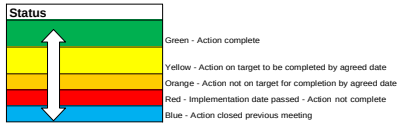
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Capital Systems Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Airising 1: Governance - Capital Procedures (Operation)** 1.1 FP01 Capital Management Procedure should be reviewed and updated.	Low	1.1 Accepted: The Capital Management Procedure will be updated and will be submitted for approval following Trust governance requirements.	Carl James, Director of Strategic Transformtion, Planning & Digital / Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting	30 November 2023	Overdue	Capital management procedure is still under review following the formation of the Strategic Capital Board. At present is on course to be completed within the agreed implementation date. A meeting of key personnel met at the Start of Sep with a further meeting scheduled for wc18th September to update and review the procedure following significant changes following the Establishment of SCB.	The procedure has been updated to reflect the changes required following the formation of the Strategic Capital Board. The procedure will be going to the Capital Planning Group on the 10th October for comment / review before following the required governance route prior to being submitted to Audit Committee in December. **Request one month extension to end of December to allow for governance approval route.**	Procedure has been updated and is currently going through the correct governance route. The procedure is still expected to be approved by Audit committee on the 19th Dec. The full timing and governance route is provided below Capital Planning Group - 14th Nov Strategic Capital Board - 16th Nov EMB - 04th Dec Audit Committee - 19th Dec	31-Dec-23	1	1	
Matters Arising 2	**Matter Arising 2: Governance - Dicisional Structure Operation)**The 2.1 VCC capital governance structure should be reviewed, and either: a) The Business Planning Group re-instigated as per the terms of reference; or b) A revised structure implemented, to ensure an appropriate forum is in place for the monitoring of capital requirements and reporting to the Senior Leadership Team.	Medium	2.1 Accepted: The VCC Business Planning Group will be re-instigated in line with the approved Term of Reference.	Carl James, Director of Strategic Transformtion, Planning & Digital	Paul Wilkins, Director of Cancer Services, Velindre Cancer Centre	30 June 2023	Action Closed	**Complete.** VCC meeting structure has been revised and the Business Planning Group has been re-intituted. Business planning group is in place and actively running. Capital planning is a standard agenda item. BPG reports into SLT. Where necessary Capital planning updates are formally submitted to SLT.	n/a	n/a	n/a			Sep-23
Matters Arising 3	**Matter Arising 3: Governance - Capital Planning Group (Operation)** 3.1 Capital Planning Group (or other equivalent forum) minutes should: • Be prepared in a timely manner after each meeting, and in readiness for sign-off at the subsequent meeting; • Clearly document any decisions taken (for example in relation to formulation of the annual discretionary programme); and • Be centrally retained in a location accessible by key forum members, including as a minimum the Chair and Deputy Chair. It is noted that a number of organisations now utilise Microsoft Teams to facilitate meeting administration, with a dedicated Teams channel being a useful central location for retention of key meeting documentation.	Medium	3.1 Accepted: The following actions will be taken: • Minutes will be made available no later than two weeks after each meeting for review by the Chair of the Group • All key decisions taken will be clearly documented • A shared folder will be established and all members of the Capital Planning Group will have access to minutes and other associated papers	Carl James, Director of Strategic Transformtion, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	30 June 2023	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 4	**Matter Arising 4: Governance - Capital Delivery Group Terms of Reference (Operation)** 4.1 The terms of reference for the Capital Delivery Group should be approved in a timely manner, in line with the wider change timeline.	Low	4.1 Accepted: The revised terms of reference will be submitted for approval through Trust agreed governance arrangements.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital	30 June 2023	Action Closed	**Complete.** Terms of reference for the capital planning group have been reviewed and refreshed e.g. removing Carl James and Matthew Bunce as members / chair / deputy chair and replaced by Phil Hodson and Steve Coliandris. These were approved by the Capital Planning Group on 8th August 2023.	n/a	n/a	31-Aug-23	2	1	Sep-23
Matters Arising 5	**Matter Arising 5: Prioritisation Framework - Consistency of application (Operation)** 5.1 Clarification is required within the Capital Prioritisation Framework as to whether there are any exceptions to the requirement to complete the Capital Prioritisation Information Template (including in the management of "discretionary" funds).	Low	5.1 Accepted: The Capital Prioritisation Framework will be reviewed and updated in line with the recommendation.	Carl James, Director of Strategic Transformtion, Planning & Digital	Deputy Director of Planning & Performance	30 June 2023	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jun-23
Matters Arising 6	**Matter Arising 6: Prioritisation Framework - Annual Approval Timeline (Operation)** 6.1 The discretionary capital programme should be formulated and agreed prior to the start of the financial year wherever possible. The planning cycle in the Divisions should be aligned to support this.	Medium	6.1 Accepted: Where possible the capital programme will be approved prior to the start of the financial year. However, it should be noted that this is not always possible due to uncertainty regarding our discretionary capital allocation from WG and / or our contribution to centrally funded schemes e.g. delay in approval of All-Wales business cases e.g. nVCC.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital With support from VCC and WBS.	31 March 2024 and ongoing thereafter	On Target		The IMTP planning process will be amended to enable the discretionary capital programme to be agreed before the commencement of each financial year. The process has commenced for 2024/2025 and is on-track	The IMTP planning process will be amended to enable the discretionary capital programme to be agreed before the commencement of each financial year. The process has commenced for 2024/2025 and is on-track	n/a	n/a	n/a	

Audit Action Plan



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

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Velindre UNHS Trust

Trust Priorities - Final Internal Audit Report | **Assurance Rating: Reasonable** | **Date Received at Audit Committee: 26 July 2023**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Enhancements to the prioritisation process (Design).** 1.1 The Trust could further enhance the benefits of the Prioritisation Framework by using it in discussions with external stakeholders (e.g., Welsh Government, commissioners, Llais, etc.) during the annual planning process.	Low	1.1 Agreed - The Trust is currently developing its engagement plan of the development of our plan during 2023/24. This will include a process for clearly articulating our key organisational priorities (output of the prioritisation framework) to both our internal and external stakeholders.	Carl James, Director of Strategic Transformtion, Planning & Digital / Matthew Bunce, Executive Director of Finance	Philip Hodson, Deputy Director of Planning & Performance	29/09/2023	Overdue	A meeting has been arranged for 27.09.2023 to develop the next IMTP 2024/2025 to 2026-2027 with Executive Team, Service Planning Leads and Enabling Leads. The key organisational priorities will be incorporated within the discussions to develop the plan.	Meeting on 27/09/2023, where organisational priorities were discussed, it was agreed that there would be a follow-up meeting on 26th October 2023 with Executive Team, Service Planning Leads and Enabling Leads. It was agreed that organisational priorities would be agreed during this meeting.	It is now assumed that the submission date for the IMTP is 28th March 2024 and NOT the 31st January 2024. Therefore it has been agreed that the Trust should use this extension to allow for further engagement with the Executive Management Board, including individual meetings with each Executive Director, the Strategic Development Committee and with the Trust Board. As a result an agreed set of priorities will now be finalised by 22nd December 2023.	Revised implementation date of 22nd December 2023.	3	1	
Matters Arising 1	1.2 The Trust could consider extending or tailoring the Prioritisation Framework to incorporate the divisional and enabling strategies to support consistency and robustness in prioritisation and decision-making at all levels within the Trust.	Low	1.2 Agreed – The Trust will review how the prioritisation framework and supporting methodology could be used to support other areas of service development. As part of this work, we will consider if it should be used to support prioritisation in divisional and enabling strategies.	Carl James, Director of Strategic Transformtion, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	31/10/2023	Complete	During the developing IMTP Meeting being held on 27.09.2023 with Executive Team, Service Planning Leads and Enabling Leads the review of the prioritisation framework and support methodology will be discussed across the whole organisation.	Meeting on 27/09/2023, with the Executive Team, Service Planning Leads and Enabling Leads, it was agreed the prioritisation framework and supporting methodology would be used to support the development of the IMTP . This will include the development of both service and enabling plans.	**Complete.** This action was completed in October 2023 as per October update but not marked as complete for October EMB in error.		n/a	n/a	Oct-23
Matters Arising 2	**Risks to delivery – finance and resourcing (Design).** 2.1 The Trust should use the deliverability section of the Framework as part of the annual planning process, alongside the existing financial planning approach to enhance the overview on the deliverability of Trust priorities as a whole, rather than potentially considering priorities on a more granular basis.	Medium	2.1 Agreed - The Trust will use the deliverability section of the Framework to support the development of our plan for 2023/24.	Carl James, Director of Strategic Transformtion, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	31/10/2023	Complete	These discussions will be held during the developing IMTP meeting on 27.09.2023.	Meeting on 27/09/2023, with the Executive Team, Service Planning Leads and Enabling Leads, it was agreed the prioritisation framework and supporting methodology would be used to support the development of the IMTP . This will include the development of both service and enabling plans.	**Complete.** This action was completed in October 2023 as per October update but not marked as complete for October EMB in error.		n/a	n/a	Oct-23
Matters Arising 2	2.2 The Trust should revisit the Prioritisation Framework, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned	Medium	2.2 Agreed - The Trust will revisit the Prioritisation Framework at the end of the financial year, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned.	Carl James, Director of Strategic Transformtion, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	31/03/2024	On Target	These discussions will be held during the developing IMTP meeting on 27.09.2023.	Trust will revisit the Prioritisation Framework at the end of the financial year, including the completion of the deliverability section.			n/a	n/a	

Audit Action Plan

Priority	
Low	< 3 months *
Medium	< 1 month *
	* Unless more appropriate timescale is identified / agreed

Velindre UNHS Trust

Follow Up: Previous Recommendations - Draft Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 26 July 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2023	Update October 2023	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
TAF 1	**Trust Assurance Framework. Completion of the TAF dashboard.** Ensure the new TAF template is used effectively to: - develop SMART action plans to clearly address control / assurance deficiencies for each strategic risk. - provide clear progress updates and justification for action closure.	Low	* Continue to operationalise and embed discussion at the weekly Trust risk meeting with specific focus on the further development of SMART Action Plans. * Establish regular touchpoints within corporate teams to embed the Trust Assurance Framework. * The new Trust Assurance Framework Template ensures the focus on actions and gaps in controls. *A one page addendum to be produced when a cycle of business is approved for a Committee each year. The addendum will assure that the Trust Risk Register and Trust Assurance Framework have been taken into account and provide a short explanation of how.	Lauren Fear - Director of Corporate Governance and Chief of Staff	Lauren Fear - Director of Corporate Governance and Chief of Staff	31/10/2023	Complete	*Operalisation and embedding of risk continues to be discussed in risk meetings. SMART Action Plans are included in the discussion and work continues to include SMART action plans in risks on Datix. *Following the refresh of the Trusat Assurance Framework work is underway to full establish the new template and move to an automated system. This will include regular attendance at team meeting to start to embed a regular update process for corporate teams. *The new template includes SMART action plans and continues to include focus on gaps in control. *Addendum will be included for committee approval, however the regular inclusion of risk and assurance in all committee discussions will be evident by inclusion of the Trust Risk Register and Trust Assurance Framework in relevant committee meetings.		**Complete.** All actions now complete.		n/a	n/a	Nov-23
FPR 1	**Follow Up.** **Trust Audit Action Tracker.** a. Re-publicise the Audit Action Tracking procedure and ensure compliance, including formal monitoring by divisional/service management teams and provision of appropriate monthly Tracker updates (repeat offenders for inadequate updates should be held accountable).	Medium	a. Agreed: Whilst the Audit Action Tracker Procedure is embedded into each Audit Report Section of the Audit Action Tracker Spreadsheet so is shared with responsible managers every time an update is requested, there needs to be a formal Re-publication of the Audit Action Tracking procedure through each of the Service Division SMT/SLT meetings and EMB. In addition, we will work with the Service Division SMT / SLT teams and EMB on how to provide information to enable them to monitor compliance with requirement to provide monthly updates.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	a. 30/09/2023	Action Closed	**Complete.** Presentation on the Audit Action Tracker Procedure added to the Agenda for VCC SLT Part 2 on the 20th September 2023, and WBS SMT Huddle 22 September 2023 and WBS SLT 11 October 2023. The Audit Action Tracker is presented monthly at EMB to note and monitor the compliance..				n/a	n/a	Sep-23
FPR 1	b. Set realistic action deadlines and monitor the frequency of deadline extension requests.	Medium	b. Agreed: As part of the Re-publication of the Audit Action Tracking procedure we will remind the SMT / SLT and EMB of the importance of setting realistic action deadlines. As well as the length of the completion date extensions requested a new column 'Extension Requests Total' has now been added to the Tracker to state how many extension dates have been requested to help monitor the frequency of deadline extension requests.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	b. 30/09/2023 - Realistic target dates reminder; Completed - Extension request frequency column added to tracker	Action Closed	n/a				n/a	n/a	Aug-23
FPR 1	c. Retain the date of action completion in the Tracker	Medium	c. Agreed: An extra column 'Date Completed' has now been added to the Tracker to capture the date the action was completed.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	c. Completed	Action Closed	n/a				n/a	n/a	Jul-23
BCE 1	**Board Committee Effectiveness. Cycles of Business and Committee Agendas.** Ensure the cross-referencing of the TAF/TRR with cycles of business is undertaken and reported to the relevant committee(s).	Low	* The new Trust Board/Committee Template in section 5 captures the requirements around strategic risk and section 6 operational risk. This will facilitate cross referencing across all Trust wide meeting papers for reporting through the governance structure. * The Executive Lead at operational level will be responsible for ensuring the visability of risk to each of the responsible Executive Lead at Committee level.	Lauren Fear - Director of Corporate Governance and Chief of Staff	Lauren Fear - Director of Corporate Governance and Chief of Staff	31/10/2023	Complete			**Complete.** All actions now complete.		n/a	n/a	Nov-23
IPC 2	**Infection Prevention & Control. IPC Reporting.** Ensure the VCC IPC upward reporting uses the agreed IPC report template, including identifying lessons learnt.	Low	As per the audit requirement the VCC IPC meeting has implemented the use of the agreed IPC report template from the meeting held June 14th 2023, this will enable and make clear the lessons learnt.	Nicola Williams Executive Director of Nursing, AHP & Health Science	Nicola Williams Executive Director of Nursing, AHP & Health Science	Complete	Action Closed	n/a				n/a	n/a	Jul-23

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 *

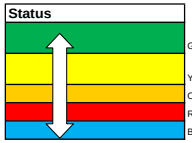
* Unless a more appropriate timescale is identified / agreed

Velindre UNHSTrust

Digital Strategy & Transformation Programme - Final Internal Audit Report	Assurance Rating: Reasonable	Date Received at Audit Committee: 19 October 2023

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Digital Strategy Publication (Operation).** 1. The digital Strategy should be published, and a communications exercise undertaken to publicise the strategy and the Trusts digital intent.	Medium	1.1 The Digital Strategy has been approved and it is being prepared for publication alongside the refreshed Trust strategy and other enabling strategies. This will include an engagement plan.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	31 October 2023	Complete	**Complete.** Digital Strategy has now been published on the Trust website.				Nov-23
Matters Arising 2	**Governance Framework (Operation).** The governance structure for digital should be re-considered, with further consideration given to establishing a group where all digital items are considered.	Medium	A Digital Programme Group is being established which will bring Digital together for oversight into the Executive Management Board.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	31st October 2023 for Digital Programme Group.	Complete	**Complete.** Digital Programme Board has been established and had it first meeting on the 5th Oct.				Nov-23
Matters Arising 2		Medium	An Executive / Board level review will be needed to look at the case for creating a single forum where Digital is owned in the Board committees	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl James, Director of Strategic Transformtion, Planning & Digital	30th November for Exec/Board Review.	Complete	**Complete.** The Strategic Develoment Committee is the primary committee to own digiital matters. It will receive its business from the Digital Programme Board				Nov-23
Matters Arising 3	**Digital Culture (Operation).** Work should be undertaken to change the digital culture within the organisation: -Communication of Digital Strategy and its aims; -Embedding digital within the service and ensuring ownership; and -Ensuring staff understand digital and their role in successful delivery of digital transformation.	Medium	The Digital Programme is in the process of being set up and the first meeting to confirm arrangements and terms of reference is scheduled for the 5th Oct. The proposed remit for the Digital Programme includes work on VUNHST as a digital organisation. The communication of the Digital Strategy is to be completed by the end of October 2023.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	31st October 2023	Complete	**Complete.** Digital Strategy has now been published on the Trust website. The embedding of a digital culture is one of the key aims of the strategy and can/will take many years to achieve (as is the case in all organisations). Progress wil be monitored using a range of KPIs over the period of the digital strategy A WTE has been funded through DHCW and started in Oct '23 to work on this for 12 months to increase resource behind the plan .				Nov-23
Matters Arising 4	**Digital Inclusion (Operation).** Work to progress the digital inclusion action plan and digital skills and awareness within the organisation should be accelerated.	Medium	A Digital Inclusion action plan is in place. This will be reviewed and opportunities where the work can be accelerated will be identified and included in the next IMTP where appropriate. Where further investment would be required to accelerate the work a business case will be prepared for EMB.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	30th November 2023	On Target	Digital inclusion will be included in the IMTP. A request for additional non-recurrent revenue funding for Digital Inclusion has been made to EMB.				
Matters Arising 5	**Older Technology Risks (Operation).** The risk relating to the use of older technologies on the delivery of the Digital Strategy and the Trusts digital transformation aims should be clearly stated.	Medium	Review risks to the Digital Strategy relating to the use of older technologies and make sure they reflected accurately in risk registers and the Trust Assurance Framework.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl Taylor, Chief Digital Officer	31st October 2023	Complete	**Complete.** Digital risks have been reviewed with and reflected in risk registers. The amount of Board level risks for Digital has correspondingly reduced.				Nov-23

Audit Action Plan



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

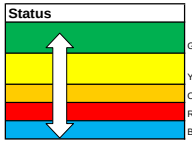
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Review of Workforce Planning Arrangements – Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 19 October 2023				
Ref	**Recommendation**	**Priority**	**Management Response**	**Executive/Director Lead**	**Responsible Manager/Officer Lead Department where lead works**	**Agreed Implementation Date**	**Status**	**Update November 2023**	**Requested Extension Date**	**Extension (Months)**	**Extension Requests Total**	**Date Completed**
Recommendation 1	**Developing an implementation plan** The Trust's People Strategy is not effectively supported by an implementation plan. This limits the Trust's ability to ensure it has sufficient resource to deliver the strategy, manage risks associated with its delivery, and provide effective oversight of its implementation at committee. The Trust should develop a plan to implement the People Strategy. The plan should include a section that identifies the costs, staff capacity, skills and other resources associated with implementing the People Strategy (high priority).	High	An implementation plan for the Strategy has been developed which highlights risk and governance arrangements.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	September 2023	Complete	**Complete.** A plan to implement the People Strategy is complete and will be presented to EMB run in December. Alongside this plan the workforce team are engaging closely with the development of the Clinical Service strategy to ensure alignment with service and workforce model development. An outline action plan for the development of a strategic workforce plan to support the clinical service strategy will be presented to EMB Shape in November. A summary of the current operational workforce plans in place will be presented to QSP in November.				Nov-23
Recommendation 2	**Developing workforce intelligence.** The Trust is developing a baseline of current workforce capacity to inform its Supply and Shape framework. The Trust should do more to understand the extent of workforce planning activity across its business and to understand future service demand and risk. The Trust should develop a consistent approach to model future service demand to understand the longer-term human and financial resource implications and potential risks to the organisation (medium priority).	Medium	A Supply and Shape governance group is being established to provide governance and accountability regarding the completion of workforce plans across the Trust: • understand the current workforce programmes; • understand the collective priorities in the programmes; • agree the alignment between collective priorities - joining up and aligning initiatives; and • agree the principles of how we work more effectively in an MDT manner. Phase 1 will be to complete a baseline assessment and ensure all departments have a workforce plan in place. Phase 2 will be to develop longer term plans that centre around each site-specific team and will take into account the projects and programmes of work that have workforce planning implications.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	First Workshop in November 2023 A full project plan to be developed following the November session	Not On Target	This has been delayed. Local work plans are being monitored via the Senior Leadership team. A need for a Strategic Workforce plan has been identified but the service model has not as yet been agreed. This is expected early in 2024. The work plan to support the agreed service model will be then be agreed and aligned to operational work plan already in place and being monitored. Following completion of the service model work an assessment of the need for a Supply and Shape group will be assessed.				
Recommendation 3	**Managing risk.** The Trust's Supply and Shape Framework has the potential to highlight new workforce risks. The Trust should review the information in its corporate and strategic risk registers using fresh insight from the Supply and Shape document to identify potential additional sources of assurance and new risks (high priority).	High	The Trust Assurance Framework (TAF) has been under review and is now in the final stages. There has been Strategic Risk refresh working collaboratively with Senior Leadership / Management Teams, Board and Committees and the Executive Management Board. The new template has been developed, taking into consideration Trust-wide frameworks.	Sarah Morley, Executive Director of Workforce and OD	Sarah Morley, Executive Director of Workforce and OD	The TAF is due to Trust Board on 28th September 2023 for approval.	Complete	**Complete.** The current Trust workforce risks have been reviewed in its corporate and strategic risk registers using fresh insight from the Supply and Shape document. The updated TAF to be presented to QSP in November				Nov-23

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 - Review of Workforce Planning Arrangements – Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 19 October 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 4	**Exit surveys.** Whilst the Trust uses exit surveys to understand the underlying reasons for staff turnover, we found that the Trust could do more to actively encourage survey completion. The Trust should develop an approach to increase exit survey response rates and ensure feedback feeds into retention activities (medium priority).	Medium	A project group has been established to review the current exit interview process and create a revised, easy to follow process that utilises technology to its best advantage and avoids single points of failure, resulting in a better experience for the end user and providing informed data for the business to use. The deliverables to achieve this scope are: • Clear and easy process – managers guide on importance of termination; • Increased uptake of return of completed exit interview forms; • Highlight service improvements; • Highlight culture and inform culture change requirements; • Removes single point of failure / reliance on one person; • Provides consistent approach across the whole Trust; • Provides valuable information for recruitment and retention; • Streamlined, digital process, rendered for easy access mobile use, utilising current technology; and • Paperless process reduces risk.	Sarah Morley, Executive Director of Workforce and OD	Amanda Jenkins, Head of Workforce and OD	December 2023	On Target	The Trust has established a Task and Finish Group to address the process with regards to Exit Surveys, to ensure an increased take up and to provide escalation and triangulation of themes. Outputs to be delivered by December 2023				
Recommendation 5	**Education commissioning process.** We found that the Trust is working on improving the basis of its education commissioning. The Trust should develop mechanisms to triangulate the number of staff it trains through the education commissioning process and how many it then employs which will provide the Trust with important intelligence to further strengthen its basis (medium priority).	Medium	Education commissioning places are agreed via the Education and Training Steering group. The students are commissioned by NHS Wales Shared Services Partnership and feedback on progress given to the Steering group. Attrition rates for commissioning are monitored via Health Education and Improvement Wales and fed into the steering group. Moving forward the Supply and Shape report will be developed to include updates on commissioning. Better triangulation with the performance report is also being worked on.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	March 2024	On Target	The Trust has in place process to agree education commissioning. Following the audit this process will be ameliorated to develop mechanisms to triangulate the number of staff it trains through the education commissioning process, reporting on how many students it has retained. This will be reported via the Education and Training Steering group and through EMB Run.				
Recommendation 6	**Monitoring and oversight.** We found weaknesses in the Trust's approach to monitoring and overseeing delivery of its People Strategy. It does not understand the impact of its efforts and a lack of clear information limits thorough scrutiny by the Quality, Safety and Performance Committee. The Trust should develop an approach to better understand the impact of key workforce initiatives and the extent that they are delivering the intended improvements and outcomes. Going forward this should be reported in the annual report on the delivery of the People's Strategy (medium priority).	Medium	Assurance is provided currently via the Workforce and Operational Design report on KPIs to: • Executive Management Board; • Quality Safety and Performance Committee; • Quarterly supply and shape papers are approved by the Executive Management Board and Quality Safety and Performance Committee. The Trust provides an annual report that summarises KPIs and provides an update on the People Strategy Moving forward the Supply and Shape report will be developed to deliver better triangulation with the performance report to provide details of the benefits of Workforce and Operational Design interventions. This will also be summarised in the Annual report.	Sarah Morley, Executive Director of Workforce and OD	Susan Thomas Deputy Director of Workforce and OD	March 2024	On Target	Since the Audit the Trust has improved on its reporting of key workforce initiatives. The Supply and Shape paper has been improved to report on the outputs of the People Strategy. This paper is reported quarterly to EMB Run and QSP. An annual report on the delivery of the People's Strategy has been developed this year also. Incremental improvement is being made.				

Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: December 2023

Document reference: ACU202312

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

About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Velindre University NHS Trust (the Trust). We presented a detailed Audit Plan for our 2023 work programme to the committee on 26 July 2023.

2 Also included is information on:

- other relevant examinations and studies published by the Audit General;
- relevant corporate documents published by Audit Wales (eg fee schemes, annual plans, annual reports); and
- details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Our external audit of the Trust's 2022-23 financial statements is complete, and an unqualified audit opinion was provided.

5 The audit of the Trust's 2022-23 charitable fund accounts has commenced. We intend to present our audit plan to the Charitable Funds Committee on 12 December 2023 and are on track to conclude the audit by the end of January, per the Charity Commission deadline.

Performance audit update

6 **Exhibit 1** summarises the status of our current and planned performance audit work.

Exhibit 1 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
2022 Audit Plan				
Local study - Operational Governance	Chief Operating Officer	A review of each division's governance arrangements to support effective scrutiny of quality, performance, and finance.	**Not started** Timing of fieldwork to be confirmed.	To be confirmed
2023 Audit Plan				
Structured Assessment	Director of Corporate	A review of the corporate arrangements in place at the Trust in relation to: • Board and committee cohesion and effectiveness;	**In clearance**	December 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	Governance and Chief of Staff	• Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.		
Structured Assessment Deep Dive – Financial efficiencies	Executive Director of Finance	Review of arrangements for making financial efficiencies – to be undertaken across all health bodies.	**Not started** Timing of fieldwork to be confirmed.	April 2024
Local project work - Follow-up of quality governance review	Executive Director of Nursing, AHP & Health Science	My audit team will follow-up the Trust's progress in implementing actions to address the findings of my 2022 report on its quality governance arrangements.	**Not started** Timing of fieldwork to be confirmed.	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local project work - Examination of the setting of well-being objectives	Executive Director of Strategic Transformation, Planning and Digital	My audit team will assess the extent to which the Trust has acted in accordance with the sustainable development principle when setting / considering / renewing its well-being objectives.	**Not started** Timing of fieldwork to be confirmed.	To be confirmed

Other relevant publications

7 **Exhibit 2** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 2 – relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Workforce data briefing	September 2023
Approaches to achieving net zero across the UK	September 2023
NHS Wales Finances Data Tool - up to March 2023	September 2023

Additional information

8 **Exhibit 3** provides information on corporate documents published by Audit Wales in the last six months. Links to the documents on our website are provided.

Exhibit 3 – Audit Wales corporate documents

Title	Publication Date
Equality Report 2022-23	**November 2023**
Supporting information for the Estimate for Audit Wales 2024-25	**October 2023**
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2025	**October 2023**
Interim Report 2023	**October 2023**
Biodiversity and Resilience of Ecosystems Plan for Audit Wales 2023 – 2027	August 2023
Annual Report and Accounts 2022-2023	June 2023

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

AUDIT COMMITTEE

Internal Audit Progress Report

DATE OF MEETING	19 December 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	SIMON COOKSON, DIRECTOR OF AUDIT & ASSURANCE
PRESENTED BY	Stephen Chaney, Head of Internal Audit, Audit & Assurance
APPROVED BY	N/A

EXECUTIVE SUMMARY	The purpose of this report is to set out progress against the 2023/24 Annual Internal Audit Plan.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to note and receive this report and agree to the action to cancel one audit.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
None	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS None, this report was prepared specifically for the Audit Committee meeting on 19 December 2023.	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** N/A

APPENDICES	
None	

1. SITUATION

Internal Audit provide a progress report to each meeting of the Audit Committee.

2. BACKGROUND

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

3. ASSESSMENT

The report provided an update on progress with the 2023/24 Internal Audit plan. Four audits have been completed since the last Audit Committee and are included on the agenda for this meeting.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Progress is being made on the Internal Audit Plan for 2023/24. There are still 11 audits to complete but resources are in place to deliver the work and 3 of the 11 are currently work in progress. The remaining reports will be presented to the next two Audit Committee meetings.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance Internal Audit reports are linked to the TAF in the Annual Internal Audit Plan. For 2023/24 onwards, this will also be done through the cover paper for each individual report, where applicable.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐

	Individual Internal Audit reports may provide assurance over the Quality Domains and Enablers. Internal Audit reports are linked to the Quality Domains and Enablers in the individual audit briefs. For 2023/24 onwards, this will also be done through the cover paper for each individual report, where applicable.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	Individual Internal Audit reports may provide assurance over the Wellbeing Goals.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: From 2023/24 onwards, Internal Audit reports will be linked to the Wellbeing Goals in the cover paper for each individual report, where applicable.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for this progress report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	From 2023/24, legal risks identified in our audits will be highlighted in the cover report for each individual report, where applicable.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Internal Audit reports are linked to the Trust Risk Register in the Annual Internal Audit Plan. For 2023/24 onwards, this will also be done through

	the cover paper for each individual report, where applicable.
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Internal Audit Progress Report

Audit Committee

19 December 2023

Velindre University NHS Trust

NWSSP Audit and Assurance Services

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

Contents

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 Internal Audit Plan for Velindre University NHS Trust to the December 2023 Audit Committee;
- note the reports completed since the last Audit Committee meeting (four reports are included on the Committee's agenda);
- seek approval for one change to the 2023/24 Internal Audit Plan, as listed within Section 5; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2023/24 Internal Audit Plan

There are currently 17 individual reviews in the 2023/24 Internal Audit.

The table below details progress against the 2023/24 Internal Audit Plan.

Reconciliation of total planned audits	
Number of audits in approved plan	14
Net changes agreed by the Audit Committee	4
Total audits 19 October 2023	18
Proposed reduction to the plan	-1
Number of audits in current plan	**17**
Status of audits	
Number of audits reported as final	5
Number of audits reported as draft	1
Number of audits work in progress	3
Number of audits at planning stage	1
Number of audits not started	7
Number of audits in current plan	**17**

The following 2023/24 final reports have been issued since the meeting of the Audit Committee on 19 October 2023:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Business Continuity	Reasonable
Recruitment & Retention	Reasonable
nVCC - Approvals	Reasonable
nVCC - Planning	Reasonable

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix B.

All Key Performance Indicators (KPIs) are on track with one exception. KPI 4 – Timely management Response to draft reports – is below target and we continue to work with management to identify ways to improve performance. The performance

against this target has not had an adverse impact on the number of reports submitted to this meeting.

4. Summary of Findings

All audit reports are considered by the Audit Committee as part of the main agenda, giving members of the Committee the opportunity to raise any questions or matters relating to the reports directly with the Auditor. All four reports submitted to this Committee meeting have been given Reasonable assurance.

5. Potential Audit Plan Changes

As we progress with our delivery of the 2023/24 Internal Audit Plan, we continue to evaluate risk, the allocation of our resources and the remainder of the agreed plan.

We currently have three audits in progress – Education Strategy, Private Patients and nVCC Enabling Works 2022/23 – and the remaining audits are planned for Quarter 4 of 2023/24. Those audits remaining to be completed will be presented to either the March 2024 Audit Committee or the meeting after.

Given that our audit of the nVCC Enabling Works 2022/23 is currently work in progress we do not believe that there will be any added value in undertaking a second audit of the enabling works position during 2023/24. As a result, we are asking for the Committee's approval to cancel that audit.

6. Other Activity

The following actions have also been progressed during the reporting period:

- an updated Integrated Capital Plan has been provided for inclusion within the FBC based on the revised timetable for the submission of the FBC and anticipated approval;
- monthly meetings with the Executive Director of Finance;
- liaison with senior management on individual audits; and
- initial planning work in relation to the 2024/25 audit plan.

7. Recommendations

The Audit Committee is invited to:

note and **receive** this progress report;

note and **receive** the four reports referred to in section 3 above and included later in the agenda; and

agree to the deferring of the enabling works 2023/24 audit referred to in section 5 above.

Appendix A: Progress against 2023/24 Internal Audit Plan

No.	Audits	Status
1	Financial & Service Sustainability	Planning
2	Recruitment & Retention	Final – Reasonable
3	Education Strategy	WIP
4	Private Patients	WIP
5	Business Continuity	Final – Reasonable
6	Decarbonisation	Q4
7	Follow-Up	Q4
8	Governance, Assurance & Risk Management	Q4
9	Medicines Management	Q4
10	Quality & Safety	Q4
11	Digital Strategy & Transformation	Final – Reasonable
12	TCS Digital	Q4
13	Integrated Radiotherapy Solution (IRS) Procurement	Q4
14	Estates Condition	Draft
15	nVCC – Enabling Works 2022/23	WIP
16	nVCC – Approvals	Final – Reasonable
17	nVCC – Planning	Final – Reasonable
	Audits deferred or cancelled	
1	nVCC – MIM Design & Change Management	Agreed AC July 2023
2	nVCC – MIM Procurement	Agreed AC July 2023
3	nVCC – Enabling Works 2023/24	For AC approval December 2023

Appendix B: Audit Assurance Ratings

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

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

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Business Continuity

DATE OF MEETING	19th December 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	STEPHEN CHANEY, ACTING HEAD OF INTERNAL AUDIT
PRESENTED BY	Stephen Chaney, Acting Head of Internal Audit /
APPROVED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SUMMARY	The purpose of this report is to present the Business Continuity audit report.
RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

N/A	N/A
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

The audit was undertaken as part of the agreed 2023/24 Annual Internal Audit Plan.

2. BACKGROUND

The purpose of this audit was to provide assurance over the Trust's ability to facilitate recovery of key business systems and processes within an agreed timescale, through the development of Trust-wide approved plans.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust has an overarching business continuity plan in place. There is monitoring of business continuity and good practice was noted within the Welsh Blood Service (WBS).

The Trust recognises work is required to ensure further improvement of the business continuity arrangements within Velindre Cancer Centre (VCC), to be consistent with those identified in WBS. A Business Continuity and Emergency Planning Work Programme is in place to implement these changes, which will bring the VCC in line with the WBS.

The key management actions identified are:

- continued implementation and monitoring of the Trust's Business Continuity and Emergency Planning Work Programme;
- clearly identifying business continuity training requirements and strengthening training records; and
- further strengthening business continuity communications to ensure consistency and maximum effectiveness.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • Trust's inability to maintain business critical services during a business continuity incident, leading to significant disruption to services and potential risk to patient and donor safety.
WHAT IS THE CURRENT RISK SCORE	Linked to three medium priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit.
All risks must be evidenced and consistent with those recorded in Datix	

Business Continuity
Final Internal Audit Report

November 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

Review reference:	VT-2324-07	
Report status:	Draft	
Fieldwork commencement:	July 2023	
Fieldwork completion:	14th September 2023	
Debrief meeting:	10th August 2023	
Draft report issued:	22nd September 2023	
Management response received:	30th October 2023	
Final report issued:	3rd November 2023	
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Laura Howells, Principal Auditor	
Executive sign-off:	Cath O'Brien, Chief Operating Officer	
Distribution:	Alan Prosser, Director of Welsh Blood Services	Laurie Thomas, Head of Validation & Risk Management
	Rachel Hennessy, Director of Velindre Cancer Centre	Lauren Fear, Director of Corporate Governance & Chief of Staff
	Andrew Mapstone, Business Continuity Lead	Non Gwilym, Assistant Director of Communications
	Mark David, Senior Manager	
Committee:	Audit Committee	

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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 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 the Velindre University NHS Trust (the 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.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To provide assurance over the Trust's ability to facilitate recovery of key business systems and processes within an agreed timescale through the development of Trust-wide approved plans.

Overview

The Trust has an appropriate business continuity planning approach in place, and we identified areas of good practice within the Welsh Blood Service (WBS). For example, a divisional Business Continuity Group, standard formats for Business Impact Analysis and Business Continuity Plans and detailed planning for business continuity testing.

The Trust recognises that work is required to ensure further improvement of the business continuity arrangements within Velindre Cancer Centre (VCC), to be consistent with those identified in WBS.

We note that action to address this is captured within the Trust's Business Continuity & Emergency Planning Work Programme and have flagged key matters identified during our audit in matter arising 1 to highlight the associated risks and importance of timely resolution.

Other matters requiring management attention are:

- clearly identifying business continuity training requirements and strengthening training records; and
- further strengthening business continuity communications to ensure consistency and maximum effectiveness.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Assurance summary[1]

Objectives		Assurance
1	Business Continuity Plans	Reasonable[2]
2	Business Continuity Training	Reasonable
3	Business Continuity Communication	Reasonable

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

[2]We have given this audit objective reasonable assurance based on the corporate and WBS business continuity plans we tested and because the actions required to address matters arising relating to VCC business continuity arrangements were known to the Trust and incorporated into the Business Continuity & Emergency Planning Work Programme prior to the audit. If these actions are not addressed in a timely manner, it could impact the level of assurance management can take from the VCC business continuity arrangements.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	VCC Business Continuity Arrangements	1	Design	Medium
2	Business Continuity Training	2	Operation	Medium
3	Business Continuity Communications	3	Design	Medium

1. Introduction

1.1 The review of Business Continuity Planning was completed in line with the 2023/24 Internal Audit Plan.

1.2 The Civil Contingencies Act 2004 defines an emergency as 'an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK'. Emergencies are split into two distinct but overlapping concepts:

- major incidents: emergencies outside of the Trust's day-to-day capabilities, including (but not limited to) severe weather, major transport incident, infectious disease outbreak or terrorist attack.
- business continuity incidents: situations in which the Trust's ability to provide core (business critical) services is seriously compromised, resulting in potential significant disruption to services and risks to patient safety.

1.3 The associated risk for the Trust is the inability to maintain business critical services during a business continuity incident, leading to significant disruption to services and potential risk to patient and donor safety.

1.4 Our review focused on preparedness for business continuity incidents. Major incidents were not included within the scope.

1.5 IT technical resilience and disaster recovery will be considered separately in a future audit plan; therefore, these areas were out of scope for this review.

2. Detailed Audit Findings

Objective 1: business continuity plans cover all aspects of the Trust's business critical operations and are fit for purpose.

2.1 The Trust has a clear methodology in its approach to business continuity.

2.2 There is a Trust-wide Business Continuity and Emergency Preparedness Group. This Group is responsible for providing assurance to the Executive Management Board that effective business continuity frameworks and supporting plans are fit-for-purpose and comply with national guidance and statutory legislation.

2.3 The Trust-wide Group is supported by the Divisional Welsh Blood Services (WBS) Business Continuity Group which has been in place since 2015 and predates the Trust-wide Group.

2.4 To ensure all business continuity matters receive appropriate attention, the Trust Group currently focuses on the Velindre Cancer Centre (VCC). For consistency in the longer term, the Trust intends to establish a VCC Business Continuity Group as part of its Business Continuity and Emergency Planning programme ('Work Programme'). **Matter arising 1**.

2.5 Once the VCC Group is in place, it will allow the Trust Group to focus on Trust wide issues, with the two divisional groups reporting up to the Trust Group.

2.6 A Trust-wide Business Continuity and Emergency Planning Policy (the 'Plan') is in place and has been approved at the Trust Business Continuity and Emergency Preparedness Group, the Executive Management Board and the Trust Board. It is available to staff via the Intranet.

2.7 The Plan adequately covers the Trust's business continuity approach, including the necessary areas expected within a high-level overarching policy. These include but are not limited to:

- Scope;
- Roles and Responsibilities;
- Aims & Objectives;
- Business Continuity Management System (BCMS) Lifecycle; and
- Governance.

2.8 Departments within VCC and WBS also produce their own business continuity plans for specific incident scenarios. We were informed by business continuity staff that:

- There are 18 departments with completed business impact analysis, and have the necessary plans in place, however due to a recent restructure two areas previously covered under existing departments are now stand-alone departments that require separate business impact analysis.
- VCC has business continuity plans in place for all but two of its 24 departments. The Trust's work programme identifies actions required to ensure all VCC departments have adequate business continuity plans in place. The work programme is on schedule and has completed actions set for Quarter 1. **Matter arising 1**.

2.9 Departments are required to carry out a business impact analysis on their area and identify those activities within the business that are critical to its function and rank these activities in order of highest priority. After doing this, business continuity plans are then developed with those activities of highest importance at the forefront of the plans. This approach was noted as good practice during the audit.

2.10 Each department for WBS and VCC should have a Business Impact Assessment (BIAs) and a Business Continuity Plan (BCP). We selected a total combination of 16 BIAs and BCPs across WBS and VCC to verify that they had been prepared were in line with the Trust's approach.

2.11 We identified that the VCC Radiology department had a business continuity plan which focused specifically on Covid-19. The plan required further elaboration to cover areas required within a standard BCP. A business impact assessment was in place for the department, which identified key areas.

2.12 The Senior Manager for VCC could not give assurance that other departments within VCC not included within our sample had the necessary standard business

continuity plans in place. However, this issue had already been identified within the Trust and was part of the Trust Work Programme which was on track to complete its actions within its scheduled timeframe. Additionally, we note that VCC is covered to an extent by Trust-wide plans for certain scenarios, e.g., the Adverse Weather Plan and the Trust Incident Response Plan. **Matter arising 1**.

2.13 We did not identify any further matters for reporting in this testing, although we note that there could be greater consistency between the divisions. The Trust is already aware of, and working towards, this. **Matter arising 1**.

2.14 WBS keeps departmental plans available to staff via QPulse as well as hard copies. VCC is in the process of developing a facility to store all departmental plans in one place for staff to view electronically. We were informed currently individual departments would have their business continuity plans on their shared drives as well as also having hard copies. **Matter arising 1**.

Conclusion:

2.15 There is robust approach regarding developing and maintaining business continuity plans for WBS. VCC should continue to implement its work programme and ensure adequate business continuity plans are in place for all departments. As the work programme is on schedule and already identified the issues raised in this report, we have given this area **reasonable assurance**. However, failure to complete the actions noted within the work programme on time would have negatively affected the assurance rating provided.

Objective 2: relevant staff are aware of business continuity plans and of the action required during a business continuity incident.

Roles and responsibilities

2.16 Staff who have business continuity responsibilities are detailed within the Trust's Business Continuity and Emergency Planning Policy. It notes that the Chief Executive is the accountable and responsible person for ensuring the Trust is prepared for emergency situations including business continuity incidents.

2.17 The Policy also states that each Division shall nominate a Business Continuity and Emergency Planning Lead who will be responsible for the development and delivery of the Trust's business continuity management arrangements. This is in place and both staff members with delegated responsibility (one for WBS and one for VCC) were interviewed during the audit. They showed a deep and clear understanding of their roles and what is required of them to ensure the Trust and their respective divisions have adequate arrangements in place in the event of a business continuity incident.

Training

2.18 Business continuity is also covered within the new Trust Incident Response Plan which details the responsibilities of bronze, silver and gold command. The Incident Response Plan states that Executives and Senior Leadership / Management teams

will be required to undertake relevant training on a pre-agreed frequency to ensure they are appropriately trained.

2.19 The WBS Business Continuity Lead maintains a Training and Testing spreadsheet for business continuity for the whole Trust. We confirmed through review of the spreadsheet that all staff who require Tactical Emergency Planning training have completed this course within the last two years.

2.20 The spreadsheet details other training available to staff as well. However, it is not clear on the spreadsheet what training each staff member must complete. Additionally, we were informed that due to a lack of resource, the spreadsheet may not been updated for the most recent training. We were informed a new staff member was starting during the audit whose responsibility would be to aid with the administration of the spreadsheet and ensure it is accurate. **Matter arising 2**.

Testing

2.21 The spreadsheet also details the testing of plans that have taken place over the past few years. A list of Trust-wide plan testing is detailed within the annual Business Continuity and Emergency Planning report. Several Trust-wide testing events have taken place recently, such as Brexit exercises and Mighty Oak Power Outage. We did not undertake testing of the plans ourselves during the audit.

2.22 The WBS Business Continuity Lead maintains a detailed multi-year plan of what business continuity testing will take place within WBS. The testing is priority rated and covers key areas of the Division's business activities. The plan is detailed and clear and we noted this as an area of good practice.

2.23 We were informed by the Senior Manager for VCC that a detailed plan for testing VCC business continuity plans does not yet exist. It is an area which the Trust had already identified and is included within the Trust's Work Programme. Currently, VCC completes testing with WBS where there is overlap between the divisions such as power outage testing. **Matter arising 1**.

Conclusion:

2.24 All staff that were interviewed during the audit had a clear understanding of their roles regarding business continuity. Testing of plans is robust within WBS. VCC must ensure they carry out the actions within their work programme to create a testing plan for VCC. As the issues raised have already been identified and are being managed by the Trust, we have given this area **reasonable assurance**.

Objective 3: the Trust can warn, inform and advise the public on a timely basis in the event of a business continuity incident.

2.25 In the event of a business continuity incident, the demand on the Trust to communicate is critical, immediate and ongoing. Depending on the nature, severity and impact of the incident, emergency or crisis, the scale and scope of communications activity will be defined by the audiences who need to be communicated with quickly, effectively and transparently; this could include the media and involve management of any media attending site.

2.26 To ensure roles and responsibilities for media duties are clear, the Trust has in place the Major Incident Communication Plan (applicable to business continuity incidents as well as major incidents) which lists the Chief Executive as the only appropriate spokesperson to give media interviews and/or lead a press conference in the context of Trust communications, or, in their absence, the most senior executive in the organisation.

2.27 The Assistant Director of Communications noted that media training was due for renewal and the Trust needed to identify who needed to complete this training. **Matter arising 2**.

2.28 The Major Incident Communication Plan identifies key audiences who may need to be informed in a business continuity event such as, but not limited to:

- patients;
- donors;
- staff;
- other service users;
- Trust Board; and
- the media.

2.29 The Major Incident Communication Plan has not been sent to any of the Trust's groups or Committees for approval. The plan has also not been tested. This issue has been identified by the Assistant Director of Communication and will be addressed within this financial year. **Matter arising 3**.

2.30 The Assistant Director of Communications was clear on her role and responsibilities as well as the role the rest of the Communications team has. Further work to improve cohesion between the Divisions and the Communications team has been identified by the Trust. It was noted that there are no on call arrangements for the Communications team, however this has been assessed and agreed at both the Trust Business Continuity & Emergency Preparedness Group and Executive Management Board as not required due to the rare frequency of requiring communications out of hours. The Trust is a planned service and there is a reimbursement of time or overtime pay arrangement in place for any staff working out of hours during a disruptive incident.

2.31 Standard communications are identified within the Major Incident Communication Plan. The Assistant Director was not aware of any standard communication held within any local business continuity plans. However, the business continuity leads for both Divisions noted that individual departments do keep prewritten communications within their local business continuity plans for donors and patients. However, these are not holding statements for media release and are specific to the continuity plan and distributed by the operational departments that communicate with donors and or patients on a daily basis as part of business as usual arrangements. There is a risk that any standard communications held within

local departmental business continuity plans may not be consistent with those held by the Trust Communication Team. **Matter arising 3**.

Conclusion:

2.32 The Trust is clear on how to inform its stakeholders in the event of a business continuity incident. However, the Trust must identify and renew the training for staff who have communication responsibilities within the Trust and ensure its Major Incident Communication Plan is appropriately approved and shared with staff. We have given this area **reasonable assurance**.

Appendix A: Management Action Plan

Matter Arising 1: Velindre Cancer Centre Business Continuity Arrangements (Design)	**Impact**
We identified several areas for improvement within VCC: • **Divisional Business Continuity Group:** the Division had yet to set this up; • **Business Continuity Plans:** – two departments had yet to put business continuity plans in place; – one department only had a business continuity plan focusing on Covid-19 and not encompassing all business continuity scenarios; and – the Senior Manager for VCC could not give assurance that other departments not within our sample had the correct business continuity plans in place. *We note that VCC is covered to an extent by Trust-wide plans for certain scenarios, e.g., the Adverse Weather Plan and the Trust Incident Response Plan.* • **Centralised storage:** electronic copies of departmental business continuity plans were stored locally by each department, rather than in a centralised location; • **Business Continuity Plan testing:** a plan for testing departmental business continuity plans did not yet exist, although some testing had been undertaken where there is overlap with WBS (e.g., power outages); and • **Consistency:** there was a lack of consistency between the templates used for business continuity planning both within the Division and with that used by WBS. Whilst these matters were known to the Trust and are included in the Trust's Business Continuity & Emergency Planning Work Programme, they are flagged here to highlight the associated risks and the importance of timely progression of the related actions to ensure robust business continuity arrangements within VCC.	Potential risk of: • inability to respond appropriately to business continuity incidents; • poor patient / donor care or experience during business continuity incidents; and • reputational and financial damage to the Trust.

Recommendations		Priority
1.1	In taking forward the actions of the Business Continuity & Emergency Planning Work Programme, management should ensure the following is in place for VCC: • business continuity plans covering all business continuity scenarios for all departments, with alignment between the departments and divisions; • a clear approval process for business continuity plans; • a rota of testing for departmental business continuity plans; • a business continuity divisional group; and • a centralised location to hold electronic versions of departmental business continuity plans which is accessible to all staff.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	To continue progressing with the Trust Business Continuity & Emergency Preparedness programme and implement the above via; • Completion of Business Impact Analysis and Business Continuity Plans • Implementation of a quality management system with approval process and provide a centralised location (sourcing electronic management system) • Review the Trust's policies of policies to ensure governance for Business Continuity Plans is clear and accurate • Review Exercise, Test & Training Programme to be adopted within VCC or on a Trust wide basis • Establish Velindre Cancer Centre business continuity group	March 2024	Business Planning Manager / Operations

Matter Arising 2: Business Continuity Training (Operation)	**Impact**
Whilst it was clear that business continuity training was being delivered within the Trust, it was not always clear what training staff should complete and whether / when it needed to be renewed. For example, the Assistant Director of Communications noted that media training was due for renewal, but that there were no records of who needed training and who had / had not attended training. Additionally, we were informed that, due to a lack of resource, the training identified within the Training and Testing spreadsheet may not be fully up to date for more recent training. However, a new staff member was starting during the audit whose responsibility would be to aid with the administration of the spreadsheet and ensure it is accurate.	Potential risk of: • staff may not be effectively trained to respond to business continuity incidents; • poor patient / donor care or experience during business continuity incidents; and • reputational and financial damage to the Trust.

Recommendations		**Priority**
2.1	Management should ensure that: • business continuity training requirements for all staff within the organisation are clearly identified, including frequency of renewal; and • business continuity training records are kept up to date (including training required, training undertaken, date of training and date of renewal) and regularly monitored to ensure all staff are appropriately trained. This includes any staff required to complete media training.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Review and update the Exercise, Test & Training Programme to include media training and frequency of renewal on the training needs analysis section	December 2023	Business Continuity Lead

Matter Arising 3: Business Continuity Communications (Design)	**Impact**
We identified the following areas for improvement within business continuity communications: • whilst standard communications are identified within the Major Incident Communication Plan, we were informed that individual departments sometimes choose to keep their own bank of communications within their local business continuity plans, thus creating a risk of inconsistency in communications during a business continuity incident; and • the Major Incident Communication Plan has not been formally approved, nor has it been subject to testing.	Potential risk of: • inability to effectively communicate with stakeholders during a business continuity incident; • poor patient / donor care or experience during business continuity incidents; and • reputational and financial damage to the Trust.

Recommendations		**Priority**
3.1	Management should ensure that: • the major incident communication plan is approved at appropriate fora and regularly tested; and • the Communications team works with those responsible for business continuity within the divisions to develop a Trust-wide bank of standard, consistent communications, including reference where local business continuity plans hold prewritten communications.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3.1	To continue progressing with the Trust Business Continuity & Emergency Preparedness programme and implement the above via; • Receive the Major Incident Communications Plan at the Trust Business Continuity & Emergency Preparedness Group 14/12/2023 for review and	February 2024	Assistant Director of Communications

	comment by the group which will include adding a statement referencing local division continuity plan communications. Note: VUNHST communications have been tested via response to live incidents i.e. adverse weather, Covid-19 pandemic and ongoing industrial action.		

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.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Recruitment and Retention

DATE OF MEETING	19th December 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	STEPHEN CHANEY, ACTING HEAD OF INTERNAL AUDIT
PRESENTED BY	Stephen Chaney, Acting Head of Internal Audit
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The purpose of this report is to present the Recruitment and Retention audit report.

RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

N/A	N/A
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

The audit was undertaken as part of the agreed 2023/24 Annual Internal Audit Plan.

2. BACKGROUND

The purpose of this audit was to review the effectiveness of the Trust's recruitment and retention activities. The review focussed on whether activities are enhancing recruitment and retention.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

We identified many different initiatives being implemented across the Trust to assist with recruitment and retention, against a backdrop of considerable work pressures. These are being progressed by the Workforce and Organisational Development Team. However, we raised the following matters for consideration:

- The Workforce Strategy, 'People Strategy: Being an employer of choice' has been approved since May 2022, but has not yet been communicated across the Trust.
- The Recruitment and Selection Policy has not been approved. Therefore, there is a risk of recruitment practices not being adhered to.
- Whilst we found that monitoring and reporting is taking place, there is no specific reporting over the effectiveness of recruitment and retention initiatives.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning

Commented [LH(AaAS1]: I've selected 10 because having adequate business continuity arrangements is good governance and the responsibility for BCP ultimately sits with Board. However, there are a number of risks it could have come under.

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required Not required for Internal Audit reports.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • The Trust is unable to recruit and / or retain staff, resulting in insufficient workforce to

	deliver services in a safe and timely manner. There is also an increased financial risk as temporary staff are appointed to reduce workforce gaps, but at a higher rate.
WHAT IS THE CURRENT RISK SCORE	Linked to two medium and one low priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit, as the recommendations relate to actions regarding the effectiveness of plans.
All risks must be evidenced and consistent with those recorded in Datix	

Recruitment and Retention
Final Internal Audit Report

December 2023

Velindre University NHS Trust

Contents

Review reference:	VT-2324-04
Report status:	Final
Fieldwork commencement:	19 September 2023
Fieldwork completion:	09 November 2023
Debrief meeting:	14 November 2023
Draft report issued:	17 November 2023
Management response received:	01 December 2023
Final report issued:	01 December 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Rhian Gard, Audit Manager
Executive sign-off:	Sarah Morley, Director of Workforce & OD
Distribution:	Susan Thomas, Deputy Director of Workforce & OD
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 Chartered Institute of Public Finance & Accountancy in April 2023

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 review the effectiveness of the Trust's recruitment and retention activities. The review focussed on whether activities are enhancing recruitment and retention. We did not audit compliance with the Trust recruitment processes.

Overview

We identified many different initiatives being implemented across the Trust to assist with recruitment and retention, against a backdrop of considerable work pressures. Alongside this, the Workforce and Organisational Development Team is progressing the implementation of these initiatives.

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Workforce Strategy, 'People Strategy: Being an employer of choice' has been approved since May 2022, but has yet to be communicated across the Trust.
- The Recruitment and Selection Policy has not been approved. Therefore, there is a risk of recruitment practices not being adhered to.
- Whilst we found that monitoring and reporting is taking place, there is no specific reporting over the effectiveness of recruitment and retention initiatives. Furthermore, there is no review of the success or otherwise of the initiatives implemented.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Trust workforce strategy	Reasonable
2	Staff recruitment	Reasonable
3	Recruitment and retention initiatives	Reasonable
4	Monitoring and reporting	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Trust workforce strategy	1	Operation	Low
2	Staff recruitment	2	Design	Medium
3	Monitoring and reporting	3,4	Design	Medium

1. Introduction

1.1 The demands upon the health services, increasingly complex service-user needs, and difficulties with recruitment and retention of staff (particularly nurses) have created significant challenges for Velindre University NHS Trust (the 'Trust') and other organisations in NHS Wales. The Trust is in the process of reviewing the supply and shape of its workforce to ensure it has the right people in the right place with the right skills, recognising the need to move away from traditional staffing models to deliver the changing service needs.

1.2 The Trust has approved a new workforce development framework (the 'framework'). Within the framework there are levers in place to ensure the Trust recruits, upskills and develops its workforce and manages the health, wellbeing and engagement of its staff. The aim is to ensure the Trust is an employer of choice, which in turn meets the commitments laid out in the Trust's People Strategy: Being an employer of choice. Work has been completed to ensure the framework is aligned to the All-Wales Workforce Planning Strategy, and training has been delivered to managers within the Trust to implement this approach.

1.3 The key risks considered in this review were:

- continued reduction in the Trust's workforce due to recruitment and retention issues not being monitored and / or corrective action being taken;
- insufficient staff within departments meaning that they are unable to consistently deliver the level of services required in a safe manner; and
- additional costs incurred by the Trust because of additional recruitment campaigns and agency costs.

2. Detailed Audit Findings

Objective 1: There is a Trust strategy that focuses on initiatives to attract and retain a skilled workforce across the organisation and is aligned to the Trust's aims and objectives

2.1 The 'People Strategy: Being an employer of choice' (the 'Strategy') was approved by the Trust's Board in May 2022. The focus of the Strategy is to ensure there is progress towards a planned and sustained workforce which are skilled and developed people who are engaged in the workplace.

2.2 The Strategy is one of a suite of enabling strategies underpinning the Trust Strategy: Destination 2033. The Strategy is aligned with the objectives and vision of the Trust and identifies the current and future workforce challenges. The main themes of the Strategy tie in with the Trust's strategic goals and values; to be accountable, to be bold, to be caring and to be dynamic.

2.3 We confirmed that the Strategy has not been communicated across the Trust and some staff are not aware of its existence. Furthermore, there is no stand-alone

implementation plan to support its deliverables, which makes it harder for the Trust to identify how successful they are in achieving them, regarding recruitment and retention. However, there is an Attraction, Recruitment and Retention (ARR) group whose role is to ensure processes for recruitment and retention are streamlined and there is appropriate engagement within these practices.

2.4 The ARR group has a project initiation document (PID) documenting its objectives, from reviewing these along with highlight reports we can see that many of the objectives have been achieved on time. However, objectives where there are external dependencies have experienced delays.

2.5 The ARR group does not maintain minutes, but a live document is in place, which is updated after meetings. Highlight reports are sent to the Executive Management Board (EMB), the last one which went to the EMB was during January 2023 and further updates are sent to the Quality, Safety and Performance (QSP) Committee. However, the ARR group has not met since December 2022, but a final evaluation report is scheduled to go to EMB in January 2024.

The above points are included within **matter arising one.**

Conclusion:

2.6 There is a Strategy in place which is one of a suite of enabling strategies underpinning the Trust's Corporate Strategy and has been approved since May 2022. However, the Strategy has not been communicated to staff. Although there is no stand-alone implementation plan in place to support its deliverables, the ARR group focuses on the implementation of some of those deliverables, but this has not met since December 2022. Therefore, we have provided **reasonable assurance** for this objective.

Objective 2: There is a recruitment and selection policy evident which details staff roles and responsibilities, and staff recruitment is carried out in accordance with the policy and framework

2.7 The Recruitment and Selection Policy (the 'Policy') was completed in January 2023 but has not yet been approved, because of this we did not undertake testing relating to the Policy content. The Policy was submitted to QSP in September 2023 for approval. We were informed that the Policy was not approved due to the lack of completion of an equality impact assessment. Consequently, the Policy will now be represented at the next available QSP Committee.

2.8 As part of the audit, we reviewed the Policy and found that it details important elements of recruitment, Welsh language, induction attendance and roles and responsibilities.

2.9 Over the last 18 months the Workforce Team has worked to implement the recruitment framework through: the Policy, a recruitment toolkit, an updated incremental policy and a new Disclosure Barring Service (DBS) procedure. However, we were informed that there is no specific work plan in place for recruitment because of the limited workforce resource available.

The above points are included within **matter arising two.**

Conclusion:

2.10 There is a Recruitment and Selection Policy, but it has not yet been approved and communicated across the organisation. The Policy is an important part of the recruitment framework so should be communicated as a matter of urgency. Therefore, we have provided **reasonable assurance** for this objective.

Objective 3: Effective initiatives are in place to recruit and retain staff, for example recruitment events, social media, engagement, succession planning and staff surveys

2.11 The Trust is involved with multiple recruitment and retention initiatives, with promotion of the Trust on the website. The Trust, alongside other NHS organisations, operates in a difficult environment when seeking to recruit and retain a skilled workforce.

2.12 There are a range of initiatives introduced to improve the overall position. For example, the revamp of the corporate induction to ensure it is more concise and engaging for new starters and to help embed them into the organisation. Furthermore, there is ongoing work regarding medical work experience, RCN nurse cadets, the armed forces covenant, and the NHS graduate scheme.

2.13 Likewise, we found numerous retention initiatives embedded to ensure staff feel valued and included.

2.14 Alongside this, a Health Education and Improvement Wales (HEIW) two-year funded role is set to be recruited and this will assist with retention in the Trust. Furthermore, exit interviews are being reviewed to ensure that they are completed and add value to the retention process. In addition, the Trust retains a clinical psychologist in post to help individuals and teams in the Trust with any issues they may have and need assistance with.

2.15 As part of the audit, we reviewed the initiatives embedded, but found that there is no ongoing monitoring over the success of these actions completed. Therefore, initiatives may or may not be effective in achieving their aims.

The above points are included within **matter arising three.**

Conclusion:

2.16 From reviewing the different initiatives for recruitment and retention it is clear to see the Trust understand the importance in ensuring they recruit and retain a skilled workforce. However, the initiatives are not currently being measured on their effectiveness. Therefore, the Trust should review on a regular basis to check what impact they are having and whether any additional work is required. Therefore, we have provided **reasonable assurance** for this objective.

Objective 4: Adequate mechanisms exist to monitor staff recruitment and retention throughout the trust at a local and Board level

2.17 There are forums within the Trust which discuss recruitment and retention. The ARR group, solely discusses the recruitment and retention process, but also

produces highlight reports for the EMB and updates are also provided to the QSP Committee, as their responsibility is to scrutinise workforce matters.

2.18 As part of the audit, we reviewed the ARR highlight reports and found the group has not met since December 2022 with the last highlight report going to EMB in January 2023. Within these reports we identified that many of the ARR group's objectives and deliverables have been completed, except where external factors are involved. An evaluation report is scheduled to go to the EMB in January 2024.

2.19 We reviewed 12 months of minutes from Strategic Board Committee (SDC), QSP Committee and Board and identified there are regular updates provided, but not on performance measures or indicators within the reporting process. Furthermore, we were not able to see any reporting or monitoring on measuring the effectiveness of the recruitment and retention initiatives. There are dashboards in place within the divisions and these are for management teams to review and put in place actions for the coming months concerning sickness, vacancy, PADR compliance and head count.

The above points are included within **matter arising three.**

Conclusion:

2.20 There is reporting and monitoring taking place, but these are mainly updates rather than performance information and measures. There does not appear to be regular monitoring or reporting of the effectiveness of recruitment and retention initiatives. Performance information should be reported to the relevant forums on a regular basis, to determine if recruitment and retention matters are improving or if further work is required. Therefore, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Trust Workforce Strategy (Operation)	**Impact**
The People Strategy: Being an Employer of Choice (the 'Strategy') was approved by the Board during May 2022. The Strategy is aligned with the corporate objectives of the Trust and is one of a suite of enabling strategies underpinning the Trust's Strategy 'Destination 2033'. The focus of the Strategy is to ensure progress is made for a sustained workforce with skilled and developed people who are engaged in the workplace. Within the document there are six main themes, including attracting and retaining the best talent. The Strategy does not include a stand-alone implementation plan (or equivalent) to support its deliverables, however there is an Attraction, Recruitment and Retention (ARR) Group (the 'Group') established. The role of the Group is to ensure processes for recruitment and retention are streamlined and there is appropriate engagement within these practices. Although the Strategy has been approved for over a year, it was hard to locate on the Trust's website and workforce staff also found it difficult to locate. The Strategy has not been communicated to staff throughout the Trust or made widely available, to assist in communicating the deliverables.	Potential risk of: • The Trust's Strategy has not been communicated resulting in staff not being fully aware of the Trust's deliverables and practices.

Recommendations		**Priority**
1.1	The Trust should look at ensuring the People Strategy: Being an employer of choice is communicated effectively throughout the organisation.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The People Strategy was formerly launched alongside the Trust strategy and other enabling strategies on the 10th November 2023. This was followed with Trust wide communications through the weeks following the launch. The strategy is now widely available and easy to locate on the Trust Intranet. The narrative and terminology within the People Strategy will be used in all staff engagement events and work programmes going forward. The Trust will have specific articles highlighting the People Strategy in January 2024 Trust and Divisional Newsletters.	31 January 2024	Deputy Director of WOD

Matter Arising 2: Staff Recruitment (Design)	**Impact**
The Trust has developed the People Strategy: Being an employer of choice, with a supporting framework in place. Within this framework there is a Recruitment and Selection Policy which was completed during January 2023. However, this policy has not yet been formally approved by the Quality Safety & Performance (QSP) Committee. It was scheduled to be approved at the September 2023 Committee, but this did not happen. It is understood there was confusion surrounding the EQIA assessment being completed. As it has not been formally approved it has not been communicated throughout the Trust. Upon reviewing the policy, we noted that the Policy uses interchangeable terminology between "policy" and "procedure" and some of the responsibilities for the applicant, recruiting manager and NHS Shared Services Partnership (NWSSP) are not clearly defined. There is no specific recruitment work plan in place, although there is a workforce alignment plan aligned with the Strategy Progress has been made with staff recruitment initiatives, in spite of the work pressures facing existing staff. Examples include: the introduction of a managers recruitment toolkit, Disclosure Barring Service (DBS) procedure and development of the incremental credit policy, and a governance process which links with successful recruitment.	Potential risk of: • Staff not aware of roles and responsibilities regarding recruitment. • The Policy has not been approved by the appropriate forum so not in accordance with the framework. • Without an approved policy in place there is a risk that the Trust will not be able to attract, recruit and develop qualified staff with the appropriate skills required.

Recommendations		**Priority**
2.1	The Trust should ensure the Recruitment and Selection Policy is approved and communicated throughout the Trust.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The Recruitment and Selection Policy has been endorsed by EMB and is on the agenda for January 2024 Quality, Safety and Performance Committee for endorsement before approval at Trust Board on 30th January 2024. The Policy will then be promoted and published on the Trust Intranet by the end of February 2024.	29th February 2024	Head of Workforce

Matter Arising 3: Monitoring and Reporting (Design)	**Impact**
There are different layers of reporting within the Trust including divisional, the Steering Group, committees, and Board level. We were able to see the flow of information regarding recruitment and retention within the divisions through dashboard reporting, the ARR Group through to the QSP Committee and then the Board. Updates are usually in the form of highlight reports and workforce updates. We reviewed highlight reports from the Attraction, Recruitment and Retention (ARR) group, but found that it last convened during December 2022 and last reported to the Executive Management Board (EMB) in January 2023. An evaluation report is scheduled to go to the EMB during January 2024. We confirmed that there is an overview of workforce issues at a Board and committee level, but there is an absence of monitoring / tracking of the success of recruitment and retention initiatives introduced. Furthermore, there is some information presented in the forums about vacancy rates decreasing, but there is no information regarding staff turnover or other related metrics.	Potential risk of: • Limiting reporting around performance of recruitment and retention actions runs the risk of progress not being fed to Board if required.

Recommendations		**Priority**
3.1a	The Trust should implement performance measures to ensure regular monitoring of the current position and the impact of actions implemented. The information should be reported into appropriate committees.	**Medium**
3.1b	The Trust should measure the effectiveness of its recruitment and retention initiatives.	

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Currently the Trust has in place Divisional dashboards to monitor recruitment and retention which are updated monthly. The Supply and Shape report that is reported to Quality Safety and Performance Committee via EMB quarterly will have a robust section on Attraction and Retention and monitor recruitment measures and hotspot areas from January 2024.	31st January 2024	Deputy Director of OD & Workforce

3.1b	The People Strategy Implementation Plan contains details of recruitment and retention activities. General reporting takes place on a monthly basis, however, the effectiveness of specific initiatives will be monitored throughout and reported on a quarterly basis through EMB onto Quality, Safety and Performance Committee. To allow sufficient time to embed current initiatives, reporting will commence in July 2024.	31st July 2024	Head of Workforce

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.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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AUDIT COMMITTEE

INTERNAL AUDIT REPORT: New Velindre Cancer Centre – Commercial Approval Points

DATE OF MEETING	19 December 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Huw Richards, Deputy Director (SSu)
PRESENTED BY	Melanie Goodman, Audit Manager (SSu)/ Huw Richards, Deputy Director (SSu)
APPROVED BY	Steve Ham, Chief Executive Officer/ Senior Responsible Officer

EXECUTIVE SUMMARY	This limited scope audit formed a part of the approved Integrated Audit Plan for the new Velindre Cancer Centre (nVCC) project and sought to determine whether appropriate arrangements were in place, and operating effectively, in the progression through Commercial Approval Points (CAPs).

RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/A	N/A
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

This limited scope audit was undertaken as part of the agreed 2022/23 Integrated Audit Plan for the new Velindre Cancer Centre (nVCC) project.

2. BACKGROUND

The purpose of this audit was to provide assurance over the progression through Commercial Approval Points (CAPs), for the project.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust successfully passed through CAPs 3 and 4 with no associated delays to the procurement timeline.

Timely reporting to Trust Board and Health Strategic Board was evidenced, with the majority of recommendations actioned in a timely manner.

The matters requiring management attention will be for application during the CAP5 process, being the final CAP stage, and include:

• More frequent progress reporting of outstanding actions to Project Board; and
• Improved timeliness in closing out some recommendations.

Recognising also that the audit has not been able to evidence Welsh Government's satisfaction that all prior CAP recommendations have been resolved (noting the WG process only provides this at CAP5), it is important that the Project Board is provided this assurance on completion of the CAP5 review and prior to Financial Close.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒

• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	01 - Demand and Capacity 09 - Future Direction of Travel
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • Failure to deliver the project business case objectives • Impact on future service delivery.
WHAT IS THE CURRENT RISK SCORE	Linked to four medium priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit.
All risks must be evidenced and consistent with those recorded in Datix	

MIM Commercial Approval Points
Final Internal Audit Report

December 2023

Velindre University NHS Trust

Contents

Review reference:	SSU VEL 2223 01
Report status:	Final
Fieldwork commencement:	19 July 2023
Fieldwork completion:	18 August 2023
Draft report issued:	8 September 2023, 17 November 2023, 27 November 2023
Management response received:	1 December 2023
Final report issued:	4 December 2023
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Steve Ham, Chief Executive Officer / Senior Responsible Officer
Distribution:	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) Andrew Davies, Principal Project Manager, TCS
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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.

University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

This audit sought to determine whether appropriate arrangements were in place, and operating effectively, in the progression through Commercial Approval Points (CAPs) 3 and 4 (mid-competitive dialogue and end of dialogue) at the new Velindre Cancer Centre (nVCC) project. This was a limited-scope review and the opinion provided is not reflective of the wider performance at the project.

Overview

We have determined reasonable assurance on this area.

The Trust successfully passed through CAPs 3 and 4 with no associated delays to the procurement timeline.

Timely reporting to Trust Board and Health Strategic Board was evidenced, with the majority of recommendations actioned in a timely manner.

The matters requiring management attention will be for application during the CAP5 process, being the final CAP stage, and include:

- More frequent progress reporting of outstanding actions to Project Board; and
- Improved timeliness in closing out some recommendations.

Recognising also that the audit has not been able to evidence Welsh Government's satisfaction that all prior CAP recommendations have been resolved (noting the WG process only provides this at CAP5), it is important the Project Board receives this assurance on completion of the CAP5 review and prior to Financial Close.

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 Arrangements	Substantial
2	Response to Recommendations	Reasonable

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

Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	More frequent progress reporting to Project Board on CAP actions.	2	Operation	Medium
2.1	Appropriate timelines should be internally allocated to recommendations and routinely monitored.	2	Operation	Medium
2.2	More accurate recording of progress made towards outstanding recommendations.	2	Operation	Medium
2.3	The disparity between the September 2023 Project Board CAP4 report and the associated minutes should be reviewed.	2	Operation	Medium

1. Introduction

1.1 This limited scope audit formed part of the approved new Velindre Cancer Centre (nVCC) approved Integrated Audit Plan and has sought to determine whether appropriate arrangements were in place, and operating effectively, in the progression through Commercial Approval Points (CAPs) 3 and 4 at the new Velindre Cancer Centre (nVCC) project.

1.2 Commercial Approval Points (CAPs) are mandatory for Mutual Investment Model (MIM) schemes which are to receive funding from the Welsh Government. They involve the focused scrutiny of a potential deal to provide Welsh Government with assurance on the commercial elements of the project as it develops through key points of the procurement phase. They consider the impact of project-specific commercial factors in relation to:

- affordability;
- value for money;
- deliverability; and the
- commercial and compliance aspects of a project.

1.3 The CAPs take place as follows:

No.	Purpose	Timing
CAP 1	**Pre-OJEU:** Ensures that all pre-procurement requirements have been completed and that there are sufficient resources in place.	This CAP must be satisfactorily completed before proceeding to procurement. CAP1 took place in March 2021.
CAP 2	**Pre-Competitive Dialogue:** Ensures that the selection of bidders shortlisted to proceed has been completed in a compliant manner and has been appropriately documented.	Undertaken once shortlisting of bidders is completed, but prior to the bidders receiving ITPD notification. CAP2 took place in August 2021.
CAP 3	**Mid Dialogue:** Assesses the progress of competitive dialogue and ensures negotiations remain on track to deliver an acceptable solution.	Following submission of Initial Solutions. CAP3 took place in February 2022.
CAP 4	**End dialogue:** Ensures that all work required to move to the Final Bid/Tender stage is completed. Takes a 'bootcamp' format and includes significant input from bidders. Will confirm the content of the bidders' proposals; their agreement to the standard form documents, their ability to deliver the project to time and budget and check that there are no issues still unresolved. Ultimately, this CAP will ensure that the project is ready to close dialogue.	Following submission of Detailed Solutions and prior to drafting of Final Tenders. CAP4 took place in May 2022.

CAP 5	**Pre Financial Close:** The purpose of this CAP is to check that the most advantageous deal has been achieved before it is signed and to check that the content of the deal has not altered. As such, Ministerial Approval to proceed is required following the completion of CAP 5.	4-6 weeks prior to contract signature. Relevant consents must be in place (planning, statutory, etc.) and promissory notes to cover the revenue profile should be ready.CAP5 is currently scheduled for October 2023.

1.4 The key risks considered within this review included:

- Failure to achieve the end-of-competitive dialogue deadline; and
- Value for money has not been demonstrated.

1.5 The scope of this review was limited to consideration of the CAP processes only and did not assess any wider approval processes operated within the Trust.

2. Detailed Audit Findings

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

Objective 1: *To obtain assurance that appropriate governance arrangements were in place to progress through the CAPs falling within the competitive dialogue procurement stage, i.e. CAP 3: Mid-Competitive Dialogue and CAP 4: End of Dialogue.*

2.2 The Welsh Government document '*Commercial Approval Points – A Guide'* (2016) was utilised by the Trust as the central reference point for the CAP process.

2.3 The CAP requirements and associated Trust governance processes were defined within key internal documents including the Delegations Framework and Procurement Strategy.

2.4 Internal governance arrangements to manage and report progress towards closure of CAP recommendations included:

- Maintenance of the 'Review Grid Action Plan' (with support from external advisers), in which all recommendations made and actions taken (with associated evidence) were captured within a central reference document which could be readily shared with internal governance forums and Welsh Government;
- Inclusion of the closure of outstanding CAP recommendations on the Programme to Financial Close, routinely monitored by the project team;
- Inclusion of a risk on the project risk register in relation to the ability to respond to CAP recommendations in a timely manner, which may delay elements of the procurement process (risk score of 4 at the time of review); and

- Reporting of Welsh Government CAP reports and progress towards closing recommendations to the Project Board, Programme Board and Trust Board (however, see findings below re timeliness of this reporting in some cases).

2.5 Recognising the above, **substantial assurance** has been determined in respect of the CAP governance arrangements applied to date.

Objective 2: *To assess the Trust's arrangements to respond timely to any recommendations or conditions raised by Welsh Government during the CAP process, and assurance that improved processes have been embedded into future procurement stages, where applicable.*

2.6 The timeline for the CAP3 and CAP4 reviews was as follows:

- CAP3: Review undertaken 14th-18th February 2022; and
- CAP4: Review undertaken 16th-20th May 2022.

2.7 The resulting reports were shared with the Chief Executive and Trust Board on receipt, together with the Review Grid Action Plan to demonstrate progress.

2.8 The Review Grid Action Plan was also shared with the Welsh Government's Health Strategic Board. Whilst management advised that verbal feedback was provided by the Board to confirm the Trust could progress through the CAP, the WG process did not include the provision of written confirmation that recommendations had been satisfactorily addressed, for the CAPs reviewed. It is recognised that the CAP5 guidance incorporates the requirement for formal approval from WG and it is important the Project Board receives this assurance prior to Financial Close.

2.9 It was noted that, whilst the Trust's internal reporting of CAP3 deemed all CAP3 recommendations to be closed, the WG CAP4 report considered one recommendation (21) to remain outstanding. This was confirmed closed at the July 2022 Project Board progress update. This was the only instance noted of varying opinion between the Trust and WG as to the closure of recommendations, and the short timescale between the above reports is recognised.

2.10 Whilst five recommendations remained outstanding at the time of the July 2022 Project Board update, no further progress updates have been identified at the time of this review. Management advised that a paper was scheduled for the September 2023 Project Board, confirming all recommendations have now been closed. More timely reporting of assurance on the actioning of recommendations would be beneficial to aid the Project Board in its scrutiny and oversight function (**MA1**).

2.11 Whilst recognising the Trust ultimately has until Financial Close to satisfactorily address all CAP recommendations, the closing of the final two recommendations outstanding from CAPs to date exceeded the timeframe for action presented within the WG's suggested timeframe for action. Whilst management have provided

assurances that this did not present any undue risks, timely action would represent good practice (**MA2**).

2.12 Whilst some areas for improvement have been identified, it is recognised that the Trust passed through CAPs 3 and 4 without any directly associated delays to the procurement timeline. **Reasonable assurance** has therefore been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Progress Reporting (Operation)	**Impact**
The WG CAP4 review report and Review Grid Action Plan were reported to the Trust Board and Health Strategic Board in May 2022, with approval granted to close dialogue. The documents were subsequently reported to Project Board and Programme Delivery Board in June 2022 noting the timing of meetings. A further progress update was provided to these forums in July 2022. As at July 2022, three recommendations were reported as outstanding from the CAP4 review, with two remaining outstanding from earlier CAPs. Whilst a further progress update was prepared for the November 2022 Project Board meeting, the paper was not included in the agenda pack. At the time of review, management advised that the next update was scheduled for September 2023, at which it will be reported that all recommendations have now been closed. In line with the Trust's prior process of routine progress reporting, it is recommended this be reinstated.	Potential risk of: • The Project Board is not appropriately sighted on outstanding risks associated with unactioned CAP recommendations; • Insufficient actions cannot be scrutinised and challenged.

Recommendations		**Priority**
1.1	The Project Board should receive more frequent updates on progress towards implementation of outstanding CAP recommendations, including the risk impact of failing to address recommendations within the stated timeframes.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The Project will complete a review of all CAP requirements for the next CAP – CAP 5. We will report on the CAP 5 requirements and all outstanding CAP recommendations that need to be actioned.	Pre CAP5 process	Assistant Project Director

Matter Arising 2: Timeliness of closure of recommendations (Operation)	**Impact**
At the time of this review, management advised that the closure of the final two outstanding CAP recommendations (5 and 33) had been achieved and was scheduled to be reported to the September 2023 Project Board. Noting the length of time since the CAP4 report was received by the Trust (May 2022), the timeliness of closing these recommendations was considered, with the following noted: • Recommendation 33 (from the CAP4 review, in relation to procurement of non-IRS key clinical equipment)): To be actioned "*as soon as possible after Successful Participant Appointment*." Noting this took place in May 2022, a 15-month timeframe for action is not considered particularly timely. Management acknowledge that this action was not considered a priority but remained 'on the radar' via inclusion on the Programme to Financial Close. • Recommendation 5 (from the CAP1 review, in relation to potential unnecessary levels of retained risks / financial exposure for the MIM contract resulting from the options considered for the IRS contract): To be actioned "*as soon as possible before close of dialogue on the IRS contract*." Noting the IRS contract was in place in November 2022, it was queried why the recommendation was only now being reported as closed, and whether there were any risks / implications of missing the recommended deadline. The Trust has provided assurance that legal advice was received and appropriate actions taken to achieve the best protection from the IRS commercial negotiations in line with the CAP recommendation. Whilst recognising that no progress reporting has taken place since July 2022 (as per **MA1**), the drafted (but not reported) November 2022 update presented this action as outstanding at that time (i.e. after the close of IRS dialogue), despite the key points having been addressed. It is also noted that, whilst the CAP report presented to the September 2023 Project Board confirmed closure of all CAP recommendations, the minutes recorded:	Potential risk of: • Identified areas for improvement are not addressed in a timely manner. Risks / control weaknesses remain.

"It was discussed that there are 2 remaining recommendations (33 & 6) from CAP1 and these need to be reviewed. MA confirmed this is relating to the IRS and the PA contract. It was confirmed that these need to be ready for CAP5." This disparity should be reviewed and it should be ensured that Project Board reports accord with the discussions held and minutes captured.		
Recommendations		**Priority**
2.1	Appropriate timelines should be internally allocated to recommendations, and monitored routinely, to ensure recommendations are closed out as soon as possible.	**Medium**
2.2	Where partial actions have been taken, but not of a sufficient nature to close a recommendation, the Review Grid Action Plan and associated progress reports should clearly document what actions remain outstanding to enable the recommendation to be closed, and what the associated risks / impacts are of the outstanding elements of work.	**Medium**
2.3	The disparity between the September 2023 Project Board CAP4 report and associated minutes should be reviewed and corrected if necessary.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Programme to FC includes all timelines for CAP 5 process. The Project will complete a review of all CAP requirements for the next CAP – CAP 5. We will report on the CAP 5 requirements and all outstanding CAP recommendations that need to be actioned.	Pre CAP5 process	Assistant Project Director

2.2	The Project will complete a review of all CAP requirements for the next CAP – CAP 5. We will report on the CAP 5 requirements and all outstanding CAP recommendations that need to be actioned.	Pre CAP5 process	Assistant Project Director
2.3	The Project Board minutes will be reviewed and, if need be, amended at the next Project Board.	December 2023	Assistant Project Director

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.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: New Velindre Cancer Centre – Planning Permissions

DATE OF MEETING	19 December 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Huw Richards, Deputy Director (SSu)
PRESENTED BY	Melanie Goodman, Audit Manager (SSu)/ Huw Richards Deputy Director (SSu)
APPROVED BY	Steve Ham, Chief Executive Officer/ Senior Responsible Officer

EXECUTIVE SUMMARY	This limited scope audit formed a part of the approved Integrated Audit Plan for the new Velindre Cancer Centre (nVCC) project and sought solely to evaluate the progression and delivery of the planning permissions required from Cardiff Council as part of the wider development of the project.

RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the contents of this Internal Audit Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/A	N/A
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix A	Management Action Plan
Appendix B	Assurance Opinion and Action Plan Risk Rating

1. SITUATION

This limited scope audit was undertaken as part of the agreed 2022/23 Integrated Audit Plan for the new Velindre Cancer Centre (nVCC) project.

2. BACKGROUND

The purpose of this audit was to provide assurance over the progression and delivery of the planning permissions required from Cardiff Council as part of the wider development of the project.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust had appointed an external planning consultant to oversee the planning approval process. Reliance was placed on the consultant to maintain their own record to accord with that held on the Cardiff Council Online Planning Portal.

Internal recording of planning progression was less formal and focused on key conditions and discussions pursuant to the same. Testing demonstrated weaknesses in the various records maintained which made reconciliation with the Cardiff Council Online Planning Portal particularly difficult e.g., common reference numbers, details of the various conditions etc.

Progress reporting was largely limited to updates provided within Board papers and highlight reports. Therefore, reporting should be reviewed to ensure that sufficient information is provided to effectively manage the risk.

Accordingly, the key management actions identified were:

- More cohesive monitoring of planning applications; and
- Enhanced reporting and scrutiny at Project Board.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item

If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
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	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
	Not required for Internal Audit reports.

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • Failure to deliver the project business case objectives • Impact on future service delivery.
WHAT IS THE CURRENT RISK SCORE	Linked to two medium priority recommendations.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during this audit.
All risks must be evidenced and consistent with those recorded in Datix	

New Velindre Cancer Centre
Final Internal Audit Report

December 2023

Velindre University NHS Trust

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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

This limited scope audit formed a part of the approved Integrated Audit Plan for the new Velindre Cancer Centre (nVCC) project and sought solely to evaluate the progression and delivery of the planning permissions required from Cardiff Council as part of the wider development of the project.

Overall Audit Opinion and Overview

The audit was undertaken ahead of a planned financial close in the final quarter of 2023; with an associated requirement for full planning consent to be in place.

The Trust had appointed an external planning consultant to oversee the planning approval process. Reliance was placed on the consultant to maintain their own record to accord with that held on the Cardiff Council Online Planning Portal. Internal recording of planning progression is less formal and focuses on key conditions and discussions pursuant to the same.

Testing demonstrated weaknesses in the various records maintained which made reconciliation with the Cardiff Council Online Planning Portal particularly difficult e.g., common reference numbers, details of the various conditions etc.

Progress reporting in this regard was largely limited to updates provided within Board papers and highlight reports. However, it has been recommended that reporting is reviewed to ensure that sufficient information is provided to effectively manage the risk.

The project team regularly met with the external consultants and the Communication Coordination Group provided adequate interaction with wider stakeholders including members of the public and the Welsh Government.

The intrinsic reliance placed on the external planning consultant, was mitigated by independent meetings held to review progression between the project team and Cardiff Council (without external consultant representation).

Minutes were not available from the meetings with the external planning consultant or Cardiff Council.

Recognising the primary objective of the area reviewed was to obtain consent for activities pursuant to the wider project objectives, based on the progress observed to date, there is a **Reasonable assurance** that all approvals will be obtained in sufficient time. However, there is a risk that if recommendations at this report are left unaddressed, there may be potential for a negative impact on the programme and achievement of financial close.

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	Planning Approvals	Substantial
2	Monitoring	Reasonable
3	Communication	Substantial
4	Reporting	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	More cohesive monitoring of planning applications.	2	Design & Operation	Medium
2	Enhanced reporting & scrutiny at Project Board.	2 & 4	Design & Operation	Medium

1. Introduction

1.1 This audit formed a part of the approved new Velindre Cancer Centre (nVCC) Integrated Audit Plan and has sought to evaluate the progression and delivery of the planning permissions required from Cardiff Council as part of the wider development of the project, to assess the adequacy of the systems and controls in place to support their successful acquisition.

1.2 The audit considered the period from 2018 to 2023, with sampling focused on the period Dec 2022 - July 2023.

1.3 The nVCC project had been targeting June 2023 for financial close but this has been postponed to Q3 2023 due to anticipated delays e.g. in obtaining an EPS licence by Natural Resources Wales (NRW).

1.4 All outstanding planning consents must be obtained by Financial Close to conform with the NHS Wales Infrastructure Investment Guidance and to ensure that the work can commence without delay.

1.5 The potential risks considered at this review included:

- Unsuccessful applications or delayed consent because of missing information or weakly implemented planning strategy impacting the preparedness of the site and incurring additional costs.
- The impact of delays in planning resulting in an ability to meet the pre-requisites for achieving financial close.
- The impact of poor communication on engagement with a wide range of stakeholders
- Reporting failing to give the Project Board oversight of the planning status, limiting ability to manage the process and any issues in a timely manner.

2 Detailed Audit Findings

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

Planning Approvals: That appropriate planning approvals had been sought reflective of the current stage of the project.

2.1 Outline planning for the new Velindre Cancer Centre was approved with a 5-year expiry date (from which date Full planning permission and commencement must complete) in 2017.

2.2 The Health Board was then required to subsequently apply for non-material amendments via a Section 96 and are invited by the Council to then apply for 'Reserved Matters' which included details informed by appointed contractors to obtain 'Full' planning permission. The deadline for applying for Reserved Matters was September 2022. Within a complex site and project, the impact of COVID on

available tendering process time, left a tight timeframe for submitting Reserved Matters.

2.3 In July 2022 an extension request was applied for via a Section 73 Application (Section 73 of the 1990 Act provides for applications for planning permission to develop land without complying with previously imposed planning conditions).

2.4 Reserved matters, however, were successfully applied for by the deadline and the approval process was completed, with Full planning approval granted on 16 March 2023, effectively re-starting the expiry which, not stated, is legislatively 2 years to commence construction, 16 March 2025.

2.5 The Health Board have advised that the 'contingent' Section 73, in the act of obtaining full planning permission, was effectively rendered void. The Project Finance Director has verbally stated that he is not able to identify or foresee any current risks to the expect construction timeline to affect the 2-year expiry date being met.

2.6 In addition to the planning applications required to fulfil the position to be attained ahead of financial close, land was also to be transferred from Cardiff and Vale University Health Board. The land transfer was complete pending a letter of comfort from the Welsh Government – at the time of reporting this was expected to be completed imminently. (**MA 3**)

2.7 Some delay to the targeted financial close date had occurred due to a number of factors, including planning and license requirements.

2.8 A significant number of planning approvals which were subject to conditions have received 'Discharge of Condition' certification, whilst the remainder were largely outstanding as they relate to a build material or process that will not be fulfilled until the build has completed and been assessed by the Council.

2.9 Subsequent to the audit, the European Protected Species Licence (EPSL) was secured from Natural Resources Wales (NRW). In view of this, and recognising progress post audit fieldwork, **substantial** assurance has been determined.

Monitoring: *To obtain assurance that a strategy was in place to monitor and progress any known planning conditions.*

2.10 The Town and County Planning Report [issued May 2019] set out the formal planning strategy for the Enabling Works, as advised by an externally appointed planning consultant.

2.11 The externally appointed planning consultant has been responsible for all planning applications and for working with the project team and Cardiff Council to obtain 'Discharge of Planning Condition Notices' ahead of the Financial Close deadline.

2.12 Cardiff Council maintained the planning portal where all planning documentation can be viewed. The planning consultants separately maintained their own records within a 'nVCC Planning Sheet', which was regularly provided to the Velindre

project team. The nVCC Planning Sheet format reflects that of a risk register or issues log and does not fully reconcile with the planning portal, it also included 'simplified' references and descriptions. The project planning team have explained that this was because many of the planning applications approved will have several attached conditions, which will subsequently have their own documents related to their discharge, so only the highest level of planning application was recorded and can be drilled down within the Cardiff Council portal.

2.13 There was no comprehensive internal document that shows all planning applications and all conditions and associated discharge statuses which reflects these electronic filings. (**MA 1**)

2.14 The planning consultant met with the project team on a two weekly basis to discuss outstanding applications and discuss the progress on applications.

2.15 The project team met with the Cardiff Council Planning Department on a two-weekly basis without attendance from the planning consultant and this is noted to act as a control; providing them with independent status verification where they can assess the progress made.

2.16 In respect of the above, the Senior Project Manager verbally confirmed that they believe that the information provided by the planning consultant had been proactive and efficient and had allowed them to facilitate discussions with both the contractors and Cardiff Council, limiting their requirement to duplicate effort or performing detailed tracking activity internally on each planning application.

2.17 A further document provided by the planning consultant to the project team entitled 'All Subs' and which included 10 applications with Cardiff Council Planning Portal references was provided during the audit (July 2023). We were advised that this was the most recent version of the document, despite it being dated January 2023, however upon sampling the 10 applications which were stated to be awaiting approval, 9 had been approved, in March 2023; the Health Board advised they were awaiting an updated version. (**MA 1**)

2.18 Progress had been made in acquiring planning consent, however it is unclear as to how 'hands on' the project team have been, or whether the Project Board have had the capacity to hold the external planning consultants to account, due to the lack of clear reporting. (**MA 1**)

2.19 The project team appear to be conversant and up to date with the current planning activities and have maintained strong communication with the external planning consultants. However, there is concern regarding the level of key-person responsibilities and risk related to retention of knowledge by an external party related to planning. The auditable trails was limited by the lack of correlation between reporting available to the project team and the Cardiff Council Planning Portal references. (**MA 2**)

2.20 Recognising the positive working relationship between the project team and external planning consultants, **reasonable** assurance has been determined at this time.

Communication: *That an appropriate communications and stakeholder engagement strategy had been appropriately applied at the project; and that management had fully consulted stakeholders and obtained full details of any objections.*

2.21 A Communications and Stakeholder Engagement Strategy, supporting the planning applications by the Trust for access to the nVCC, was approved by the Trust Board in December 2019.

2.22 The intention of the strategy was to maximise *"communications and engagement opportunities by being proactive and 'going the extra mile' where possible".*

2.23 A *'Communications and Engagements update'* section of the Project Board papers and Highlight report recognised ongoing engagement with internal staff, local residents, general public and Ward Councillors. Publicly published Project Board papers note that public engagement meetings have been held in Whitchurch library on various dates with limited to no attendance by members of the public, despite being advertised on social media.

2.24 Social media activity is evident with members of the public encouraged to join the 'Velindre Voices Community Panel'; the Health Board stating they will *"provide an inclusive and safe space where those with an active interest in new Velindre Cancer Centre can have their say, feedback on plans, make suggestions and have a voice in decision making"* *www.facebook.com/velindrecc 7 July 2023.*

2.25 There is evidence of Board commitment to openly discussing communication strategies and their value to all stakeholders. Activity is evidenced on a variety of levels. As a result of this a **substantial** assurance rating has been concluded in this area.

Reporting: Reporting processes were operating effectively within the governance structure to ensure risks / issues are highlighted in a timely manner.

2.26 The Project Board received regular updates on planning issues via the Highlight Report, there was also evidence of specific issues being raised under 'Any Other Business'. This was a high-level update and there was evidence that this information was not consistently updated and included contradictions (e.g., the July 2023 highlight report included a risk for a layby approval submitted in April 2022 but also noted the status as Green with planning consent received 30th June 2023).

2.27 Below the Project Board, internal reporting related to planning was limited to informal notes from meetings with the external planning consultants or Cardiff Council. Most information provided to the Project Board was derived from reporting generated by the external planning consultants. This was a sheet set out in the

format of an issues register and by its nature was useful in highlighting areas of concern, however it tended to be thematic and neither the reference nor description of the items correlated with the Cardiff Council Planning Portal.

2.28 Due to the lack of complete oversight over the planning applications, and in the absence of a definitive list showing all applications (including e.g., Cardiff Council Planning Portal reference, approval status) there is concern that the project team and the Project Board could not easily hold the external consultant to account, were it required.

2.29 For note, a report was provided by the Assistant Project Director before the audit report had been finalised: '230816 VCC FBC Planning', which was produced by the external planning consultants and offered a form of rounded and contextual planning status reporting. (**MA 1**)

2.30 The Board has actively challenged lack of reporting of some planning and licensing items; in 'Items for Note' in the June 2023 Transforming Cancer Services New Velindre Cancer Centre Board Meeting, the minutes state *"It was discussed that the risk of EPSL and Land Transfer are not being captured within this highlight report or risk paper"*; the delay in obtaining an EPSL from NRW resulting in a postponed Financial Close (expected October 2023, originally planned for June 2023).

2.31 Due to the apparent reliance on external monitoring and tracking of the planning applications, a **reasonable** assurance rating has been concluded for this element.

Appendix A: Management Action Plan

Matter Arising 1: More cohesive monitoring of planning applications (Design & Operation)		**Impact**
Planning applications associated with the nVCC site were available to view, with all associated documents, on the Cardiff Council Planning Portal using either a reference number or description to search for them. It stands to reason that an internally maintained listing showing correlating information would allow for all potential users of the information to easily identify all applications that have been made and access the portal to see their status. The use of an external planning consultant lessened the physical need to manage the process, however the ability should still exist to scrutinise the activities undertaken by the external consultant, to reduce key dependencies. During the audit it was noted that reporting provided by the external planning consultant to the project team largely did not include comprehensive listings of all planning applications, licences, and/or conditions in a single document – and did not include planning portal references. Whilst the project team were conversant with current planning activities, there was no single, comprehensive, point of reference for the status of planning approvals, which could be referred to by Project Board.		Potential risk of: • Unsuccessful applications or delayed consent because of missing information or weakly implemented planning strategy impacting the achievement of financial close. • Reporting failing to give the Project Board comprehensive oversight of the planning status, limiting ability to manage the process and any issues in a timely manner.
Recommendations		**Priority**
1.1	A comprehensive list of all applications made to Cardiff Council, Natural Resources Wales, and other organisations should be maintained using portal reference numbers/ descriptions, noting approval status (including conditions and Discharge of Conditions) and expiry dates of consent.	**Medium**

	The report mentioned in 2.29 above would be an appropriate report to be obtained from the external planning consultants on a monthly basis.	
1.2	The full aforementioned list should be published as an appendix to the Project Board papers or otherwise distributed to the Project Board, on a monthly basis, to facilitate discussion and raise awareness of planning, licencing and land transfer issues, and possible impacts	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	A database for all statutory approvals (planning permissions; EPSL approvals) relating to the nVCC will be developed that aligns to the Cardiff County Council and NRW reference numbers. The database will outline any statutory approvals awaiting approvals such as discharging planning conditions.	March 2024	Assistant Project Director
1.2	Monthly Statutory approvals report to be developed for Project Board.	March 2024	Assistant Project Director

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that the project achieves its key delivery objectives and 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

AUDIT COMMITTEE

Counter Fraud Progress Report

DATE OF MEETING	19/12/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	GARETH LAVINGTON
PRESENTED BY	Gareth Lavington
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The counter fraud progress report provides a detailed breakdown of the work carried out by the team during the relevant period. The report breaks down the areas of work into the most relevant work streams that align with the NHS Counter Fraud Authority requirements for compliance. These areas are: Infrastructure/Annual Plan Promotion and Awareness and Education

	Prevention Referrals Investigations Fraud Risk National Fraud Initiative Any further information that it is felt that should be presented to the committee is provided in Section 3 - Other

RECOMMENDATION / ACTIONS	It is recommended that committee note the report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS NA	

7 LEVELS OF ASSURANCE	
NA	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
3	NA

1. SITUATION

The purpose of the Counter Fraud Progress Report is to provide the Audit Committee with a breakdown of the work carried out by the Local Counter Fraud team on behalf of the organisation during the relevant time period. The report's style has been adopted, in consultation with the Director of Finance. This report consists of:

a. Counter Fraud Progress Report

2. BACKGROUND

In compliance with the NHS CFA standards Counter Fraud is a standing item at Audit Committee. Regular progress reports are written and presented by the counter fraud manager. The provision is overseen by the Director of Finance within the organisation. The report seeks to highlight all work carried out by the team and breaks this down into proactive and reactive areas.

3. ASSESSMENT

It is proposed that the report is noted.

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐

<table>
<tr><td colspan="2">

- An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
- A sustainable organisation that plays its part in creating a better future for people across the globe ☒

</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>Choose an item</td></tr>
<tr><td rowspan="3">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>There are no specific quality and safety implications related to the activity outined in this report.</td></tr>
<tr><td>Safe ☐
Timely ☐
Effective ☐
Equitable ☐
Efficient ☐
Patient Centred ☐</td></tr>
<tr><td>The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

[Please include narrative to explain the selected domain in no more than 3 succinct points].

Click or tap here to enter text</td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information:
https://www.gov.wales/socio-economic-duty-overview</td><td>Choose an item</td></tr>
<tr><td>[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].

Counter Fraud Progress report – An administrative report only.</td></tr>
</table>

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosporous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].

All risks must be evidenced and consistent with those recorded in Datix

NHS WALES

Counter Fraud Progress Report

08/09/2023-01/12/2023

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Velindre UNHST.

This report relates to activity for the reporting period 08/09/2023-01/12/2023

2. Progress

Infrastructure/Annual Plan

The below activity has taken place -

i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.

ii. Continued maintenance of Counter Fraud digital platform – Members of the Audit Committee are encouraged to visit the site at the link/QR code here. The site can also be accessed via the VUNHST intranet site within the finance share point pages.

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

Corporate Induction– Liaison with Information Governance has assured that Counter Fraud will now be made an awareness activity for all new starters. Awareness sessions

have been agreed for in person activities at Velindre HQ and at the Welsh Blood Service on the following dates:

14/11/2023

13/12/2023

14/12/2023

20/12/2023

17/01/2024

21/02/2024

Intranet Site- during this Quarter the intranet site has received 216 visits.

Other/Ad Hoc/Trial promotional activity- Promotional activity has taken place in relation to International Fraud Awareness Week. This has involved digital offerings via the dedicated Counter Fraud Share Point pages throughout the week, and supported by visits to Velindre UNHST sites with pop stalls and promotional material.

E- Learning – The new e-Learning package is now Live on the ESR system and available to staff. Liaison made with WOD to target new starters with an objective of completing the module.

VUNHST staff uptake – Not available until January

NHS Wales staff uptake – Not available until January

(since launch 04/23)

Prevention

Local Bulletins/Alerts – (0)

IBURN (intelligence bulletin) – (0)

FPN – (Fraud prevention notice) – (1) 1 x FPN has been issued. Relating to the impersonation of Medical Professionals. FPN disseminated to key stakeholders and support material supplied. Local Proactive work in relation to this subject area commenced. No issues identified to date. Work continues.

LPE (0)

Fraud Risk

A further 3 fraud risk assessments commenced in relation to the following subject areas. (Based upon inherent fraud risks as identified by the Counter Fraud Authority)

- Petty Cash
- Credit Cards
- Cheque Usage Fraud

When complete these will be submitted to relevant stakeholders for review and action.

National Fraud Initiative

Work has commenced into the latest NFI data dump. The below table provides the total matches that require investigation by the Counter Fraud Team

Report Type	Total No. of Matches	No. Cleared
Payroll to Payroll - NI	20	20
Payroll to Payroll - Tel. No.	7	7
Payroll to Pension	15	15
Payroll to Company Director/Trade Creditor	6	0
Payroll to Creditor	17	0

3. Referrals & Investigations

NA

4. Other

NA

5. Appendices

NA

AUDIT COMMITTEE

Losses & Special Payments Report 2023/2024

DATE OF MEETING	19/12/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Tracy Hughes, Interim Head of Financial Operations
PRESENTED BY	Tracy Hughes, Interim Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 This paper has been prepared to provide the Audit Committee with an update in relation to debts written off and losses paid in respect of loss or damage of personal property, during the period 01/09/2023 – 30/11/2023. A summary of the 2023/2024 year to date position is also provided.

1.2 This report does not include the NWSSP losses and special payments, such as stock losses, which are reported separately to the NWSSP Audit Committee.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 There have been no new debt write-offs in the period 01/09/2023-30/11/2023.

2.2 As previously reported, the total amount of debt written-off to date in this financial year is £12,910. These debts are summarised below and have all been authorised in line with the Scheme of Delegation within the Trust's Standing Orders & Standing Financial Instructions.

Summary	**Trust**	**Hosted**	**Total**
	£	**£**	**£**
Salary Overpayment		3,847	3,847
Trade & Commercial	8,737	501	9,238
Other	79	-254	-175
Total	8,816	4,094	**12,910**

2.3 These debts were included in the 2022/2023 provision for expected credit losses and therefore will not result in an additional charge to the Trust's Income & Expenditure statement for 2023/2024.

2.4 The age range of the debts written off is between the years 2012 – 2020.

2.5 No further items have been agreed through the Losses and Compensation procedure. The total expenditure to date remains at £6,600, consisting of:

2.5.1 Reimbursement for the cost of replacing glasses;

2.5.2 Reimbursement for damage to a car.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Committee are informed that during the period 1/9/2023 – 30/11/2023, there have been: • No further debt write-offs, and • No payments agreed under the Losses and Compensation Procedure. The 2023/2024 year to date position consists of: • Debt write-offs totaling £12,910; • Two payments under the Losses and Compensation Procedure totaling £6,600.

4. RECOMMENDATION

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

AUDIT COMMITTEE

CAPITAL MANAGEMENT PROCEDURE REIVEW

DATE OF MEETING	19/12/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting
PRESENTED BY	Steve Coliandris – Head of Financial Planning & Reporting
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The Capital Management Procedure has been reviewed with updates attached.
RECOMMENDATION / ACTIONS	Audit Committee is asked to **APPROVE** this procedure. The procedure was reviewed at the CP&DG on the 14.11.2023. The procedure was reviewed by the SCB via an out of meeting.

	This procedure was endorsed for approval by EMB on the 04.12.2023

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Capital Planning & Delivery Group (CP&DG)	14/11/2023
Strategic Capital Board (SCB) (Out of meeting)	21/11/2023
Executive Management Board (EMB)	04/12/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The procedure was reviewed at the CP&DG on the 14.11.2023. The procedure was reviewed by the SCB via an out of meeting request on the 21/11/2023. The procedure was endorsed for approval by the EMB on the 04/12/2023.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed. N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the* ***"How to Guide for Reporting to Trust Board and Committees"*** N/A

APPENDICES	
Appendix 1	Capital Management Procedure (Clean copy)
Appendix 2	Capital Management Procedure (Tracked Changes)

1. SITUATION/ BACKGROUND

1.1 This procedure has been developed to ensure that Velindre UNHS Trust has appropriate management and governance arrangements in place around capital expenditure. These will determine how capital is planned, prioritised and managed in-year within the Trust.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Significant changes have been made to the procedure following the formation of the Strategic Capital Board and new accounting treatment for leases. Refer to current review changes on page one of the procedure also listed below.

Major Changes Include:

1. IFRS 16 – Inclusion of guidance of new accounting standard for leases.
2. Updated guidance ensuring that Medical Devices and Equipment bids are supported by the Medical Devices Group.
3. Project Bank Account – Inclusion of guidance on when to use Project Bank Account.
4. Escrow Account – guidance included on use of an Escrow account/ agent.
5. Updated Guidance on business case governance route following the formation of the Strategic Capital Board.
6. Updated TOR for Capital Planning and Delivery Group
7. New Trust Discretionary Prioritisation and Business Case Template (Attached as appendix 2)
8. Updated Roles and Responsibilities

2.2 Engagement on this policy is as follows:

Meeting	**Date**	**Recommendation**
Capital Planning & Delivery Group	14th Nov	**Reviewed**
Strategic Capital Board	21st Nov	**Reviewed**
Executive Management Board	04th Dec	**Endorsed for Approval**

Audit Committee	19th Dec	For Approval

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The procedure relates mainly to financial processes and does not directly impact adversely on people. Discussed and agreed with W&OD Equality and Diversity manager. An EQIA is not required for the Capital Management Procedure as EQIAs are undertaken as part of the Strategy development

	and IMTP process in relation to service plans and associated changes to services that lead to prioritisation decisions for investment, including how the Trust capital funding is invested. These EQIAs on Strategies and IMTP priorities are required to ensure the decision-making processes are fair and do not present barriers to participation or disadvantage any protected groups from participation
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	N/A
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust
Financial Control Procedure (FCP 01)

CAPITAL MANAGEMENT PROCEDURE

Date to be reviewed:	October 2023	**No of pages:**	42
Author job title(s):	• Head of Financial Planning & Reporting • Deputy Director of Planning & Performance		
Responsible Director:	Executive Director of Finance / Director of Strategic Transformation, Planning and Digital		
Approved by:			
Date approved:			
Effective Date (live):			
Version:	2		

Documents to be read alongside this policy:	This procedure should be read in conjunction with: • Trust's Standing Orders and Standing Financial Instructions. • Trust's Scheme of Delegation • Other Financial Control Procedures including FCP 2 – Noncurrent Fixed Assets • Medical Devices and Equipment Management Policy (QS24) • Other guidance issued by the Welsh Government (WG) in particular the NHS Trusts Manual of Accounts. • Other internal and external guidance as appropriate.

Current review changes:

Significant Changes following the establishment of the Strategic Capital Board and introduction of new accounting treatment for Leases.

Major Changes Include:

1. IFRS 16 – Inclusion of guidance of new accounting standard for leases.
2. Updated guidance ensuring that Medical Devices and Equipment bids are supported by the Medical Devices Group.
3. Project Bank Account – Inclusion of guidance on when to use Project Bank Account.
4. Escrow Account – guidance included on use of an Escrow account/ agent.
5. Updated Guidance on business case governance route following the formation of the Strategic Capital Board.
6. Updated TOR for Capital Planning and Delivery Group
7. New Trust Discretionary Prioritisation and Business Case Template (Attached as appendix 2)
8. Updated Roles and Responsibilities

Executive Summary

This procedure is provided to ensure that Velindre UNHS Trust has appropriate management and governance arrangements in place around capital expenditure. These will determine how capital is planned, prioritised and managed in-year within the Trust's structure. This procedure introduces a standardised approach for producing discretionary capital Business Cases. This procedure does not apply to NWSSP.

First operational:	April 2017				
Previously reviewed:	Oct 2022				
Changes made yes/no:	Yes				

Contents

1. Introduction and Purpose

1.1 This procedure has been developed to ensure that Velindre UNHS Trust has appropriate management and governance arrangements in place around capital expenditure. These will determine how capital is planned, prioritised and managed in-year within the Trust.

1.2 This procedure provides advice on how to prepare bids for consideration by the Capital Planning and Delivery Group or Strategic Capital Board and for successful bids.

1.3 This procedure includes HTW but does not apply to NWSSP. This document does not offer a definitive guide to the procurement of projects.

2. Scope

2.1 This procedure is intended for use by all staff, and anyone involved, or with an interest in capital bids and allocation.

3. What Is Capital?

3.1 **Capital expenditure** is expenditure in excess of £5,000 (including VAT where this is not recoverable) on:

a) Acquisition of land and premises, lump sum and payment for related rights (including capitalised rents), and payments made under the Land Compensation Act 1973 and associated fees.
b) Individual works schemes for the initial provision, extension, improvement of, adaptation (including upgrading), renewal, replacement or demolition of buildings, building elements (e.g. roofs), external works, engineering services or plant.
c) A single item of equipment.
d) All vehicles.

3.2 **Grouped assets** are a collection of assets which individually may be valued at less than £5,000 but which together form a single collective asset with a group value of £5,000 or more because the items fulfil all the following criteria:

- The items are functionally interdependent.
- The items are acquired at about the same date and are planned for disposal at about the same date.
- The items are under single managerial control; and
- Each individual asset thus grouped has a value of at least £250, however this deminimus value does not apply in dealing with the initial equipping of hospitals.
- The distinction between assets that are in some way dependent on each other for their effective and efficient operation, and those

that are “stand-alone” items can be a fine one. Where items are used within a system (e.g trays of sterile instruments are designed to be used with a specific sterilisation system), those items are likely to be considered interdependent even though they also have a value in “stand alone” use.

This is applicable to both tangible and intangible assets.

IT Equipment may be considered interdependent if it is attached to a network, the fact that it may be capable of stand-alone use notwithstanding. The effect of this will be that all IT equipment purchases, where the final three criteria above apply, will be capitalised.

Software which is integral to the operation of hardware (e.g. an operating system) is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware (e.g. application software) is capitalised as an intangible asset.

3.3 The cost of an item of property, plant and equipment comprises its purchase price, any directly attributable costs and the initial estimate of the costs of dismantling and removing the item and restoring the site on which it is located.

Directly attributable costs include the following:

- Costs of employee benefits arising directly from the construction or acquisition of the item of property, plant and equipment.
- Costs of site preparation.
- Initial delivery and handling costs.
- Installation and assembly costs.
- Costs of testing whether the asset is functioning properly.
- Professional fees.

- Only those directly attributable labour costs (employee benefits) that relate to the time spent by employees on constructing or acquiring the specific asset should be capitalised. Where an entity’s own staff are involved in the acquisition, construction or development of a piece of property, plant and equipment, **the relevant proportion of the internal costs relating to those staff should**, if material and if the other criteria for capitalisation referred to in this section are met, be included in the cost of the asset.

- Such internal costs will include own employees’ (e.g. site workers, in-house architects and surveyors) salaries and expenses arising directly from the construction and acquisition of the specific tangible fixed asset. Administration and other general overhead costs should be excluded from the cost. Employee costs not related to the specific asset (such as site selection activities) are not directly attributable costs.

- the incremental costs to the entity that would have been avoided only if the tangible fixed asset had not been constructed or acquired. These include:
  - ◊ acquisition costs such as stamp duty, import duty and non-refundable tax
  - ◊ the cost of site preparation and clearance
  - ◊ initial delivery and handling costs
  - ◊ installation costs, and
  - ◊ professional fees (such as legal, architects' and engineers' fees).

Included in these definitions would be items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost. In addition, any expenditure incurred relating to costs in relation to safety regulations or statutory legislation should be capitalised.

Non-attributable costs that should be regarded as revenue expenditure include the following:

- Costs of opening a new facility.
- Costs introducing a new product or service (including costs of advertising and promotional activities).
- Costs of conducting business in a new location or with a new class of customer (including costs of staff training).
- Administration and other general overhead costs.
- Training costs.

3.4 Expenditure on maintaining capital assets in effective working order, or in good repair, is charged to revenue irrespective of cost. The exception is where the repairs include improvements to the original standard, in which case that cost will be charged to capital if it falls within the above definition of capital expenditure.

3.5 Items charged against the Capital Programme shall be in accordance with the above definition. Compliance is also required with International Financial Reporting Standards (IFRS), the Government Financial Reporting Manual (FReM) and the capital section of the Manual for Accounts, on the identification of and accounting for, capital expenditure.

The Link to the Government Financial Reporting Manual (FReM) can be found below:

https://www.gov.uk/government/collections/government-financial-reporting-manual-frem

3.6 A **lease** is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time. The following points (individually or

in combination) would normally lead to a lease being classified as a Capital purchase:

- The asset transfers ownership at the end of the lease.
- There is an option to buy the asset at the end of the lease term at a favourable price.
- The lease term is for the major part of the asset's life.
- The present value of the minimum lease payments is substantially all of the fair value of the asset.
- The asset is of a specialised nature and cannot be used by another lessee without major modification.
- If the lessee can cancel the lease and any lessor losses associated with the cancellation are borne by the lessee.
- Gains or losses from the fluctuation of the fair value fall to lessee.
- The lessee has an option to continue the lease for a secondary period and the rent is substantially lower than market rent.

The treatment of Leases has been affected by IFRS16 which is a new international financial reporting standard (IFRS) for lease accounting which came into effect from 1st January 2019 and came into force for the NHS from 1st April 2022.

IFRS 16 takes a totally new approach to accounting for leases, called the 'right-of-use' model. This means that if a company has control over, or right to use, an asset they are renting, it is classified as a lease for accounting purposes and, under the new rules, must be recognised on the company's balance sheet.

IFRS16 effectively removes the distinction between operating leasing and finance leasing. Both Lease elements will now form part of the balance sheet.

The 'right of use model' says a "contract is, or contains, a lease if it conveys the right to control the use of an identified asset for a period of time in exchange for considerations".

Examples of Leases which will now fall under IFRS16 and classed as a Capital Purchase include:

- Rented Property
- Pool Vehicles
- Managed Contracts (Depended on Contract agreement)

Exceptions to the rule

There are two specific types of lease which don't come under IFRS 16 leases and which don't have to be recorded as an asset:

1. A lease where the value of the item when new is *low value*, currently indicated as less than £5000.
2. A lease with a shorter than 12-month term and which does not have an option to buy the leased item at the end of the lease.

So, for example, if you were to use a scheme where the lease period on a vehicle is less than 12 months and you don't have the option to buy the cars at the end of the contract, then these would not be included under IFRS 16.

4. Where Does Capital Funding Come From?

4.1 Each year the Trust receives a Capital Expenditure Limit (CEL) allocation from the Welsh Government (WG). The Trust has an annual financial duty to ensure that its capital expenditure does not exceed this allocation. The funding comprises two elements:

- **Capital Funding issued by WG for a Specific Purpose** – WG has a number of capital budgets which the Trust can bid against.

  Discretionary Capital – This is a one-off annual allocation given to the Trust by WG every year to meet statutory obligations (such as health and safety and firecode), to maintain the fabric of the estate and to timely replace equipment. As the title implies, the Trust is free to prioritise the sum allocated as it best sees fit.

4.2 In addition, capital funding may also be obtained from alternative sources such as:

- Charitable Funds.
- Donated Monies e.g other Charities.
- Grant funding.
- Private Sector

5. The Capital Planning Process

Discretionary Allocation

5.1 Divisions will develop a prioritised list of capital schemes that have been signed off by their respective Senior Management or Leadership Teams or sub delegated to Divisional Business Planning Groups. These will be forwarded to the Capital Planning and Delivery Group for consideration against the Trust Discretionary allocation.

5.2 Digital will also develop a list of Digital investment schemes that are required across the Trust and submit this to the Capital Planning and Delivery Group for consideration.

5.3 The Capital Planning and Delivery Group will meet and recommend how discretionary capital is allocated, managed and monitored on an annual basis taking into account both the short term and long term investment plans of the Trust.

5.4 There may be pre-commitments to the Capital Programme in any one year to fund, for example:

- Capital slippage from the previous year.
- Agreed top-slicing of discretionary capital funding for Divisions, Estates and Digital.
- Agreed rolling programmes of equipment replacement.
- Agreed projects whose timescales mean that funding straddles two or more financial years.
- Agreed contingency sums to address in year equipment breakdowns and minor works.

This funding is top sliced from the discretionary capital allocation before any other bids are considered.

5.5 The Capital Planning and Delivery Group membership ensures equitable access and a transparent process for all areas of the organisation to bid for the available discretionary capital and provides a Group which has an overall view of discretionary capital prioritisation and investment at any one particular time and monitors the expenditure of capital. The terms of reference of this Group are attached in Appendix 1.

5.6 The Capital Planning and Delivery Group considers the bids for discretionary capital funding and recommends which should be submitted for approval.

5.7 The recommended capital programme for utilisation of the discretionary programme is then submitted to the strategic Capital Board for endorsement before being submitted to the Executive Management Board for approval.

5.8 Once the discretionary Capital Programme has been approved by Executive Management Board, the Trust's Deputy Director of Planning & Performance will formally notify the Capital Planning and Delivery Group.

5.9 Once a discretionary capital scheme has been approved by Executive Management Board (EMB), a discretionary capital Business Case must be completed and authorised correctly and ultimately by the appropriate Divisional Director. A copy of the business case should be sent to both the Trust's Planning &Financial Planning & Reporting team.

5.10 The process of producing a discretionary capital Business Case should remain within the Division although advice will be available from the

Trust Financial Planning & Reporting Department, the Trust Capital Planning Department and the NWSSP Procurement Service as required.

5.11 The Capital Planning and Delivery Group will then oversee the management of the Trust's approved Capital discretionary Programme. The Group meets regularly (usually monthly but more frequently towards the end of the financial year) and is responsible to the SCB & EMB for the effective, efficient and best value use of the discretionary capital monies available to the Trust as dictated by the CEL.

5.12 The SCB, EMB, and Trust Board will be informed of the approved capital discretionary programme at the start of the financial year and be given regular updates thereafter through a highlight report to SCB, and via the Trust Finance Report for EMB and Trust Board.

5.13 All business cases requesting funding over £100k exceeds the Chief Executive approval and must be approved by both EMB and the Trust Board.

5.14 A draft capital plan is approved by Trust Board as part of the Three Year Integrated Medium Term Plan (IMTP) process.

All Wales Capital Bids

5.15 The responsibility for considering recommendations for All Wales capital funded schemes sits with the Strategic Capital Board (SCB). These schemes should be included within the Trust integrated medium term plan (IMTP). Further details are provided under section 8.

6. Making Capital Bids against the Discretionary Capital Programme

6.1 Towards the end of the last quarter of the financial year information will be issued to the members of the Capital Planning and Delivery Group by the Head of Financial Planning & Reporting, which will include the Trust's discretionary capital allocation and pre-commitments against this for the next financial year.

6.2 The Trust Financial Operations Team will provide the Capital Planning and Delivery Group with a list of tangible and intangible assets (by Division and then Department) which has been taken from the Trust's Fixed Asset Register. This should assist Divisions in identifying goods that are approaching the end of their useful asset life.

6.3 Divisions will then be asked to submit their list of prioritised capital schemes for consideration for the following year.

6.4 Divisions may also submit any discretionary capital bids for future years that may need early approval because they have a long lead-in time e.g.

schemes that must be tendered via the Official Journal of the European Union (OJEU).

6.5 Identifying capital requirements for the year ahead must be undertaken at a Divisional level and ultimately approved by the Divisional Senior Management / Leadership Teams. All bids should be analysed from a service point of view. A range of options should be considered and analysed with the best approach identified (records of the selection criteria and short-listing process should be maintained to demonstrate the worthiness of the selected option). If this requires investment of a capital nature, then the following must be considered:

a) What will be the benefits and costs both in financial (including VAT where it is not recoverable) and non-financial terms?

b) Can the required investment be justified? Although a new piece of equipment may be desirable, if it cannot be justified on the grounds of achieving the Trust's IMTP then it should be rejected at this early stage.

c) If a proposal is deemed justifiable then the next stage is to consider the impact on other services. Although a scheme may appear to achieve corporate aims and be efficient in isolation, the broader costs/aims may reverse this assessment and lead to rejection of the proposal.

d) Revenue implications must also be taken into account. Increases in revenue costs (such as staff, maintenance, fuel costs, consumables, insurances etc) are rarely funded, which means service managers must identify ways of funding these increased costs within existing resources. The fact that revenue funding cannot be identified does not preclude a proposal from being submitted, as funding may be available from else-where, however the chances of success are diminished, especially where these costs are significant.

e) The Service must consider other costs associated with the proposal such as those associated with temporary housing of personnel whilst the project is carried out, decanting of wards, the transfer of records in electronic format (all of which can be included in the capital costs). These can prove significant and are required in order for the proposal to be fully appraised. If these costs are identified at some later date, it may necessitate the cancellation of the project and the loss of the funds expended to that date – plus any other funds that have been committed.

f) Division Directors/Service Leads must consider the broader picture and appraise how the proposal in question will affect other activities that are envisaged in the forthcoming year, or

timescale of the proposed project and to ensure that the correct approach is being put forward. They will have to consider the project management arrangements and what roles are to be filled by which personnel – and are these people properly trained and available for the roles intended? Compliance with standards and guidance (such as NICE, Data Protection Act) will also have to be taken into account.

6.6 Ultimately it is the Divisional Director and the Senior Management / Leadership Teams that submit discretionary capital scheme proposals to the Capital Planning and Delivery Group. Each bid must have sufficient supporting documentation accompanying it for a reasonable appraisal to be made and decided upon. All bids should include:

- Value Added Tax (VAT) and take into account enabling works and revenue costs i.e. consumables and/or utility costs associated with the bid.

- Proposals to replace existing equipment must identify the equipment being replaced by noting the asset identification number and the net book value of the item as detailed in the asset register. This information can be obtained from the Trust's Financial Planning & Reporting Function. Assets which are shown as not having reached the end of their designated life, and therefore having a positive net book value, will not be replaced without an explanation as to the circumstances and an assessment that the need to replace is unavoidable.

- An estimate of purchase and whole life costs must be provided and validated wherever possible by the Procurement Department.

- Bids for building/refurbishment projects and those which include enabling works/utility costs must be validated by the Estates Department to ensure that the bid can be delivered. Discussions with the Estates team should take place as a part of developing the prioritisation and business case template, in advance of the bid being submitted to the Capital Planning Group for approval.

- Bids for Digital Systems or with Digital implications must be reviewed by the Digital Department to ensure that the bid can be delivered. Discussions with the Digital team should take place as a part of developing the prioritisation and business case template, in advance of the bid being submitted to the Capital Planning Group for approval,

- All Welsh Blood Service bids must also be appraised by the Welsh Blood Service Regulatory Compliance and Quality Assurance Department in terms of impact and Good Manufacturing Practice (GMP)/validation resources.

- All Medical Devices and Equipment bids that meet the capital definition in Section 3 must be reviewed and supported by the Trust Medical Devices Group in accordance with the Trust Medical Devices and Equipment Policy (QS24).

  https://velindre.nhs.wales/policies/quality-and-safety/qs24-medical-devices-and-equipment/

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6.7 The Capital Planning and Delivery Group meets, discusses and assesses all the bids submitted in order to develop a draft Discretionary Capital Programme which will then be submitted to the Strategic Capital Board (SCB) for endorsement before being submitted to the Executive Management Board (EMB) for approval. This programme once approved will be monitored by the Capital Planning and Delivery Group.

6.8 It may be necessary during the financial year to adjust the approved allocation for capital schemes either as a result of savings or increased spends. Adjustments to planned expenditure (both increases and decreases) must be reported to the Capital Planning and Delivery Group.

6.9 Where there is an emergency request for capital to address urgent medical equipment, estates maintenance or statutory compliance issues and there is no time to wait until the next meeting of the Capital Planning and Delivery Group, the Chair of the Capital Planning and Delivery Group can take forward the approval of the scheme with the appropriate individuals and Boards according to the Trust's Standing Orders and Standing Financial Instructions which can be found via the below link.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx

There may also be times such as yearend where invitation to the Capital Planning & Delivery group is extended to ensure that decisions on Capital expenditure can be made more efficiently. This may include but not limited to inviting the Executive Director of Finance, or the Director of Strategic Transformation, Planning and Digital.

6.10 Occasionally there are opportunities to bid for additional discretionary capital allocations in year when the Welsh Government identify slippage or monies available for specific developments. The bids for these monies are also co-ordinated via the Capital Planning and Delivery Group.

6.11 Divisions should at all times maintain a live, prioritised register of Capital schemes.

6.12 **VAT**

The assessment of VAT treatment needs to be considered for all Capital schemes and as part of developing the prioritisation and business case template. Where necessary advice on the treatment of VAT should be sought from the Finance team. Users should also refer to the HMRC VAT partial exemption guidance in the link below:

https://www.gov.uk/hmrc-internal-manuals/vat-partial-exemption-guidance

7. Discretionary Capital Business Case Development

7.1 A standardised approach for producing discretionary capital Business Cases will ensure:

- Consistency of approach in the presentation of Business Cases.
- The provision of relevant information to support decision making.
- Business Cases align with the Trust's strategic aims and objectives.
- A consistent approach is provided to processing proposed Divisional developments in order to achieve approval from the appropriate body.
- The concentration of time and effort on proposals which are a priority for the Trust.
- A suitable audit trail is provided in relation to investment decision making.
- There is an opportunity to share proposed developments with other Divisions and identify the potential impact on other Divisions across the Trust.
- The Trust is able to supply copies of Business Cases, and associated documents when requested.

7.2 The template to be used for Business Cases that require discretionary capital funding is detailed in Appendix 2. The information required includes:

- A summary of the proposal.
- Identities of the project lead and sponsor.
- The key drivers behind the changes and the benefits of the proposal.
- Identification of the options and selection of the preferred option.
- An assessment of risk, both strategic and operational, associated with the proposal.
- A financial analysis of the preferred option which covers capital costs and revenue costs and/or savings.
- An equality impact assessment.

- A procurement plan.
- An outline of the Digital and Estates resources required to complete the project.
- Project management arrangements and timescales.
- Details of any existing assets being replaced or traded in.

7.3 Sustainability must be a central planning tenet when a Business Case is developed. All new buildings or extensions to existing buildings must be designed in a manner that delivers environmentally responsive architecture, offering high levels of efficiency, sustainable materials and excellent internal environments.

7.4 Whilst a due process needs to be followed, **the resources committed to Business Case production should be commensurate with the materiality and potential risks associated with the project**. Whilst a Business Case which is intending to commit Trust resources needs to be suitably robust, it should not be unduly onerous.

8. Bids for All Wales Capital Funding

8.1 For any capital schemes, which are required to be funded via the Welsh Government's All Wales Capital Programme must be considered by the Strategic Capital Board and a business case will need to be submitted to the Welsh Government and will be considered for approval by the Investment Infrastructure Board (IIB). The schemes identified must align to the Trust's Integrated Medium Term Plan. A business case must demonstrate that the proposed investment has been properly scoped and planned; offers optimum value for money; is commercially viable; affordable and achievable. In addition, a case for any investments should show that the proposal has clearly identified service delivery benefits.

8.2 Before embarking on the preparation of the business case, the Trust is required, in the majority of cases, to agree the nature, type and content of each business case with the WG via a scoping document.

8.3 For major investment proposals the Better Business Case approach using the five-case model should be followed.

As set out in the Better Business Case Templates guidance[1], the following should be considered with regards to whether a scheme classifies as a Major Capital Programme:

- the value thresholds,
- the complexity and risk involved,
- whether the situation is novel or contentious,

- whether procurement is required and the scale of the procurement, and
- whether there are any dependencies, e.g. with business as usual matters or other projects.

In line with the available business case templates, the guidelines below, including value thresholds, help to address which business cases should be classified as a Major Capital Programmes:

For Procurements and Projects (enabling outputs, activities and infrastructure):

1. Single Stage Business Case - Low Value and Risk (£0 to £250k value of procurement).
2. Single Stage Business Case - Medium Value and Risk (£250k to £2 million value of procurement)
3. Three Stage Business Case (SOC, OBC, FBC) – High Value (Over £2 million value of procurement)

[1]https://www.gov.wales/five-case-model-templates

8.4 Programmes should be developed, and cost justified using Programme Business Case (PBC). Major, novel or contentious projects should be developed, and cost justified through three key iterations of the Business Case where formal approval to proceed is required; Programme Business Case (PBC), Outline Business Case (OBC) and Full Business Case (FBC).

8.5 The Business Justification Case (BJC) provides the Trust with a simpler, truncated approach for smaller and less complex investments. The shorter approach retains compliance with the major requirements of good corporate governance and details strategic context, case for change, option appraisal, procurement route, affordability and management. The BJC should be adopted as the standard approach for most schemes under £2million.

8.5 The costs associated with developing these business cases may have to be funded initially out of the Discretionary Capital Programme which would be reimbursed if the scheme was successful in securing Welsh Government funding.

8.6 As soon as any All Wales capital projects are approved by the Welsh Government an appropriate Project Board will be established to ensure projects are completed both within budget and agreed timescales.

8.7 The SCB will expect to see regular updates on approved Capital projects and will be in charge of overseeing the management of the approved

project and is responsible to the EMB for the effective and efficient use of the project in line with the WG funding award letter.

8.8 The financial state of each All Wales capital funded scheme must be reported to the Welsh Government on a monthly basis as part of the Trust's financial monitoring returns. Comments must be included in the letter accompanying the monitoring returns if there are any issues being experienced with a particular scheme. The Executive Director of Finance shall be responsible for submitting the return, liaising closely with the Director of Strategic Transformation, Planning, and Digital.

8.9 **Project Bank Account**

Organisations will be required under Welsh Government rules to use PBAs in infrastructure projects and other appropriate contracts which are valued at £2.00m (net of VAT and other costs that do not affect the supply chain) or more.

For projects less than £2.00m the frequency of payment and length of contract will likely be deciding factors (e.g., greater than monthly payment cycles or contracts less than 6 months in length may not see many benefits).

PBAs are "ring-fenced interest-bearing bank accounts" that have trust status from which payments are made directly and simultaneously to members of the supply chain removing the need for higher tier contractors to process payments. The trust status of these bank accounts means that it helps prevent delays in the transfer of funds and in cases of insolvency the monies in the account relate to an underlying transaction, protecting the supply chain and unable to be used to settle other liabilities.

Further guidance on project bank account can be found on the link below:

ttps://www.gov.uk/government/publications/project-bank-accounts

8.10 **Escrow Account**

Bids that are either large or complex in nature should consider using and Escrow bank account or agent. An escrow account is an account where funds are held in trust whilst two or more parties complete a transaction. This means a trusted third party usually a bank or escrow agent will secure the funds in a trust account. The funds will be disbursed to the merchant after they have fulfilled the escrow agreement. If the merchant fails to deliver their obligation, then the funds are returned to the buyer. Having an escrow account reduces the risk of non-payment. It is a

temporary account that operates only up to the completion of the transaction.

9. Roles and Responsibilities

9.1 Successful delivery of the Capital discretionary Programme will be achieved if named individuals have clear roles and responsibilities as well as delegated authority. These have all been set out in Appendix 3

9.2 The Capital Planning and Delivery Group is responsible for making recommendations to the Trust's Strategic Capital Board and Executive Management Board as to which discretionary capital schemes should be approved. The Capital Planning and Delivery Group is also responsible for overseeing the management of the Trust's Discretionary Capital Programme and for providing regular reports to the Strategic Capital Board

9.3 The Strategic Capital Board will be responsible for reviewing proposed all Wales Capital funded schemes to be included within the Trust Three Year Integrated Medium Term Plan (IMTP).

9.3 To assist Project Managers in managing discretionary capital schemes, a discretionary capital schemes Project Manager's checklist has been devised (Appendix 4).

9.4 Project Managers should make use of project management tools appropriate to project size and complexity. Program Evaluation Review Technique (PERT), Critical Path Method (CPM) and Gantt Charts are commonly used project management tools that can be produced manually or with commercially available project management software.

9.5 Approval of Capital Expenditure must be in line with the Delegated Financial Limits as set out in the Trust SOs / SFIs and the scheme of Delegation Governance framework for major capital programmes.

10. Capital Purchases

10.1 Once a discretionary capital scheme has been approved, the capital scheme Project Manager should obtain indicative costs from the Trust's Procurement department based on a given specification. The indicative costs should also include ongoing revenue consequences such as maintenance. Advice should also be sought as to how the equipment can be procured i.e. National Framework, Quotation/Tender or OJEU etc.

10.2 The Project Manager shall then arrange for the purchases to be made in accordance with the procurement rules contained within the Trust's Standing Financial Instructions.

10.3 The Divisions shall be responsible for raising capital requisitions. Authorisation of all capital requisitions must be in accordance with the Trust's financial limits.

11. Monitoring and Reporting on the Capital Programme

11.1 The discretionary Capital Programme is monitored throughout the financial year as an ongoing process, by the Capital Planning and Delivery Group, chaired by the Deputy Director of Planning. The approved Discretionary Capital Programme will form the basis of the capital monitoring process.

11.2 Commitment and spend against the approved Discretionary Capital Programme is reported to the Capital Planning and Delivery Group on a monthly basis and more frequently at the end of the financial year.

11.3 The All Wales Capital Programme is monitored throughout the financial year as an ongoing process, by the Strategic Capital Board, chaired by the Chief Executive. The approved All Wales Capital Programme will form the basis of the capital monitoring process.

11.4 Commitment and spend against the approved All Wales Capital Programme is reported to the Strategic Capital Board on a monthly basis.

11.5 The Financial Planning & Reporting Function shall analyse all capital expenditure processed through the general ledger and ensure that all expenditure is allocated to the correct cost centre.

11.6 The Financial Planning & Reporting Function shall monitor capital expenditure throughout the year and produce a monthly expenditure statement for each capital scheme and for the Capital Programme as a whole.

11.7 The Financial Planning & Reporting Function will update forecasts throughout the year to identify at the earliest opportunities underspends, overspends and slippages to subsequent years, to enable effective reallocation of funding in order to maximise use of resources whilst complying with the Capital Resource Limit. Reporting should include orders placed along with expenditure to date in order to provide an accurate position on planned spend.

11.8 The Head of Financial Planning & Reporting shall report progress and a spend position on the Capital Programme to the SCB, Executive Management Board, Trust Board and the Welsh Government.

11.9 The key monitoring functions of the Capital Planning and Delivery Group are:

- Monitor the implementation of the approved Discretionary Capital Programme.
- Review discretionary projects currently in progress and just completed. This enables additions to and depletions from the available resources, owing to over and under spends, to be identified.
- Receive and review any reports, cost or otherwise, for discretionary capital schemes that are not on target on an exception reporting basis.
- Recommend changes to the Discretionary Capital Programme as required.
- Administer any reserve within the Discretionary Capital Programme.
- Proactively manage through the year risk of not achieving the CEL.
- Advise the Strategic Capital Board and Executive Management Board on expected and actual projected outturn figures.

11.10 The key monitoring functions of the Strategic Capital Board are:

- Monitor the implementation of the approved All Wales Capital Programme.
- Review All Wales projects currently in progress and just completed. This enables additions to and depletions from the available resources, owing to over and under spends, to be identified.
- Receive and review any reports, cost or otherwise, for All Wales capital schemes that are not on target on an exception reporting basis.
- Recommend changes to the All Wales Capital Programme as required which will need to be reported to WG.
- Advise the Executive Management Board on expected and actual projected outturn figures.

The Trust CEL is fixed by WG in October, any overspend or slippage after this point is expected to be managed internally by the Trust.

12. Fixed Asset Register

12.1 The Director of Finance is required to compile and maintain an up to date Fixed Asset Register to ensure proper management and control over Trust assets. This responsibility is delegated to the Financial Operations team. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance.

12.2 Divisions will regularly be provided with a list of assets they hold on the Trust's Fixed Asset Register. To ensure the accuracy of the Trust's Fixed Asset Register, it is important to verify the existence and continued use of assets. Therefore, on an annual basis, the Financial Operations team

will lead a validation of all Trust assets with support from the Trust Service Managers.

12.3 Where practical, assets should be marked as Trust property.

12.4 Refer to Financial Control Procedure 2 (FCP2) Non-Current assets for maintenance of the fixed asset register including additions and disposal guidance and forms.

13. Training

13.1 Whilst there are no formal training programmes in place to ensure implementation of this procedure, each Executive Director, Divisional Director, Clinical Director, Divisional Manager, Head of Departments must ensure that managers and all staff, clinical and non clinical, are made aware of the procedure provisions and that they are adhered to at all times.

14. Resources

14.1 The implementation and management arrangements associated with this procedure do not present any significant resource implications to the Trust.

15. Implementation and Monitoring

15.1 This procedure will be implemented and monitored by the Capital Planning and Delivery Group.

15.2 Please refer to the responsibilities section (Appendix 3) for further information in relation to the responsibilities in connection with this procedure.

15.3 The Trust will be audited against the delivery of the procedure by Internal and External Audit.

16. Procedure Conformance / Non Compliance

16.1 If any Trust employee fails to comply with this procedure, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this procedure could be considered to be gross misconduct.

17. Distribution

17.1 The procedure will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Finance-Policies.aspx

18. Review

18.1 The Capital Planning and Delivery Group will review this procedure when necessary and at least every three years.

19. Further Information

19.1 For more information please contact either:

- Head of Financial Planning & Reporting on 02920 615888 x6619 or via email: steven.coliandris@wales.nhs.uk
- Deputy Director of Planning & Performance on 02920 615888 or via email: Philip.Hodson@wales.nhs.uk

APPENDIX 1

Velindre University NHS Trust Capital Planning & Delivery Group - Terms of Reference

Name of Group:	Velindre University NHS Trust Capital Planning & Delivery Group
Summary of Role:	The Velindre University NHS Trust ('Trust') Capital Planning & Delivery Group is responsible for overseeing the development and delivery of the annual Trust discretionary capital programme. Following the development of a recommended Trust discretionary capital programme this must be approved by both the Trust Strategic Capital Board and the Trust Executive Management Board. Following approval of the Trust discretionary capital programme the Capital Planning & Delivery Group will be responsible for its delivery.
Remit:	**Capital Strategic Planning & Delivery:** • The development of a Trust capital planning prioritisation framework in respect of our Welsh Government discretionary capital allocation. This will support the prioritisation of capital investment against Trust strategic priorities. • The evaluation and prioritisation of discretionary capital investment proposals from across the Trust. • The development of a prioritised Trust discretionary capital programme for the Trust. • The re-profiling of the Trust discretionary capital programme in response to in-year changes. These may include project over / under spend and / or the availability of additional capital funding in-year. • The delivery of a balanced Trust discretionary capital plan. • The provision of regular monitoring reports to the Welsh Government in relation to delivery against our Welsh Government discretionary capital allocation. **Policy and Procedures:** • The development of the Trust discretionary capital planning policy and procedure. • To ensure that appropriate systems are in place to prioritise discretionary capital bids.

	• To ensure strategic alignment between the Trust's discretionary capital programme and the Trust's major transformation Programmes. **Assurance:** • To advise and make recommendations to the Trust Strategic Capital Planning Board and the Trust Executive Management Board in all matters relating to Trust discretionary capital. (Note: The Trust Executive Management Board is accountable for approving the Trust annual discretionary capital programme following approval by the Trust Strategic Capital Board). • To ensure that policies and procedures are adhered in relation to capital planning. • To regularly monitor and review the Trust discretionary capital programme to ensure continued alignment with national and local strategies.
Reporting to: **Communicates with:**	Trust Strategic Capital Board Trust Executive Management Board Welsh Government Capital Review Group Trust Strategic Development Committee WBS Senior Management Team VCC Senior Leadership Team
Sub Committees:	N/A
Chaired by:	Deputy Director of Planning and Performance
Membership:	• Trust Head of Financial Planning and Reporting (Deputy Chair) • Deputy Director of Finance • Trust Finance Business Partner – Capital • Trust Senior Finance Business & Reporting Manger Partner • Trust Financial Operations Manager • Trust Head of Digital Delivery • Trust Assistant Director of Estates, Environment & Capital Development • Trust Technical Services Manager • General Manager Welsh Blood Service (or deputy) • Welsh Blood Service Capital Planning Manager

	• General Manager Velindre Cancer Service (or deputy) • Velindre Cancer Service Planning and Performance Manager • Corporate Head of Capital Planning (to be appointed) • Corporate Head of Capital Delivery • Trust Business Support Officer (Strategic Transformation, Planning and Digital) • Trust procurement representative **By Invitation:** The Trust Capital Planning & Delivery Group may extend invitations as required to individuals from within or outside the Trust who the group consider should attend. This will take account of the investment proposals that are under consideration at each meeting.	
Meeting Frequency:	Monthly	
Documentation Required:	• Relevant Welsh Government correspondence • Trust discretionary capital programme • Trust discretionary capital planning prioritisation framework • Trust capital asset register • Divisional and corporate investment proposals • Full minutes from the Trust Strategic Capital Board to all members of the Trust Capital Planning Group	
Outputs: (i.e. minutes of meeting submitted to other committee meetings)	• Full minutes from the Trust Capital Planning & Delivery Group to all members of the Strategic Capital Board • Action log to all Trust Capital Planning & Delivery Group members • Trust discretionary capital planning prioritisation framework • Prioritised Trust discretionary capital programme • Trust capital planning & management procedure /policy	
Contact:	**Date ToR Last Revised**	**Next Review Date**
Mr. Philip Hodson Mr. Steven Coliandris	Currently in drat following the establishment of the Trust Strategic Capital Board (Draft TOR developed July 2023)	12 months following approval

Appendix 2

VELINDRE UNHS TRUST – DISCRETIONARY CAPITAL PRIORITISATION AND BUSINESS CASE TEMPLATE

Document Purpose

The Velindre University NHS Trust Capital Planning Prioritisation Framework has been developed to support the assessment and prioritisation of capital funding proposals from across the Trust. The framework outlines a clear, rational approach and a fair, transparent process to ensure that capital resource is prioritised against greatest need.
Following Executive Management Board approval the document much be signed in line with the approved delegation.
In order to provide the Trust with this information, please complete this form for your individual schemes.

Scheme Name:			
Departmental/Location:			
Responsible Lead:		**Date:**	

1. Brief Description of Scheme
2. Main Benefits *What do you want to achieve/what benefits do you hope to realise?*
3. What are the risks if funding for the scheme is not obtained. *Brief outline of Risks* *Detail any Counter measures that can be put in place to reduce risk.* *How long could scheme be delayed before it becomes critical*

Has a Risk Assessment been completed and attached	Yes / No
Is Risk Highlighted on Trust Risk Register	Yes / No
Is Risk Highlighted on Divisional Risk Register	Yes / No

Risk Rating	Critical / High / Medium / Low

4. Estimated Capital & Revenue Costs (£)

Please estimate costs including VAT where applicable. A financial analysis may be attached as an Appendix if preferred.

Capital Cost	Year 1 £'000	Year 2 £'000	Year 3 £'000	Total £'000
Building Works				
Fees				
Equipment				
Commissioning				
IT				
Other (please specify)				
TOTAL				
Estimated Life of Any Equipment (Years)				
Have any other alternative sources of funding been explored? If Yes, please give details				
Revenue Cost & Savings	**Year 1 £'000**	**Year 2 £'000**	**Year 3 £'000**	**Total £'000**
Staff Costs				
Maintenance Costs				
Training				
Other Costs (specify)				
Savings (specify)				
TOTAL				

5. Estimated Delivery Timeframe (months) inc BC Development	
Latest Date that Scheme would need to be approved in order to ensure the scheme was completed in this financial year	

6. Critical Success Factor (tick if applicable and the reason & evidence for your selection)			Reason(s) / Evidence for selection
	Strategic Fit & Business Needs *(The capital proposal must demonstrate: Alignment with the Trust's strategic objectives; Holistic fit and synergy with other major programmes and projects)*	☐	
	WBFGA (Well-being of Future Generations Act) https://futuregenerations.wales/wp-content/uploads/2017/02/150623-guide-to-the-fg-act-en.pdf		
	• *A prosperous Wales (where everyone has jobs & there is no poverty)*	☐	

	• *A resilient Wales (prepared for things like floods)*	☐	
	• *A healthier Wales (everyone healthier & able to see a doctor)*	☐	
	• A more equal Wales *(equal chance whatever their background)*	☐	
	• A Wales of cohesive communities *(communities can live together happily)*	☐	
	• A Wales of vibrant culture & thriving Welsh Language *(do different things & lots of people speak Welsh)*	☐	
	• A Wales of vibrant culture & thriving Welsh Language *(do different things & lots of people speak Welsh)*	☐	
	• A globally responsible Wales *(look after environment & think about other people around the world)*	☐	

		SCORE (Refer to Fibonacci Scoring Sequence (Appendix 1)	**Reason(s) / Evidence for selection**
7. Key Drivers & Evaluation Criteria (score low, medium or high) and the reason & evidence for your selection	Compliance		
	Critical Service Continuity		
	Tier 1 Targets		
	Deliverability		
	Patient/Donor Experience & Environment		

KEY DRIVERS & EVALUATION CRITERIA	
Compliance Requirement	*The capital proposal will support the Trust in meeting statutory, regulatory, accreditation or organisational requirements and accepted best practice. For example, new health and safety legislation or building standards.*
Critical Service Continuity (Replacement) - Risk	*The capital proposal is required to re-procure services or equipment in order to avert service failure. For example, at the end of a service contract or when an enabling or equipment asset is no longer fit for purpose*
Tier 1 Targets	*Improve/ avoid deterioration in performance against core targets e.g. Activity / waiting times.*
Deliverability	*Level of assurance for management of scheme within cost. The capital proposal will reduce the cost of service delivery in terms of the required inputs. For example, investment in innovative technologies, quality of service provision for patients and / or donors and will support the delivery of agreed outcomes and time constraints*
Patient/Donor Experience & Environment	*Improve Poor Environments and enhance quality of service.*

8. Does this Capital Scheme directly impact on any other WBS Departments i.e. Estates, Facilities, IM&T, QA etc.

Resource Required *(Required to provide resource to support implementation of the change e.g. validation support required, IT support required, WTAIL input etc.)*	**Department Involved** *(Involved in decision making and may be involved in any working groups that are established but not directly required to provide resource to support)*

9. Details of Existing Assets being Replaced / Traded in.	Asset Number	
	Serial Number	
	Make	
	Model	

	Year Acquired (if known)	

10. Procurement Plan		
Is this Single Tender Action (STA) / Single Quotation Action (SQA)		Yes / No
Which Procurement Route is to be followed?	OJEC Advert Required	Yes / No
	Existing Framework	Yes / No
	Tenders Required	Yes / No
	Quotations Required	Yes / No

ADDITTIONAL COMMENTS - ***Please insert any additional information i.e. any procurement information, timescales etc.***

Completed By	

PLEASE SEND COMPLETED FORM TO: JEFF O'SULLIVAN (VCS) / ANGELA ROBINS, (WBS) / CARL TAYLOR (DIGITAL) / JASON HOSKINS (ESTATES)	TO BE COMPLETED BY SERVICE / FUNCTINAL LEAD	
	Information transferred to Capital Plan	
	Date	

Appendix 1

FIBONACCI SCORING SEQUENCE

Relative Value	1 Compliance	2 Critical Service Continuity (Risk)	3 Tier 1 Targets	4 Deliverability	5 Patient/Donor Experience & Environment
1				Low	
2			Low	Significant	
3		Low	Significant	Critical	
5		Significant	Critical		
8	Low	Critical			Low
13	Significant				Significant
21	Critical				Critical
34					
55					

SCORE	Priority Rating
0-22	Low
23-36	Significant
37 - 58	Critical

FOR COMPLETION FOLLOWING BID APPROVAL

11. Equality Impact Assessment *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item

12. Authorisation

Project Manager

Name			
Signed		Date	

Project Sponsor

Name			
Signed		Date	

Finance Manager

Name			
Signed		Date	

Director

Name			
Signed		Date	

PLEASE SEND COMPLETED FORM TO:
Capital Planning & Financial Planning & Reporting Teams
Philip.Hodson@wales.nhs.uk
Steven.coliandris@wales.nhs.uk

APPENDIX 3

Capital Management – Key Roles and Responsibilities

The Chief Executive

- The Chief Executive has overall responsibility for delivery of the Trust's Capital Programme.
- The Chief Executive may act as Project Owner and has overall responsibility for the management of capital schemes at all stages of the process, from inception to post project evaluation and for ensuring the recording of assets once acquired.
- The Chief Executive must ensure that the Project Manager appointed to manage an approved capital scheme receives notification of delegated authority to commit expenditure, to proceed to tender or to accept a successful tender as required.
- That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model.
- That the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.
- The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically. The Chief Executive may delegate capital investment management in accordance with Welsh Government guidance and the Trust's Standing Orders.
- The Chief Executive shall have the delegated authority to approve capital investment up to a value of £100k.

Director of Strategic Transformation, Planning and Digital

- The Director of Strategic Transformation, Planning_and Digital is responsible for the development of a Capital plan and detailed Capital programme, for the organisation that sets out a detailed Capital investment plan to support the objectives set out in the IMTP.
- Ensure that the decision to invest capital is in accordance with the Trust's overall strategic aims.
- Seek the approval of the Executive Management Board for inclusion of a capital investment proposal within the Trust's Capital Programme.
- Ensure that a Project Director and Project Manager are appointed for each capital project and that there are adequate project management, monitoring and control arrangements in place.
- Support the development of a rolling capital programme for inclusion in the Trust's Integrated Medium Term Plan (IMTP).
- Lead and chair as required Project Teams delivering major projects.
- Report as required to the Trust on capital project progress and issues.
- Ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all relevant consequences, including capital charges.

- The Director of Strategic Transformation, Planning and Digital and Executive Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered.

Executive Director of Finance

- The Executive Director of Finance is responsible for establishing management control and financial reporting systems ensuring that the programme delivers within the funding envelope.
- Ensure that the decision to invest capital funding is in accordance with the Trust's overall strategic aims.
- Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans. The Executive Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Trust's Scheme of Delegation.
- Support the development of a rolling capital programme for inclusion in the Trust's Integrated Medium Term Plan (IMTP).
- Lead liaison with the Welsh Government with reference to capital funding.
- Lead and chair as required Project Teams delivering major projects.
- Report as required to the Trust on capital project progress and issues.
- Ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all relevant consequences, including capital charges.
- Sign off the quality/cost split for any OJEU procurements.
- The Executive Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
- The Executive Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Executive Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.
- The Executive Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.
- The Director of Strategic Transformation, Planning and Digital and Executive Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits

for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered.

Deputy Director of Planning & Performance

- The Deputy Director of Planning & Performance is operationally responsible for the development of a Capital plan and detailed Capital programme, for the organisation that sets out a detailed Capital investment plan to support the objectives set out in the IMTP.
- Ensure that the decision to invest capital is in accordance with the Trust's overall strategic aims.
- Reviewing all authorised discretionary capital Business Cases to ensure they have been completed in full and are fit for purpose.
- Seek endorsement from the Strategic Capital Board for inclusion of a capital investment proposal within the Trust's Capital Programme.
- Keeping a record of all authorised discretionary capital Business Cases and circulating them to Capital Planning and Delivery Group members for information.
- Operationally ensure that a Project Director and Project Manager are appointed for each capital project and that there are adequate project management, monitoring and control arrangements in place.
- Support the development of a rolling capital programme for inclusion in the Trust's Integrated Medium Term Plan (IMTP).
- Lead and chair the Capital Planning & Development Group
- Report as required to the Trust on capital project progress and issues.

Assistant Director of Estates, Environment and Capital Development

Capital Programme:

- Develop proposals for submission/consideration for inclusion in the Capital Programme.
- Develop a programme for Statutory Compliance, Health and Safety issues and Backlog Maintenance.
- Management of Statutory Compliance, Health and Safety and Backlog Maintenance programme element of the Trust approved capital programme.
- Provide routine reports on progress, cost control and any changes to the Statutory Compliance, Health and Safety and Backlog Maintenance programme to the Capital Planning and Delivery Group.
- Liaise with the Planning Directorate to allocate appropriate resources to support the development of capital schemes at all stages of the planning process.
- Support feasibility studies for developments of business cases for capital developments. Provide support and regular reporting to capital meetings.

Technical/Professional Project Management:

- Accountable to the client project manager for the provision of specialist technical project management and support.
- Allocate design team resources.
- Support the development of user requirements.
- Provide technical advice on feasibility of user options.
- Undertake and support option appraisal for business case development.
- Provide outline costing, identifying the costing basis.
- Provide comprehensive cost information and estimates in line with the requirements of the Capital Expenditure Limit ensuring that cost variances are identified separately for the effects of programme and cost changes.
- Advice on statutory approval requirements.
- Advice on project timetable.
- Advising and supporting the appointment of external project managers and design teams as appropriate. Advising on the compliance with the Construction, Design and Management (CDM) regulations where required.
- Provide appropriate support through membership of Capital Project teams.
- Ongoing management and control of capital schemes.
- Assist in developing an agreed programme.
- Assist in prioritising capital schemes.
- Advice on requirement of Capital Procedures compliance.
- Support the submission of Project start up documents with appropriate advice on status of any cost provided.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes the Welsh Government.

Capital and Operations Manager

- Provide effective management, co-ordination and development of the Trust capital programme including the development, maintenance and implementation at a corporate level of the estate's capital programme, ensuring balance with the organisation's Capital Expenditure Limit.
- Provide effective management, co-ordination and development of estates capital investment proposals and to encourage the use of good practice in the preparation of estates capital business cases.
- Assist and/or lead in the production of appropriate documentation and analysis, business cases etc and ensure that for each estates approved project a business case or business justification document is produced which contains a full appraisal of options against potential benefits and known costs for each investment proposal.
- Ensure that the Executive Director of Finance has certified the costs and revenue consequences of any estate's capital proposal.
- Produce, lead or assist in the production of, appropriate documentation and analysis, Business Cases and Capital Programmes and Reports for Trust and Capital Planning and Delivery Group.
- Provide practical support to Project Owners, Directors and Managers including the clarification of investment objectives, provision of a quality assurance role and implementation of project management techniques.

- Provide as required Capital and Project Briefings for the Trust.
- Support the ongoing improvement in Trust capital investment protocols and practices to ensure that the maximum benefit is gained from limited capital resources.
- In co-operation with the designated staff from the Finance Directorate, develop plans for discretionary capital expenditure.
- To be responsible for the regular review and reporting of the Estates-related Capital Programme.
- When property transactions form part of a capital project ensure that appropriate procedures are followed.

Head of Financial Planning& Reporting

- Lead the financial delivery of the Discretionary Capital programme and provide capital financial advice to all business cases.
- Provide financial support for the development, co-ordination and monitoring of capital investment proposals and to encourage the use of good practice in the preparation of business cases that identify a requirement for capital investment.
- Ensure that all necessary information is provided, and action initiated to successfully meet the requirements of the Capital Expenditure Limit.
- Lead and/or assist in the production of, appropriate documentation and analysis, Business cases and Capital Programmes and Reports for the Trust and other Trust meetings.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes the Welsh Government.
- Apply capital investment techniques including development of strategic and financial contexts, identification of benefits criteria, option and financial appraisals and risk analysis to capital investment proposals and overall appraisal of capital investment proposals.
- Contribute to the ongoing development of the Trust's Capital Investment protocols and practices.
- Providing advice and assistance to all staff that are completing the discretionary capital Business Case template.
- Keeping a record of all authorised discretionary capital Business Cases and circulating them to Capital Planning and Delivery Group members for information.
- Reconcile the Capital Programme to the Capital Expenditure Limit received from the Welsh Government.
- Produce capital monitoring information for the monthly Welsh Government financial return.
- Carry out a monthly reconciliation of capital expenditure to the general ledger.
- Shall deputise and chair the Capital Planning & Development Group in the absence of the Director of Planning & Performance.

Financial Accountant

- Responsible for capital accounting, including capital charges, International Financial Reporting Standard implications and revenue implications of all capital schemes.

- Ensure the upkeep and future development of the capital asset register.
- Produce periodic estimates of capital charges resulting from the Trust's Capital Programme, in accordance with WG guidelines and timescale.

Divisional Capital Leads

Divisional capital leads are responsible for:

- Presenting the prioritised Divisional All Wales & discretionary capital bids to the Capital Planning and Delivery Group for consideration.
- For each successful discretionary capital scheme bid, ensure a Project Manager is appointed who is, in the first instance, tasked with completing the discretionary capital Business Case for the scheme.
- Providing support and assistance to staff who have been asked to write a discretionary capital Business Case.
- Ensuring all discretionary capital Business Cases are completed in full and are authorised correctly ultimately by the Divisional Director.
- Sending a copy of all authorised discretionary capital Business Cases to the Capital Planning lead and Financial Planning & Reporting team.
- Ensuring copies of discretionary capital Business Cases are attached to capital requisitions to ensure they can be approved quickly.
- Report back to the Capital Planning and Delivery Group on delivery of all discretionary capital projects.

Capital Project Director

- Lead and direct (on behalf of the Project Owner) the Project Board and Project Team(s) towards the successful delivery of the project objectives as agreed with the Project Owner (Chief Executive) and Trust Board.
- Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

The Project Director shall ensure that:

- A Project Manager is appointed.
- A clearly established structure including a Project Board and Project Team, which include as required appropriate skills and expertise, representatives of all interested departments and stakeholders, has been given responsibility for the project and appropriate training is available.
- The appointment of project officers is recorded.
- There is a clear scheme of delegation that supports each individual's levels of responsibility.

The Project Director shall also ensure that the Project Manager has a clear brief including:

- Terms of reference and duties including contractual objectives/business needs.
- Capital expenditure limit requirements and delegated authority.
- Resources available.
- Responsibilities for Health and Safety.
- Relationships with (Internal) specialist support, (External) Project Manager and the Supply Chain Partner (SCP) change management responsibilities.
- Training needs and resources.
- Appropriate techniques and components from relevant project management qualifications, including PRINCE2, may be used as required to help with the delivery of the project.
- Ensuring the responsibility and ownership of the project is retained by Trust and not delegated to external contractors.

The Project Director shall also ensure that the Project Team has:

- Clear responsibilities and methods of working.
- A timetable for key events; co-ordinated plans; guidance notes; monitoring information.
- Project documentation and records.
- Lines of communication are clearly specified.
- One person to direct the activities of consultants, advisers, contractors and third parties.
- External management team members providing professional services who are appointed on a competitive basis.
- Reports on a regular basis using financial and non-financial monitoring.

Appropriate project files and documentation are kept. These should include:

- Business case documentation.
- All correspondence including approvals.
- Project approach and procurement strategy output specifications.
- Project plans, quality plans and risk log.
- Communications plan.
- Records of all meetings and decisions taken.
- File notes of conversations where actions are agreed, decisions taken and authorisations given.
- Details of the appointment of the Project Team and Job Descriptions.
- Details of the appointment of any external experts or advisers.
- Records of all reports made and approvals received.
- Change controls.
- Details of the appointment of the Supply Chain Partner contract documentation.
- Scheme development and design.

Capital Project Managers

The Project Manager for each capital project and will:

- Lead and direct (on behalf of the Project Director and Project Owner) the Project Team(s) towards the delivery of the project objectives as determined by the SRO, Project Board, Chief Executive and Trust Board.
- Ensure that appropriate and adequate communication mechanisms exist between the Project Director and Project Owner, Project Manager and external organisations, and between the Project Manager, Project Director and the rest of the Trust.
- Act as the one point of contact between the Trust and the Contractor/Supply Chain Partner (via the External Project Manager who will have formal responsibility under the appropriate form of contract). This will require ensuring that appropriate formal processes are in place for the provision of professional and technical support and guidance.

In conjunction with, and as delegated by, Project Director, the Project Manager will ensure that:

- A clearly established structure including a Project Team(s) which includes as required appropriate skills and expertise, representatives of all interested departments and stakeholders, has been given responsibility for the project.
- Ensure that the project complies with relevant WG and NHS Estates and Capital Guidance
- The Project Team has clear objectives, defined responsibilities and methods of working, a timetable for key events, co-ordinated plans, guidance notes, monitoring information and project documentation and records.
- There is a clear scheme of delegation that supports each individual's levels of responsibility.
- An appropriate business case is developed and remains robust at the procurement stage.
- To ensure appropriate clinical involvement and sign-off of requirements.
- There is a brief and project execution plan with clearly defined outcomes and an indicative and achievable programme including cost and time.
- To submit timely monthly financial reports of actual cost and accurately forecast costs; and forecast and actual cash flows on the forms provided by finance.
- Appropriate techniques and components from an appropriate project management tool are used as required to help with the delivery of the project.
- Ownership of the project is retained by the Trust and not delegated to external contractors.
- There is liaison with the project manager to direct the activities of consultants, advisers, contractors and lines of communication are clearly specified and are short and direct.
- The design produced meets all the requirements of the project and is signed off as required.
- Ensure that adequate procedures are in place to monitor and control cost, time and quality thereby ensuring Capital Expenditure Limit compliance.

- To obtain robust project costs and act in accordance with Standing Orders and standing financial instructions utilising appropriate delegated input such as provision of build costs.
- To take overall responsibility for the project being delivered within budget, including being informed of and agreement of works budget variations, and direct control of non-works variations (e.g. equipment and fees).
- To include reporting of pre-contract costs e.g. survey and feasibility work, including agreement of budgets.
- To ensure that all project matters and costs are appropriately authorised and notified to appropriate parties.
- To liaise effectively with the technical project manager (usually works and estates), attending project team meetings and ensuring arrangements are in place for specific queries in their absence.
- To ensure that adviser fees are appropriately related to activities when agreed, and similarly checked when incurred.
- To ensure that an equipment schedule is derived to an appropriate stage to enable both initial and final budget estimates, the latter schedules to contain identified suppliers, lead times and itemised costs.
- To agree with the works project manager and contractor, items to be supplied and fitted by the contractor as part of the build, including agreement of cost.
- Provide a regular report to the project director identifying cost, time and quality performance.
- Ensure the project is completed and handed over to the Trust in a managed way.
- To co-ordinate the user commissioning programme, providing time allocations and responsibilities.
- A post-completion evaluation of the scheme takes place.

Appropriate project files and documentation are produced and kept. These should include:

- Business Case documentation.
- All correspondence including approvals, project approach and procurement strategy output specifications.
- Project plans, communications plan, quality plans and risk log.
- Records of all meetings and decisions taken.
- File notes of conversations where actions are agreed, decisions taken and authorisations given.
- Details of the appointment of the Project Team and Job Descriptions.
- Details of the appointment of any external experts or advisers.
- Change controls/variations.
- Details of the appointment of the Supply Chain Partners contract documentation.
- Scheme development and design.
- Cost changes and authorisations.

APPENDIX 4

DISCRETIONARY CAPITAL SCHEME – PROJECT MANAGER'S CHECKLIST

Division:	
Scheme Name:	
Budget:	
Date Approved:	
Project Manager:	

Task	Completed	Date
Project Team Established		
Appropriate Project Management Tools Used		
Business Case Completed and Authorised		
Project Plan Developed and Signed Off		
Procurement		
a) Familiarisation and compliance with SFI procurement requirements.		
b) Consultation with Procurement on availability of resources to deliver the scheme within timeframes.		
c) Quality/Cost assessment (including whole life costs) have been agreed and approved prior to tendering.		
d) Project Team "sign off" of final agreed tender documents (approved scheme).		
e) Tender evaluation of tenders received and verified.		
f) Completion of "Contract Acceptance paper" upon receipt of an acceptable tender.		
g) Develop contract monitoring record and method of agreeing contract variations.		
Estates		
a) Discussion with Estates. Estates requirements in scheme agreed.		
b) Consultation with Estates on availability of resources to deliver the scheme within timeframes.		
c) Project Team "sign off" of design layouts (where applicable).		
Digital		
a) Discussion with Digital and Digital requirements in scheme agreed.		
b) Consultation with Digital on availability of resources to deliver the scheme within timeframes.		

c) Project Team sign off of final agreed specification (approved scheme).		
Finance		
a) An appropriate capital budget has been allocated and cost centre established.		
b) Revenue consequences determined and agreed.		
c) financial responsibilities for agreeing variations.		
d) An order(s) been raised for the scheme(s).		
e) Monthly monitoring procedures and protocols established for reporting back to the Capital Planning and Delivery Group and the Welsh Government (if applicable).		
f) Orders goods receipted in timely manner.		
g) Invoices monitored especially any that are “on hold” with a view to resolving any issues as soon as possible to ensure 30 day payment policy is complied with.		
Project Evaluation Plan		
Benefits Realisation		

Velindre University NHS Trust
Financial Control Procedure (FCP 01)

CAPITAL MANAGEMENT PROCEDURE

Date to be reviewed:	October 2023	**No of pages:**	
Author job title(s):	• Head of Financial Planning & Reporting • Deputy Director of Planning & Performance		
Responsible Director:	Executive Director of Finance / Director of Strategic Transformation, Planning and Digital		
Approved by:			
Date approved:			
Effective Date (live):			
Version:	2		

Documents to be read alongside this policy:	This procedure should be read in conjunction with: • Trust's Standing Orders and Standing Financial Instructions. • Trust's Scheme of Delegation • Other Financial Control Procedures including FCP 2 – Non current Fixed Assets • Medical Devices and Equipment Management Policy (QS24) • Other guidance issued by the Welsh Government (WG) in particular the NHS Trusts Manual of Accounts. • Other internal and external guidance as appropriate.

Current review changes:

Significant Changes following the establishment of the Strategic Capital Board and introduction of new accounting treatment for Leases.

Major Changes Include:

1. IFRS 16 – Inclusion of guidance of new accounting standard for leases.
2. Updated guidance ensuring that Medical Devices and Equipment bids are supported by the Medical Devices Group.
3. Project Bank Account – Inclusion of guidance on when to use Project Bank Account.
4. Escrow Account –guidance included on use of an Escrow account/ agent.
5. Updated Guidance on business case governance route following the formation of the Strategic Capital Board.
6. Updated TOR for Capital Planning and Delivery Group
7. New Trust Discretionary Prioritisation and Business Case Template (Attached as appendix 2)
8. Updated Roles and Responsibilities.

Executive Summary

This procedure is provided to ensure that Velindre UNHS Trust has appropriate management and governance arrangements in place around capital expenditure. These will determine how capital is planned, prioritised and managed in-year within the Trust's structure. This procedure introduces a standardised approach for producing discretionary capital Business Cases. This procedure does not apply to NWSSP.

First operational:	April 2017				
Previously reviewed:	Oct 2022				
Changes made yes/no:	Yes				

Contents

1. Introduction and Purpose

1.1 This procedure has been developed to ensure that Velindre UNHS Trust has appropriate management and governance arrangements in place around capital expenditure. These will determine how capital is planned, prioritised and managed in-year within the Trust.

1.2 This procedure provides advice on how to prepare bids for consideration by the Capital Planning and Delivery Group or Strategic Capital Board and for successful bids.

1.3 This procedure includes HTW but does not apply to NWSSP. This document does not offer a definitive guide to the procurement of projects.

2. Scope

2.1 This procedure is intended for use by all staff, and anyone involved, or with an interest in capital bids and allocation.

3. What Is Capital?

3.1 **Capital expenditure** is expenditure in excess of £5,000 (including VAT where this is not recoverable) on:

a) Acquisition of land and premises, lump sum and payment for related rights (including capitalised rents), and payments made under the Land Compensation Act 1973 and associated fees.
b) Individual works schemes for the initial provision, extension, improvement of, adaptation (including upgrading), renewal, replacement or demolition of buildings, building elements (e.g. roofs), external works, engineering services or plant.
c) A single item of equipment.
d) All vehicles.

3.2 **Grouped assets** are a collection of assets which individually may be valued at less than £5,000 but which together form a single collective asset with a group value of £5,000 or more because the items fulfil all the following criteria:

- The items are functionally interdependent;
- The items are acquired at about the same date and are planned for disposal at about the same date.
- The items are under single managerial control; and
- Each individual asset thus grouped has a value of at least £250, however this deminimus value does not apply in dealing with the initial equipping of hospitals.
- The distinction between assets that are in some way dependent on each other for their effective and efficient operation, and those that are “stand-alone” items can be a fine one. Where items are

used within a system (e.g trays of sterile instruments are designed to be used with a specific sterilisation system), those items are likely to be considered interdependent even though they also have a value in “stand alone” use.

This is applicable to both tangible and intangible assets.

IT Equipment may be considered interdependent if it is attached to a network, the fact that it may be capable of stand-alone use notwithstanding. The effect of this will be that all IT equipment purchases, where the final three criteria above apply, will be capitalised.

Software which is integral to the operation of hardware (e.g. an operating system) is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware (e.g. application software) is capitalised as an intangible asset.

3.3 The cost of an item of property, plant and equipment comprises its purchase price, any directly attributable costs and the initial estimate of the costs of dismantling and removing the item and restoring the site on which it is located.

Directly attributable costs include the following:

- Costs of employee benefits arising directly from the construction or acquisition of the item of property, plant and equipment.
- Costs of site preparation.
- Initial delivery and handling costs.
- Installation and assembly costs.
- Costs of testing whether the asset is functioning properly.
- Professional fees.

- Only those directly attributable labour costs (employee benefits) that relate to the time spent by employees on constructing or acquiring the specific asset should be capitalised. Where an entity’s own staff are involved in the acquisition, construction or development of a piece of property, plant and equipment, **the relevant proportion of the internal costs relating to those staff should**, if material and if the other criteria for capitalisation referred to in this section are met, be included in the cost of the asset.

- Such internal costs will include own employees’ (e.g. site workers, in-house architects and surveyors) salaries and expenses arising directly from the construction and acquisition of the specific tangible fixed asset. Administration and other general overhead costs should be excluded from the cost. Employee costs not related to the specific asset (such as site selection activities) are not directly attributable costs.

- the incremental costs to the entity that would have been avoided only if the tangible fixed asset had not been constructed or acquired. These include:
  - ◊ acquisition costs such as stamp duty, import duty and non-refundable tax
  - ◊ the cost of site preparation and clearance
  - ◊ initial delivery and handling costs
  - ◊ installation costs, and
  - ◊ professional fees (such as legal, architects' and engineers' fees).

Included in these definitions would be items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost. In addition, any expenditure incurred relating to costs in relation to safety regulations or statutory legislation should be capitalised.

Non-attributable costs that should be regarded as revenue expenditure include the following:

- Costs of opening a new facility.
- Costs introducing a new product or service (including costs of advertising and promotional activities).
- Costs of conducting business in a new location or with a new class of customer (including costs of staff training).
- Administration and other general overhead costs.
- Training costs.

3.4 Expenditure on maintaining capital assets in effective working order, or in good repair, is charged to revenue irrespective of cost. The exception is where the repairs include improvements to the original standard, in which case that cost will be charged to capital if it falls within the above definition of capital expenditure.

3.5 Items charged against the Capital Programme shall be in accordance with the above definition. Compliance is also required with International Financial Reporting Standards (IFRS), the Government Financial Reporting Manual (FReM) and the capital section of the Manual for Accounts, on the identification of and accounting for, capital expenditure.

The Link to the Government Financial Reporting Manual (FReM) can be found below:

https://www.gov.uk/government/collections/government-financial-reporting-manual-frem

3.6 A **lease** is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time. The following points (individually or in combination) would normally lead to a lease being classified as a Capital purchase:

- The asset transfers ownership at the end of the lease.
- There is an option to buy the asset at the end of the lease term at a favourable price.
- The lease term is for the major part of the asset's life.
- The present value of the minimum lease payments is substantially all of the fair value of the asset.
- The asset is of a specialised nature and cannot be used by another lessee without major modification.
- If the lessee can cancel the lease and any lessor losses associated with the cancellation are borne by the lessee.
- Gains or losses from the fluctuation of the fair value fall to lessee.
- The lessee has an option to continue the lease for a secondary period and the rent is substantially lower than market rent.

The treatment of Leases has been affected by IFRS16 which is a new international financial reporting standard (IFRS) for lease accounting which came into effect from 1st January 2019 and came into force for the NHS from 1st April 2022.

IFRS 16 takes a totally new approach to accounting for leases, called the 'right-of-use' model. This means that if a company has control over, or right to use, an asset they are renting, it is classified as a lease for accounting purposes and, under the new rules, must be recognised on the company's balance sheet.

IFRS16 effectively removes the distinction between operating leasing and finance leasing. Both Lease elements will now form part of the balance sheet.

The 'right of use model' says a "contract is, or contains, a lease if it conveys the right to control the use of an identified asset for a period of time in exchange for considerations".

Examples of Leases which will now fall under IFRS16 and classed as a Capital Purchase include:

- Rented Property
- Pool Vehicles
- Managed Contracts (Depended on Contract agreement)

Exceptions to the rule

There are two specific types of lease which don't come under IFRS 16 leases and which don't have to be recorded as an asset:

1. A lease where the value of the item when new is *low value*, currently indicated as less than £5000.

2. A lease with a shorter than 12-month term and which does not have an option to buy the leased item at the end of the lease.

So, for example, if you were to use a scheme where the lease period on a vehicle is less than 12 months and you don't have the option to buy the cars at the end of the contract, then these would not be included under IFRS 16.

4. Where Does Capital Funding Come From?

4.1 Each year the Trust receives a Capital Expenditure Limit (CEL) allocation from the Welsh Government (WG). The Trust has an annual financial duty to ensure that its capital expenditure does not exceed this allocation. The funding comprises two elements:

- **Capital Funding issued by WG for a Specific Purpose** – WG has a number of capital budgets which the Trust can bid against.

  Discretionary Capital – This is a one-off annual allocation given to the Trust by WG every year to meet statutory obligations (such as health and safety and firecode), to maintain the fabric of the estate and to timely replace equipment. As the title implies, the Trust is free to prioritise the sum allocated as it best sees fit.

4.2 In addition, capital funding may also be obtained from alternative sources such as:

- Charitable Funds.
- Donated Monies e.g other Charities.
- Grant funding.
- Private Sector

5. The Capital Planning Process

Discretionary Allocation

5.1 Divisions will develop a prioritised list of capital schemes that have been signed off by their respective Senior Management or Leadership Teams or sub delegated to Divisional Business Planning Groups. These will be forwarded to the Capital Planning and Delivery Group for consideration against the Trust Discretionary allocation.

5.2 Digital will also develop a list of Digital investment schemes that are required across the Trust and submit this to the Capital Planning and Delivery Group for consideration.

5.3 The Capital Planning and Delivery Group will meet and recommend how discretionary capital is allocated, managed and monitored on an

annual basis taking into account both the short term and long term investment plans of the Trust.

5.4 There may be pre-commitments to the Capital Programme in any one year to fund, for example:

- Capital slippage from the previous year.
- Agreed top-slicing of discretionary capital funding for Divisions, Estates and Digital.
- Agreed rolling programmes of equipment replacement.
- Agreed projects whose timescales mean that funding straddles two or more financial years.
- Agreed contingency sums to address in year equipment breakdowns and minor works.

This funding is top-sliced from the discretionary capital allocation before any other bids are considered.

5.5 The Capital Planning and Delivery Group membership ensures equitable access and a transparent process for all areas of the organisation to bid for the available discretionary capital and provides a Group which has an overall view of discretionary capital prioritisation and investment at any one particular time and monitors the expenditure of capital. The terms of reference of this Group are attached in Appendix 1.

5.6 The Capital Planning and Delivery Group considers the bids for discretionary capital funding and recommends which should be submitted for approval.

5.7

5.7 The recommended capital programme for utilisation of the discretionary programme is then submitted to the strategic Capital Board for endorsement before being submitted to the Executive Management Board for approval.

5.8 Once the discretionary Capital Programme has been approved by Executive Management Board, the Trust's Deputy Director of Planning & Performance will formally notify the Capital Planning and Delivery Group.

5.9 Once a discretionary capital scheme has been approved by Executive Management Board (EMB), a discretionary capital Business Case must be completed and authorised correctly and ultimately by the appropriate Divisional Director. A copy of the business case should be sent to both the Trust's Planning &Financial Planning & Reporting team.

5.10 The process of producing a discretionary capital Business Case should remain within the Division although advice will be available from the

Trust Financial Planning & Reporting Department, the Trust Capital Planning Department and the NWSSP Procurement Service as required.

5.11 The Capital Planning and Delivery Group will then oversee the management of the Trust's approved Capital discretionary Programme. The Group meets regularly (usually monthly but more frequently towards the end of the financial year) and is responsible to the SCB & EMB for the effective, efficient and best value use of the discretionary capital monies available to the Trust as dictated by the CEL.

5.12 The SCB, EMB, and Trust Board will be informed of the approved capital discretionary programme at the start of the financial year and be given regular updates thereafter through a highlight report to SCB, and via the Trust Finance Report for EMB and Trust Board.

5.13 All business cases requesting funding over £100k exceeds the Chief Executive approval and must be approved by both EMB and the Trust Board.

5.14 A draft capital plan is approved by Trust Board as part of the Three Year Integrated Medium Term Plan (IMTP) process.

All Wales Capital Bids

5.15 The responsibility for considering recommendations for All Wales capital funded schemes sits with the Strategic Capital Board (SCB). These schemes should be included within the Trust integrated medium term plan (IMTP). Further details are provided under section 8.

6. Making Capital Bids against the Discretionary Capital Programme

6.1 Towards the end of the last quarter of the financial year information will be issued to the members of the Capital Planning and Delivery Group by the Head of Financial Planning & Reporting, which will include the Trust's discretionary capital allocation and pre-commitments against this for the next financial year.

6.2 The Trust Financial Operations Team will provide the Capital Planning and Delivery Group with a list of tangible and intangible assets (by Division and then Department) which has been taken from the Trust's Fixed Asset Register. This should assist Divisions in identifying goods that are approaching the end of their useful asset life.

6.3 Divisions will then be asked to submit their list of prioritised capital schemes for consideration for the following year.

6.4 Divisions may also submit any discretionary capital bids for future years that may need early approval because they have a long lead-in time e.g.

schemes that must be tendered via the Official Journal of the European Union (OJEU).

6.5 Identifying capital requirements for the year ahead must be undertaken at a Divisional level and ultimately approved by the Divisional Senior Management / Leadership Teams. All bids should be analysed from a service point of view. A range of options should be considered and analysed with the best approach identified (records of the selection criteria and short-listing process should be maintained to demonstrate the worthiness of the selected option). If this requires investment of a capital nature, then the following must be considered:

a) What will be the benefits and costs both in financial (including VAT where it is not recoverable) and non-financial terms?

b) Can the required investment be justified? Although a new piece of equipment may be desirable, if it cannot be justified on the grounds of achieving the Trust's IMTP then it should be rejected at this early stage.

c) If a proposal is deemed justifiable then the next stage is to consider the impact on other services. Although a scheme may appear to achieve corporate aims and be efficient in isolation, the broader costs/aims may reverse this assessment and lead to rejection of the proposal.

d) Revenue implications must also be taken into account. Increases in revenue costs (such as staff, maintenance, fuel costs, consumables, insurances etc) are rarely funded, which means service managers must identify ways of funding these increased costs within existing resources. The fact that revenue funding cannot be identified does not preclude a proposal from being submitted, as funding may be available from else-where, however the chances of success are diminished, especially where these costs are significant.

e) The Service must consider other costs associated with the proposal such as those associated with temporary housing of personnel whilst the project is carried out, decanting of wards, the transfer of records in electronic format (all of which can be included in the capital costs). These can prove significant and are required in order for the proposal to be fully appraised. If these costs are identified at some later date, it may necessitate the cancellation of the project and the loss of the funds expended to that date – plus any other funds that have been committed.

f) Division Directors/Service Leads must consider the broader picture and appraise how the proposal in question will affect other activities that are envisaged in the forthcoming year, or

timescale of the proposed project and to ensure that the correct approach is being put forward. They will have to consider the project management arrangements and what roles are to be filled by which personnel – and are these people properly trained and available for the roles intended? Compliance with standards and guidance (such as NICE, Data Protection Act) will also have to be taken into account.

6.6 Ultimately it is the Divisional Director and the Senior Management / Leadership Teams that submit discretionary capital scheme proposals to the Capital Planning and Delivery Group. Each bid must have sufficient supporting documentation accompanying it for a reasonable appraisal to be made and decided upon. All bids should include:

- Value Added Tax (VAT) and take into account enabling works and revenue costs i.e. consumables and/or utility costs associated with the bid.

- Proposals to replace existing equipment must identify the equipment being replaced by noting the asset identification number and the net book value of the item as detailed in the asset register. This information can be obtained from the Trust's Financial Planning & Reporting Function. Assets which are shown as not having reached the end of their designated life, and therefore having a positive net book value, will not be replaced without an explanation as to the circumstances and an assessment that the need to replace is unavoidable.

- An estimate of purchase and whole life costs must be provided and validated wherever possible by the Procurement Department.

Bids for building/refurbishment projects and those which include enabling works/utility costs must be validated by the Estates Department to ensure that the bid can be delivered. Discussions with the Estates team should take place as a part of developing the prioritisation and business case template, in advance of the bid being submitted to the Capital Planning Group for approval.

- Bids for Digital Systems or with Digital implications must be reviewed by the Digital Department to ensure that the bid can be delivered. Discussions with the Digital team should take place as a part of developing the prioritisation and business case template, in advance of the bid being submitted to the Capital Planning Group for approval,

- All Welsh Blood Service bids must also be appraised by the Welsh Blood Service Regulatory Compliance and Quality Assurance Department in terms of impact and Good Manufacturing Practice (GMP)/validation resources.

- All Medical Devices and Equipment bids that meet the capital definition in Section 3 must be reviewed and supported by the Trust Medical Devices Group in accordance with the Trust Medical Devices and Equipment Policy (QS24).

  https://velindre.nhs.wales/policies/quality-and-safety/qs24-medical-devices-and-equipment/

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6.7 The Capital Planning and Delivery Group meets, discusses and assesses all the bids submitted in order to develop a draft Discretionary Capital Programme which will then be submitted to the Strategic Capital Board (SCB) for endorsement before being submitted to the Executive Management Board (EMB) for approval. This programme once approved will be monitored by the Capital Planning and Delivery Group.

6.8 It may be necessary during the financial year to adjust the approved allocation for capital schemes either as a result of savings or increased spends. Adjustments to planned expenditure (both increases and decreases) must be reported to the Capital Planning and Delivery Group.

The ability to approve expenditure is set out in the Trust's SOs / SFIs: Delegated Financial limits and the Scheme of Delegation and Governance Framework for major Capital Programmes.

6.9 Where there is an emergency request for capital to address urgent medical equipment, estates maintenance or statutory compliance issues and there is no time to wait until the next meeting of the Capital Planning and Delivery Group, the Chair of the Capital Planning and Delivery Group can take forward the approval of the scheme with the appropriate individuals and Boards according to the Trust's Standing Orders and Standing Financial Instructions which can be found via the below link.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx

There may also be times such as yearend where invitation to the Capital Planning & Delivery group is extended to ensure that decisions on Capital expenditure can be made more efficiently. This may include but not limited to inviting the Executive Director of Finance, or the Director of Strategic Transformation, Planning and Digital.

6.10 Occasionally there are opportunities to bid for additional discretionary capital allocations in year when the Welsh Government identify slippage or monies available for specific developments. The bids for these monies are also co-ordinated via the Capital Planning and Delivery Group.

6.11 Divisions should at all times maintain a live, prioritised register of Capital schemes.

6.12 **VAT**

The assessment of VAT treatment needs to be considered for all Capital schemes and as part of developing the prioritisation and business case template. Where necessary advice on the treatment of VAT should be sought from the Finance team. Users should also refer to the HMRC VAT partial exemption guidance in the link below:

https://www.gov.uk/hmrc-internal-manuals/vat-partial-exemption-guidance

7. Discretionary Capital Business Case Development

7.1 A standardised approach for producing discretionary capital Business Cases will ensure:

- Consistency of approach in the presentation of Business Cases.
- The provision of relevant information to support decision making.
- Business Cases align with the Trust's strategic aims and objectives.
- A consistent approach is provided to processing proposed Divisional developments in order to achieve approval from the appropriate body.
- The concentration of time and effort on proposals which are a priority for the Trust.
- A suitable audit trail is provided in relation to investment decision making.
- There is an opportunity to share proposed developments with other Divisions and identify the potential impact on other Divisions across the Trust.
- The Trust is able to supply copies of Business Cases, and associated documents when requested.

7.2 The template to be used for Business Cases that require discretionary capital funding is detailed in Appendix 2. The information required includes:

- A summary of the proposal.
- Identities of the project lead and sponsor.
- The key drivers behind the changes and the benefits of the proposal.
- Identification of the options and selection of the preferred option.
- An assessment of risk, both strategic and operational, associated with the proposal.
- A financial analysis of the preferred option which covers capital costs and revenue costs and/or savings.

- An equality impact assessment.
- A procurement plan.
- An outline of the Digital and Estates resources required to complete the project.
- Project management arrangements and timescales.
- Details of any existing assets being replaced or traded in.

7.3 Sustainability must be a central planning tenet when a Business Case is developed. All new buildings or extensions to existing buildings must be designed in a manner that delivers environmentally responsive architecture, offering high levels of efficiency, sustainable materials and excellent internal environments.

7.4 Whilst a due process needs to be followed, **the resources committed to Business Case production should be commensurate with the materiality and potential risks associated with the project**. Whilst a Business Case which is intending to commit Trust resources needs to be suitably robust, it should not be unduly onerous.

8. Bids for All Wales Capital Funding

8.1 For any capital schemes, which are required to be funded via the Welsh Government's All Wales Capital Programme must be considered by the Strategic Capital Board and a business case will need to be submitted to the Welsh Government and will be considered for approval by the Investment Infrastructure Board (IIB). The schemes identified must align to the Trust's Integrated Medium Term Plan. A business case must demonstrate that the proposed investment has been properly scoped and planned; offers optimum value for money; is commercially viable; affordable and achievable. In addition, a case for any investments should show that the proposal has clearly identified service delivery benefits.

8.2 Before embarking on the preparation of the business case, the Trust is required, in the majority of cases, to agree the nature, type and content of each business case with the WG via a scoping document.

8.3 For major investment proposals the Better Business Case approach using the five-case model should be followed.

As set out in the Better Business Case Templates guidance[1], the following should be considered with regards to whether a scheme classifies as a Major Capital Programme:

- the value thresholds,
- the complexity and risk involved,

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- whether the situation is novel or contentious,
- whether procurement is required and the scale of the procurement, and
- whether there are any dependencies, e.g. with business as usual matters or other projects.

In line with the available business case templates, the guidelines below, including value thresholds, help to address which business cases should be classified as a Major Capital Programmes:

For Procurements and Projects (enabling outputs, activities and infrastructure):

1. Single Stage Business Case - Low Value and Risk (£0 to £250k value of procurement).
2. Single Stage Business Case - Medium Value and Risk (£250k to £2 million value of procurement)
3. Three Stage Business Case (SOC, OBC, FBC) – High Value (Over £2 million value of procurement)

[1]https://www.gov.wales/five-case-model-templates

8.4 Programmes should be developed, and cost justified using Programme Business Case (PBC). Major, novel or contentious projects should be developed, and cost justified through three key iterations of the Business Case where formal approval to proceed is required; Programme Business Case (PBC), Outline Business Case (OBC) and Full Business Case (FBC).

8.5 The Business Justification Case (BJC) provides the Trust with a simpler, truncated approach for smaller and less complex investments. The shorter approach retains compliance with the major requirements of good corporate governance and details strategic context, case for change, option appraisal, procurement route, affordability and management. The BJC should be adopted as the standard approach for most schemes under £2million.

8.5 The costs associated with developing these business cases may have to be funded initially out of the Discretionary Capital Programme which would be reimbursed if the scheme was successful in securing Welsh Government funding.

8.6 As soon as any All Wales capital projects are approved by the Welsh Government an appropriate Project Board will be established to ensure projects are completed both within budget and agreed timescales.

8.7 The SCB will expect to see regular updates on approved Capital projects and will be in charge of overseeing the management of the approved project and is responsible to the EMB for the effective and efficient use of the project in line with the WG funding award letter.

8.8 The financial state of each All Wales capital funded scheme must be reported to the Welsh Government on a monthly basis as part of the Trust's financial monitoring returns. Comments must be included in the letter accompanying the monitoring returns if there are any issues being experienced with a particular scheme. The Executive Director of Finance shall be responsible for submitting the return, liaising closely with the Director of Strategic Transformation, Planning, and Digital.

8.9 **Project Bank Account**

Organisations will be required under Welsh Government rules to use PBAs in infrastructure projects and other appropriate contracts which are valued at £2.00m (net of VAT and other costs that do not affect the supply chain) or more.

For projects less than £2.00m the frequency of payment and length of contract will likely be deciding factors (e.g., greater than monthly payment cycles or contracts less than 6 months in length may not see many benefits).

PBAs are "ring-fenced interest-bearing bank accounts" that have trust status from which payments are made directly and simultaneously to members of the supply chain removing the need for higher tier contractors to process payments. The trust status of these bank accounts means that it helps prevent delays in the transfer of funds and in cases of insolvency the monies in the account relate to an underlying transaction, protecting the supply chain and unable to be used to settle other liabilities.

Further guidance on project bank account can be found on the link below:

ttps://www.gov.uk/government/publications/project-bank-accounts

8.10 **Escrow Account**

Bids that are either large or complex in nature should consider using and Escrow bank account or agent. An escrow account is an account where funds are held in trust whilst two or more parties complete a transaction. This means a trusted third party usually a bank or escrow agent will secure the funds in a trust account. The funds will be disbursed to the merchant after they have fulfilled the escrow agreement. If the merchant fails to deliver their obligation, then the funds are returned to the buyer. Having an escrow account reduces the risk of non-payment. It is a

temporary account that operates only up to the completion of the transaction.

9. Roles and Responsibilities

9.1 Successful delivery of the Capital discretionary Programme will be achieved if named individuals have clear roles and responsibilities as well as delegated authority. These have all been set out in Appendix 3

9.2 The Capital Planning and Delivery Group is responsible for making recommendations to the Trust's Strategic Capital Board and Executive Management Board as to which discretionary capital schemes should be approved. The Capital Planning and Delivery Group is also responsible for overseeing the management of the Trust's Discretionary Capital Programme and for providing regular reports to the Strategic Capital Board

9.3 The Strategic Capital Board will be responsible for reviewing proposed all Wales Capital funded schemes to be included within the Trust Three Year Integrated Medium Term Plan (IMTP)

9.3 To assist Project Managers in managing discretionary capital schemes, a discretionary capital schemes Project Manager's checklist has been devised (Appendix 4).

9.4 Project Managers should make use of project management tools appropriate to project size and complexity. Program Evaluation Review Technique (PERT), Critical Path Method (CPM) and Gantt Charts are commonly used project management tools that can be produced manually or with commercially available project management software.

9.5 Approval of Capital Expenditure must be in line with the Delegated Financial Limits as set out in the Trust SOs / SFIs and the scheme of Delegation Governance framework for major capital programmes.

10. Capital Purchases

10.1 Once a discretionary capital scheme has been approved, the capital scheme Project Manager should obtain indicative costs from the Trust's Procurement department based on a given specification. The indicative costs should also include ongoing revenue consequences such as maintenance. Advice should also be sought as to how the equipment can be procured i.e. National Framework, Quotation/Tender or OJEU etc.

10.2 The Project Manager shall then arrange for the purchases to be made in accordance with the procurement rules contained within the Trust's Standing Financial Instructions.

10.3 The Divisions shall be responsible for raising capital requisitions. Authorisation of all capital requisitions must be in accordance with the Trust's financial limits.

11. Monitoring and Reporting on the Capital Programme

11.1 The discretionary Capital Programme is monitored throughout the financial year as an ongoing process, by the Capital Planning and Delivery Group, chaired by the Deputy Director of Planning. The approved Discretionary Capital Programme will form the basis of the capital monitoring process.

11.2 Commitment and spend against the approved Discretionary Capital Programme is reported to the Capital Planning and Delivery Group on a monthly basis and more frequently at the end of the financial year.

11.3 The All Wales Capital Programme is monitored throughout the financial year as an ongoing process, by the Strategic Capital Board, chaired by the Chief Executive. The approved All Wales Capital Programme will form the basis of the capital monitoring process.

11.4 Commitment and spend against the approved All Wales Capital Programme is reported to the Strategic Capital Board on a monthly basis.

11.5The Financial Planning & Reporting Function shall analyse all capital expenditure processed through the general ledger, and ensure that all expenditure is allocated to the correct cost centre.

11.6 The Financial Planning & Reporting Function shall monitor capital expenditure throughout the year and produce a monthly expenditure statement for each capital scheme and for the Capital Programme as a whole.

11.7 The Financial Planning & Reporting Function will update forecasts throughout the year to identify at the earliest opportunities underspends, overspends and slippages to subsequent years, to enable effective reallocation of funding in order to maximise use of resources whilst complying with the Capital Resource Limit. Reporting should include orders placed along with expenditure to date in order to provide an accurate position on planned spend.

11.8 The Head of Financial Planning & Reporting shall report progress and a spend position on the Capital Programme to the SCB, Executive Management Board, , Trust Board and the Welsh Government.

11.9 The key monitoring functions of the Capital Planning and Delivery Group are:

- Monitor the implementation of the approved Discretionary Capital Programme.

- Review discretionary projects currently in progress and just completed. This enables additions to and depletions from the available resources, owing to over and under spends, to be identified.
- Receive and review any reports, cost or otherwise, for discretionary capital schemes that are not on target on an exception reporting basis.
- Recommend changes to the Discretionary Capital Programme as required.
- Administer any reserve within the Discretionary Capital Programme.
- Proactively manage through the year risk of not achieving the CEL.
- Advise the Strategic Capital Board and Executive Management Board on expected and actual projected outturn figures.

11.10 The key monitoring functions of the Strategic Capital Board are:

- Monitor the implementation of the approved All Wales Capital Programme.
- Review All Wales projects currently in progress and just completed. This enables additions to and depletions from the available resources, owing to over and under spends, to be identified.
- Receive and review any reports, cost or otherwise, for All Wales capital schemes that are not on target on an exception reporting basis.
- Recommend changes to the All Wales Capital Programme as required which will need to be reported to WG.
- Advise the Executive Management Board on expected and actual projected outturn figures.

The Trust CEL is fixed by WG in October, any overspend or slippage after this point is expected to be managed internally by the Trust.

12. Fixed Asset Register

12.1 The Director of Finance is required to compile and maintain an up to date Fixed Asset Register to ensure proper management and control over Trust assets. This responsibility is delegated to the Financial Operations team. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance.

12.2 Divisions will regularly be provided with a list of assets they hold on the Trust's Fixed Asset Register. To ensure the accuracy of the Trust's Fixed Asset Register, it is important to verify the existence and continued use of assets. Therefore, on an annual basis, the Financial Operations team

will lead a validation of all Trust assets with support from the Trust Service Managers.

12.3 Where practical, assets should be marked as Trust property.

12.4 Refer to Financial Control Procedure 2 (FCP2) Non-Current assets for maintenance of the fixed asset register including additions and disposal guidance and forms.

13. Training

13.1 Whilst there are no formal training programmes in place to ensure implementation of this procedure, each Executive Director, Divisional Director, Clinical Director, Divisional Manager, Head of Departments must ensure that managers and all staff, clinical and non clinical, are made aware of the procedure provisions and that they are adhered to at all times.

14. Resources

14.1 The implementation and management arrangements associated with this procedure do not present any significant resource implications to the Trust.

15. Implementation and Monitoring

15.1 This procedure will be implemented and monitored by the Capital Planning and Delivery Group.

15.2 Please refer to the responsibilities section (Appendix 3) for further information in relation to the responsibilities in connection with this procedure.

15.3 The Trust will be audited against the delivery of the procedure by Internal and External Audit.

16. Procedure Conformance / Non Compliance

16.1 If any Trust employee fails to comply with this procedure, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this procedure could be considered to be gross misconduct.

17. Distribution

17.1 The procedure will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Finance-Policies.aspx

18. Review

18.1 The Capital Planning and Delivery Group will review this procedure when necessary and at least every three years.

19. Further Information

19.1 For more information please contact either:

- Head of Financial Planning & Reporting on 02920 615888 x6619 or via email: steven.coliandris@wales.nhs.uk
- Deputy Director of Planning & Performance on 02920 615888 or via email: Philip.Hodson@wales.nhs.uk

Velindre University NHS Trust Capital Planning & Delivery Group - Terms of Reference

Name of Group:	Velindre University NHS Trust Capital Planning & Delivery Group
Summary of Role:	The Velindre University NHS Trust ('Trust') Capital Planning & Delivery Group is responsible for overseeing the development and delivery of the annual Trust discretionary capital programme. Following the development of a recommended Trust discretionary capital programme this must be approved by both the Trust Strategic Capital Board and the Trust Executive Management Board. Following approval of the Trust discretionary capital programme the Capital Planning & Delivery Group will be responsible for its delivery.
Remit:	**Capital Strategic Planning & Delivery:** • The development of a Trust capital planning prioritisation framework in respect of our Welsh Government discretionary capital allocation. This will support the prioritisation of capital investment against Trust strategic priorities. • The evaluation and prioritisation of discretionary capital investment proposals from across the Trust. • The development of a prioritised Trust discretionary capital programme for the Trust. • The re-profiling of the Trust discretionary capital programme in response to in-year changes. These may include project over / under spend and / or the availability of additional capital funding in-year. • The delivery of a balanced Trust discretionary capital plan. • The provision of regular monitoring reports to the Welsh Government in relation to delivery against our Welsh Government discretionary capital allocation. **Policy and Procedures:**

	• The development of the Trust discretionary capital planning policy and procedure. • To ensure that appropriate systems are in place to prioritise discretionary capital bids. • To ensure strategic alignment between the Trust's discretionary capital programme and the Trust's major transformation Programmes. **Assurance:** • To advise and make recommendations to the Trust Strategic Capital Planning Board and the Trust Executive Management Board in all matters relating to Trust discretionary capital. (Note: The Trust Executive Management Board is accountable for approving the Trust annual discretionary capital programme following approval by the Trust Strategic Capital Board). • To ensure that policies and procedures are adhered in relation to capital planning. • To regularly monitor and review the Trust discretionary capital programme to ensure continued alignment with national and local strategies.
Reporting to: **Communicates with:**	Trust Strategic Capital Board Trust Executive Management Board Welsh Government Capital Review Group Trust Strategic Development Committee WBS Senior Management Team VCC Senior Leadership Team
Sub Committees:	N/A
Chaired by:	Deputy Director of Planning and Performance
Membership:	• Trust Head of Financial Planning and Reporting – (Deputy Chair) • Deputy Director of Finance • Trust Finance Business Partner – Capital • Trust Senior Finance Business & Reporting Manger Partner • Trust Financial Operations Manager • Trust Head of Digital Delivery

	• Trust Assistant Director of Estates, Environment & Capital Development • Trust Technical Services Manager • General Manager Welsh Blood Service (or deputy) • Welsh Blood Service Capital Planning Manager • General Manager Velindre Cancer Service (or deputy) • Velindre Cancer Service Planning and Performance Manager • Corporate Head of Capital Planning (to be appointed) • Corporate Head of Capital Delivery • Trust Business Support Officer (Strategic Transformation, Planning and Digital) • Trust procurement representative **By Invitation:** The Trust Capital Planning & Delivery Group may extend invitations as required to individuals from within or outside the Trust who the group consider should attend. This will take account of the investment proposals that are under consideration at each meeting.	
Meeting Frequency:	Monthly	
Documentation Required:	• Relevant Welsh Government correspondence • Trust discretionary capital programme • Trust discretionary capital planning prioritisation framework • Trust capital asset register • Divisional and corporate investment proposals • Full minutes from the Trust Strategic Capital Board to all members of the Trust Capital Planning Group	
Outputs: (i.e. minutes of meeting submitted to other committee meetings)	• Full minutes from the Trust Capital Planning & Delivery Group to all members of the Strategic Capital Board • Action log to all Trust Capital Planning & Delivery Group members • Trust discretionary capital planning prioritisation framework • Prioritised Trust discretionary capital programme • Trust capital planning & management procedure /policy	
Contact:	**Date ToR Last Revised**	**Next Review Date**

Mr. Philip Hodson Mr. Steven Coliandris	Currently in drat following the establishment of the Trust Strategic Capital Board (Draft TOR developed July 2023)	12 months following approval

Appendix 2

VELINDRE UNHS TRUST – DISCRETIONARY CAPITAL PRIORITISATION AND BUSINESS CASE TEMPLATE

Document Purpose

The Velindre University NHS Trust Capital Planning Prioritisation Framework has been developed to support the assessment and prioritisation of capital funding proposals from across the Trust. The framework outlines a clear, rational approach and a fair, transparent process to ensure that capital resource is prioritised against greatest need.
Following Executive Management Board approval the document much be signed in line with the approved delegation.
In order to provide the Trust with this information, please complete this form for your individual schemes.

Scheme Name:			
Departmental/Location:			
Responsible Lead:		**Date:**	

1. Brief Description of Scheme
2. Main Benefits *What do you want to achieve/what benefits do you hope to realise?*
3. What are the risks if funding for the scheme is not obtained. *Brief outline of Risks* *Detail any Counter measures that can be put in place to reduce risk.* *How long could scheme be delayed before it becomes critical*

Has a Risk Assessment been completed and attached	Yes / No
Is Risk Highlighted on Trust Risk Register	Yes / No
Is Risk Highlighted on Divisional Risk Register	Yes / No
Risk Rating	Critical / High / Medium / Low

4. Estimated Capital & Revenue Costs (£)

Please estimate costs including VAT where applicable. A financial analysis may be attached as an Appendix if preferred.

Capital Cost	Year 1 £'000	Year 2 £'000	Year 3 £'000	Total £'000
Building Works				
Fees				
Equipment				
Commissioning				
IT				
Other (please specify)				
TOTAL				
Estimated Life of Any Equipment (Years)				
Have any other alternative sources of funding been explored? If Yes, please give details				
Revenue Cost & Savings	**Year 1 £'000**	**Year 2 £'000**	**Year 3 £'000**	**Total £'000**
Staff Costs				
Maintenance Costs				
Training				
Other Costs (specify)				
Savings (specify)				
TOTAL				

5. Estimated Delivery Timeframe (months) inc BC Development	

Latest Date that Scheme would need to be approved in order to ensure the scheme was completed in this financial year			
6. Critical Success Factor (tick if applicable and the reason & evidence for your selection)			Reason(s) / Evidence for selection
	Strategic Fit & Business Needs *(The capital proposal must demonstrate: Alignment with the Trust's strategic objectives; Holistic fit and synergy with other major programmes and projects)*	☐	
	WBFGA (Well-being of Future Generations Act) https://futuregenerations.wales/wp-content/uploads/2017/02/150623-guide-to-the-fg-act-en.pdf		
	• *A prosperous Wales (where everyone has jobs & there is no poverty)*	☐	
	• *A resilient Wales (prepared for things like floods)*	☐	
	• *A healthier Wales (everyone healthier & able to see a doctor)*	☐	
	• A more equal Wales *(equal chance whatever their background)*	☐	
	• A Wales of cohesive communities *(communities can live together happily)*	☐	
	• A Wales of vibrant culture & thriving Welsh Language *(do different things & lots of people speak Welsh)*	☐	
	• A Wales of vibrant culture & thriving Welsh Language *(do different things & lots of people speak Welsh)*	☐	
	• A globally responsible Wales *(look after environment & think about other people around the world)*	☐	

7. Key Drivers & Evaluation Criteria (score low, medium or high) and the reason & evidence for your selection		**SCORE** (Refer to Fibonacci Scoring Sequence (Appendix 1)	**Reason(s) / Evidence for selection**
	Compliance		
	Critical Service Continuity		
	Tier 1 Targets		
	Deliverability		
	Patient/Donor Experience & Environment		

KEY DRIVERS & EVALUATION CRITERIA	
Compliance Requirement	*The capital proposal will support the Trust in meeting statutory, regulatory, accreditation or organisational requirements and accepted best practice. For example, new health and safety legislation or building standards.*
Critical Service Continuity (Replacement) - Risk	*The capital proposal is required to re-procure services or equipment in order to avert service failure. For example, at the end of a service contract or when an enabling or equipment asset is no longer fit for purpose*
Tier 1 Targets	*Improve/ avoid deterioration in performance against core targets e.g. Activity / waiting times.*
Deliverability	*Level of assurance for management of scheme within cost. The capital proposal will reduce the cost of service delivery in terms of the required inputs. For example, investment in innovative technologies, quality of service provision for patients and / or donors and will support the delivery of agreed outcomes and time constraints*
Patient/Donor Experience & Environment	*Improve Poor Environments and enhance quality of service.*

8. Does this Capital Scheme directly impact on any other WBS Departments i.e. Estates, Facilities, IM&T, QA etc.

Resource Required *(Required to provide resource to support implementation of the change e.g. validation support required, IT support required, WTAIL input etc.)*		Department Involved *(Involved in decision making and may be involved in any working groups that are established but not directly required to provide resource to support)*
9. Details of Existing Assets being Replaced / Traded in.	Asset Number	
	Serial Number	
	Make	
	Model	
	Year Acquired (if known)	

10. Procurement Plan		
Is this Single Tender Action (STA) / Single Quotation Action (SQA)		Yes / No
Which Procurement Route is to be followed?	OJEC Advert Required	Yes / No
	Existing Framework	Yes / No
	Tenders Required	Yes / No
	Quotations Required	Yes / No

ADDITTIONAL COMMENTS - ***Please insert any additional information i.e. any procurement information, timescales etc.***

Completed By	

PLEASE SEND COMPLETED FORM TO: JEFF O'SULLIVAN (VCS) / ANGELA ROBINS, (WBS) / CARL TAYLOR (DIGITAL) / JASON HOSKINS (ESTATES)	TO BE COMPLETED BY SERVICE / FUNCTINAL LEAD	
	Information transferred to Capital Plan	
	Date	

Appendix 1

FIBONACCI SCORING SEQUENCE

Relative Value	1 Compliance	2 Critical Service Continuity (Risk)	3 Tier 1 Targets	4 Deliverability	5 Patient/Donor Experience & Environment
1				Low	
2			Low	Significant	
3		Low	Significant	Critical	
5		Significant	Critical		
8	Low	Critical			Low
13	Significant				Significant
21	Critical				Critical
34					
55					

SCORE	Priority Rating
0-22	Low
23-36	Significant
37 - 58	Critical

FOR COMPLETION FOLLOWING BID APPROVAL

11. Equality Impact Assessment *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item

12. Authorisation

Project Manager

Name			
Signed		Date	

Project Sponsor

Name			
Signed		Date	

Finance Manager

Name			
Signed		Date	

Director

Name			
Signed		Date	

PLEASE SEND COMPLETED FORM TO:
Capital Planning & Financial Planning & Reporting Teams
Philip.Hodson@wales.nhs.uk
Steven.coliandris@wales.nhs.uk

APPENDIX 3

Capital Management – Key Roles and Responsibilities

The Chief Executive

- The Chief Executive has overall responsibility for delivery of the Trust's Capital Programme.
- The Chief Executive may act as Project Owner and has overall responsibility for the management of capital schemes at all stages of the process, from inception to post project evaluation and for ensuring the recording of assets once acquired.
- The Chief Executive must ensure that the Project Manager appointed to manage an approved capital scheme receives notification of delegated authority to commit expenditure, to proceed to tender or to accept a successful tender as required.
- That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model.
- That the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.
- The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically. The Chief Executive may delegate capital investment management in accordance with Welsh Government guidance and the Trust's Standing Orders.
- The Chief Executive shall have the delegated authority to approve capital investment up to a value of £100k.

Director of Strategic Transformation, Planning and Digital

- The Director of Strategic Transformation, Planning and Digital is responsible for the development of a Capital plan and detailed Capital programme, for the organisation that sets out a detailed Capital investment plan to support the objectives set out in the IMTP.
- Ensure that the decision to invest capital is in accordance with the Trust's overall strategic aims.
- Seek the approval of the Executive Management Board for inclusion of a capital investment proposal within the Trust's Capital Programme.
- Ensure that a Project Director and Project Manager are appointed for each capital project and that there are adequate project management, monitoring and control arrangements in place.
- Support the development of a rolling capital programme for inclusion in the Trust's Integrated Medium Term Plan (IMTP).
- Lead and chair as required Project Teams delivering major projects.
- Report as required to the Trust on capital project progress and issues.
- Ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all relevant consequences, including capital charges.

- The Director of Strategic Transformation, Planning and Digital and Executive Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered.

Executive Director of Finance

- The Executive Director of Finance is responsible for establishing management control and financial reporting systems ensuring that the programme delivers within the funding envelope.
- Shall have delegated authority to approve capital investment up to a value of £60k.
- Ensure that the decision to invest capital funding is in accordance with the Trust's overall strategic aims.
- Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans. The Executive Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Trust's Scheme of Delegation.
- Support the development of a rolling capital programme for inclusion in the Trust's Integrated Medium Term Plan (IMTP).
- Lead liaison with the Welsh Government with reference to capital funding.
- Lead and chair as required Project Teams delivering major projects.
- Report as required to the Trust on capital project progress and issues.
- Ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all relevant consequences, including capital charges.
- Sign off the quality/cost split for any OJEU procurements.
- The Executive Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
- The Executive Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Executive Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.
- The Executive Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.
- The Director of Strategic Transformation, Planning and Digital and Executive Director of Finance shall issue detailed procedures governing the project,

financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered.

Deputy Director of Planning & Performance

- The Deputy Director of Planning & Performance is operationally responsible for the development of a Capital plan and detailed Capital programme, for the organisation that sets out a detailed Capital investment plan to support the objectives set out in the IMTP.
- Ensure that the decision to invest capital is in accordance with the Trust's overall strategic aims.
- Reviewing all authorised discretionary capital Business Cases to ensure they have been completed in full and are fit for purpose.
- Seek endorsement from the Strategic Capital Board for inclusion of a capital investment proposal within the Trust's Capital Programme.
- Keeping a record of all authorised discretionary capital Business Cases and circulating them to Capital Planning and Delivery Group members for information.
- Operationally ensure that a Project Director and Project Manager are appointed for each capital project and that there are adequate project management, monitoring and control arrangements in place.
- Support the development of a rolling capital programme for inclusion in the Trust's Integrated Medium Term Plan (IMTP).
- Lead and chair the Capital Planning & Development Group
- Report as required to the Trust on capital project progress and issues.

Assistant Director of Estates, Environment and Capital Development

Capital Programme:

- Develop proposals for submission/consideration for inclusion in the Capital Programme.
- Develop a programme for Statutory Compliance, Health and Safety issues and Backlog Maintenance.
- Management of Statutory Compliance, Health and Safety and Backlog Maintenance programme element of the Trust approved capital programme.
- Provide routine reports on progress, cost control and any changes to the Statutory Compliance, Health and Safety and Backlog Maintenance programme to the Capital Planning and Delivery Group.
- Liaise with the Planning Directorate to allocate appropriate resources to support the development of capital schemes at all stages of the planning process.

- Support feasibility studies for developments of business cases for capital developments. Provide support and regular reporting to capital meetings.

Technical/Professional Project Management:

- Accountable to the client project manager for the provision of specialist technical project management and support.
- Allocate design team resources.
- Support the development of user requirements.
- Provide technical advice on feasibility of user options.
- Undertake and support option appraisal for business case development.
- Provide outline costing, identifying the costing basis.
- Provide comprehensive cost information and estimates in line with the requirements of the Capital Expenditure Limit ensuring that cost variances are identified separately for the effects of programme and cost changes.
- Advice on statutory approval requirements.
- Advice on project timetable.
- Advising and supporting the appointment of external project managers and design teams as appropriate. Advising on the compliance with the Construction, Design and Management (CDM) regulations where required.
- Provide appropriate support through membership of Capital Project teams.
- Ongoing management and control of capital schemes.
- Assist in developing an agreed programme.
- Assist in prioritising capital schemes.
- Advice on requirement of Capital Procedures compliance.
- Support the submission of Project start up documents with appropriate advice on status of any cost provided.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes the Welsh Government.

Capital and Operations Manager

- Provide effective management, co-ordination and development of the Trust capital programme including the development, maintenance and implementation at a corporate level of the estate's capital programme, ensuring balance with the organisation's Capital Expenditure Limit.
- Provide effective management, co-ordination and development of estates capital investment proposals and to encourage the use of good practice in the preparation of estates capital business cases.
- Assist and/or lead in the production of appropriate documentation and analysis, business cases etc and ensure that for each estates approved project a business case or business justification document is produced which contains a full appraisal of options against potential benefits and known costs for each investment proposal.
- Ensure that the Executive Director of Finance has certified the costs and revenue consequences of any estate's capital proposal.

- Produce, lead or assist in the production of, appropriate documentation and analysis, Business Cases and Capital Programmes and Reports for Trust and Capital Planning and Delivery Group.
- Provide practical support to Project Owners, Directors and Managers including the clarification of investment objectives, provision of a quality assurance role and implementation of project management techniques.
- Provide as required Capital and Project Briefings for the Trust.
- Support the ongoing improvement in Trust capital investment protocols and practices to ensure that the maximum benefit is gained from limited capital resources.
- In co-operation with the designated staff from the Finance Directorate, develop plans for discretionary capital expenditure.
- To be responsible for the regular review and reporting of the Estates-related Capital Programme.
- When property transactions form part of a capital project ensure that appropriate procedures are followed.

Head of Financial Planning& Reporting

- Lead the financial delivery of the Discretionary Capital programme and provide capital financial advice to all business cases.
- Provide financial support for the development, co-ordination and monitoring of capital investment proposals and to encourage the use of good practice in the preparation of business cases that identify a requirement for capital investment.
- Ensure that all necessary information is provided and action initiated to successfully meet the requirements of the Capital Expenditure Limit.
- Lead and/or assist in the production of, appropriate documentation and analysis, Business cases and Capital Programmes and Reports for the Trust and other Trust meetings.
- Maintain links with external groups or bodies who have a key role in the allocation of capital resources. This includes the Welsh Government.
- Apply capital investment techniques including development of strategic and financial contexts, identification of benefits criteria, option and financial appraisals and risk analysis to capital investment proposals and overall appraisal of capital investment proposals.
- Contribute to the ongoing development of the Trust's Capital Investment protocols and practices.
- Providing advice and assistance to all staff that are completing the discretionary capital Business Case template.
- Keeping a record of all authorised discretionary capital Business Cases and circulating them to Capital Planning and Delivery Group members for information.
- Reconcile the Capital Programme to the Capital Expenditure Limit received from the Welsh Government.
- Produce capital monitoring information for the monthly Welsh Government financial return.
- Carry out a monthly reconciliation of capital expenditure to the general ledger.
- Shall deputise and chair the Capital Planning & Development Group in the absence of the Director of Planning & Performance.

Financial Accountant

- Responsible for capital accounting, including capital charges, International Financial Reporting Standard implications and revenue implications of all capital schemes.
- Ensure the upkeep and future development of the capital asset register.
- Produce periodic estimates of capital charges resulting from the Trust's Capital Programme, in accordance with WG guidelines and timescale.

Divisional Capital Leads

Divisional capital leads are responsible for:

- Presenting the prioritised Divisional All Wales & discretionary capital bids to the Capital Planning and Delivery Group for consideration.
- For each successful discretionary capital scheme bid, ensure a Project Manager is appointed who is, in the first instance, tasked with completing the discretionary capital Business Case for the scheme.
- Providing support and assistance to staff who have been asked to write a discretionary capital Business Case.
- Ensuring all discretionary capital Business Cases are completed in full and are authorised correctly ultimately by the Divisional Director.
- Sending a copy of all authorised discretionary capital Business Cases to the Capital Planning lead and Financial Planning & Reporting team.
- Ensuring copies of discretionary capital Business Cases are attached to capital requisitions to ensure they can be approved quickly.
- Report back to the Capital Planning and Delivery Group on delivery of all discretionary capital projects.

Capital Project Director

- Lead and direct (on behalf of the Project Owner) the Project Board and Project Team(s) towards the successful delivery of the project objectives as agreed with the Project Owner (Chief Executive) and Trust Board.
- Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

The Project Director shall ensure that:

- A Project Manager is appointed.
- A clearly established structure including a Project Board and Project Team, which include as required appropriate skills and expertise, representatives of all interested departments and stakeholders, has been given responsibility for the project and appropriate training is available.
- The appointment of project officers is recorded.

- There is a clear scheme of delegation that supports each individual's levels of responsibility.

The Project Director shall also ensure that the Project Manager has a clear brief including:

- Terms of reference and duties including contractual objectives/business needs.
- Capital expenditure limit requirements and delegated authority.
- Resources available.
- Responsibilities for Health and Safety.
- Relationships with (Internal) specialist support, (External) Project Manager and the Supply Chain Partner (SCP) change management responsibilities.
- Training needs and resources.
- Appropriate techniques and components from relevant project management qualifications, including PRINCE2, may be used as required to help with the delivery of the project.
- Ensuring the responsibility and ownership of the project is retained by Trust and not delegated to external contractors.

The Project Director shall also ensure that the Project Team has:

- Clear responsibilities and methods of working.
- A timetable for key events; co-ordinated plans; guidance notes; monitoring information.
- Project documentation and records.
- Lines of communication are clearly specified.
- One person to direct the activities of consultants, advisers, contractors and third parties.
- External management team members providing professional services who are appointed on a competitive basis.
- Reports on a regular basis using financial and non-financial monitoring.

Appropriate project files and documentation are kept. These should include:

- Business case documentation.
- All correspondence including approvals.
- Project approach and procurement strategy output specifications.
- Project plans, quality plans and risk log.
- Communications plan.
- Records of all meetings and decisions taken.
- File notes of conversations where actions are agreed, decisions taken and authorisations given.
- Details of the appointment of the Project Team and Job Descriptions.
- Details of the appointment of any external experts or advisers.
- Records of all reports made and approvals received.
- Change controls.

- Details of the appointment of the Supply Chain Partner contract documentation.
- Scheme development and design.

Capital Project Managers

The Project Manager for each capital project and will:

- Lead and direct (on behalf of the Project Director and Project Owner) the Project Team(s) towards the delivery of the project objectives as determined by the SRO, Project Board, Chief Executive and Trust Board.
- Ensure that appropriate and adequate communication mechanisms exist between the Project Director and Project Owner, Project Manager and external organisations, and between the Project Manager, Project Director and the rest of the Trust.
- Act as the one point of contact between the Trust and the Contractor/Supply Chain Partner (via the External Project Manager who will have formal responsibility under the appropriate form of contract). This will require ensuring that appropriate formal processes are in place for the provision of professional and technical support and guidance.

In conjunction with, and as delegated by, Project Director, the Project Manager will ensure that:

- A clearly established structure including a Project Team(s) which includes as required appropriate skills and expertise, representatives of all interested departments and stakeholders, has been given responsibility for the project.
- Ensure that the project complies with relevant WG and NHS Estates and Capital Guidance
- The Project Team has clear objectives, defined responsibilities and methods of working, a timetable for key events, co-ordinated plans, guidance notes, monitoring information and project documentation and records.
- There is a clear scheme of delegation that supports each individual's levels of responsibility.
- An appropriate business case is developed and remains robust at the procurement stage.
- To ensure appropriate clinical involvement and sign-off of requirements.
- There is a brief and project execution plan with clearly defined outcomes and an indicative and achievable programme including cost and time.
- To submit timely monthly financial reports of actual cost and accurately forecast costs; and forecast and actual cash flows on the forms provided by finance.
- Appropriate techniques and components from an appropriate project management tool are used as required to help with the delivery of the project.
- Ownership of the project is retained by the Trust and not delegated to external contractors.
- There is liaison with the project manager to direct the activities of consultants, advisers, contractors and lines of communication are clearly specified and are short and direct.

- The design produced meets all the requirements of the project and is signed off as required.
- Ensure that adequate procedures are in place to monitor and control cost, time and quality thereby ensuring Capital Expenditure Limit compliance.
- To obtain robust project costs and act in accordance with Standing Orders and standing financial instructions utilising appropriate delegated input such as provision of build costs.
- To take overall responsibility for the project being delivered within budget, including being informed of and agreement of works budget variations, and direct control of non-works variations (e.g. equipment and fees).
- To include reporting of pre-contract costs e.g. survey and feasibility work, including agreement of budgets.
- To ensure that all project matters and costs are appropriately authorised and notified to appropriate parties.
- To liaise effectively with the technical project manager (usually works and estates), attending project team meetings and ensuring arrangements are in place for specific queries in their absence.
- To ensure that adviser fees are appropriately related to activities when agreed, and similarly checked when incurred.
- To ensure that an equipment schedule is derived to an appropriate stage to enable both initial and final budget estimates, the latter schedules to contain identified suppliers, lead times and itemised costs.
- To agree with the works project manager and contractor, items to be supplied and fitted by the contractor as part of the build, including agreement of cost.
- Provide a regular report to the project director identifying cost, time and quality performance.
- Ensure the project is completed and handed over to the Trust in a managed way.
- To co-ordinate the user commissioning programme, providing time allocations and responsibilities.
- A post-completion evaluation of the scheme takes place.

Appropriate project files and documentation are produced and kept. These should include:

- Business Case documentation.
- All correspondence including approvals, project approach and procurement strategy output specifications.
- Project plans, communications plan, quality plans and risk log.
- Records of all meetings and decisions taken.
- File notes of conversations where actions are agreed, decisions taken and authorisations given.
- Details of the appointment of the Project Team and Job Descriptions.
- Details of the appointment of any external experts or advisers.
- Change controls/variations.
- Details of the appointment of the Supply Chain Partners contract documentation.
- Scheme development and design.
- Cost changes and authorisations.

APPENDIX 4

DISCRETIONARY CAPITAL SCHEME – PROJECT MANAGER'S CHECKLIST

Division:	
Scheme Name:	
Budget:	
Date Approved:	
Project Manager:	

Task	Completed	Date
Project Team Established		
Appropriate Project Management Tools Used		
Business Case Completed and Authorised		
Project Plan Developed and Signed Off		
Procurement		
a) Familiarisation and compliance with SFI procurement requirements.		
b) Consultation with Procurement on availability of resources to deliver the scheme within timeframes.		

c) Quality/Cost assessment (including whole life costs) have been agreed and approved prior to tendering.		
d) Project Team “sign off” of final agreed tender documents (approved scheme).		
e) Tender evaluation of tenders received and verified.		
f) Completion of “Contract Acceptance paper” upon receipt of an acceptable tender.		
g) Develop contract monitoring record and method of agreeing contract variations.		
Estates		
a) Discussion with Estates. Estates requirements in scheme agreed.		
b) Consultation with Estates on availability of resources to deliver the scheme within timeframes.		
c) Project Team “sign off” of design layouts (where applicable).		
Digital		
a) Discussion with Digital and Digital requirements in scheme agreed.		
b) Consultation with Digital on availability of resources to deliver the scheme within timeframes.		
c) Project Team sign off of final agreed specification (approved scheme).		
Finance		
a) An appropriate capital budget has been allocated and cost centre established.		
b) Revenue consequences determined and agreed.		
c) Financial responsibilities for agreeing variations.		
d) An order(s) been raised for the scheme(s).		
e) Monthly monitoring procedures and protocols established for reporting back to the Capital Planning and Delivery Group and the Welsh Government (if applicable).		
f) Orders goods receipted in timely manner.		
g) Invoices monitored especially any that are “on hold” with a view to resolving any issues as soon as possible to ensure 30 day payment policy is complied with.		
Project Evaluation Plan		
Benefits Realisation		

Audit Committee

PROCUREMENT COMPLIANCE REPORT
1st September – 30th November 2023
(Reporting Period)

DATE OF MEETING	19/12/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Wyn Owens, Acting Head of Procurement Sophie Stacey, Senior Procurement Business Manager
PRESENTED BY	Chris Moreton, Deputy Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 1st September 2023 – 30th November 2023 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.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to **NOTE** the information provided in this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – The report was taken to Executive Management Report to provide assurance in relation to procurement activity undertaken during the period 1st September 2023 – 30th November 2023. The Executive Management Board **NOTED** the Report.	04/12/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
[Insert Appendix Number]	List the title of any appendices

1. SITUATION

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 1st September 2023 – 30th November 2023 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 (DG) 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	3
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	3
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	0
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes)	22

2. BACKGROUND

As above in section 1.

3. ASSESSMENT

As below in section 4.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 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 scrutinised the request, assessed the Value for Money element and has endorsed this approach.

	VCC & Corporate	WBS	Total	Repeat Submission
SQA's	3	0	3	0
STA's	2	1	3	0
Total	**5**	**1**	**6**	**0**

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.

Further Matters / Non-Compliance (Appendix 1.2)

Highlights other procurement matters that are not SQA's or STA's i.e. Contract Extensions, Change Control Notes (CCNs) and Variation of Terms as well as 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 (File Notes).

Whilst it has been common practice for service areas to undertake competition for the procurement of goods and/or services up to £25,000, it is on the basis that the quotations procedure within SFI's is followed. Where service leads have failed to undertake competition or not sought quotations in accordance with SFI'S there is a breach of SO's/SFI's and 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.

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

4.2 **General Observations Update**

The Procurement department has undertaken a review of the SQA and STA requests that were submitted and approved from 1st September 2023 – 30th November 2023.

Single Quotation Action (SQA) Requests

As part of the strategy to reduce the number of STA/STA's, there are no SQA's to report this period, any requests received were discussed with the service and another route to market sourced, i.e. direct award via framework or quotation exercise via the Multiquote portal.

VCC / Corporate (SQA's)

Three SQA's was submitted and approved for this period.

WBS (SQA's)

No SQA were submitted/considered for this period.

Single Tender Action (STA) Requests

VCC / Corporate (STA's)

Two STA's was submitted and approved for this period.

WBS (STA's)

One STA was submitted and approved for this period.

Publication of Contract Awards

In accordance with procurement regulations contract award notices have been published for all contracts awarded above £25,000. 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

As part of the NWSSP Integrated Partnership the Velindre Frontline Procurement team has been relocated to the Cardiff and Vale University Health Board Frontline Procurement teams base at Woodland House in Cardiff, we are in the process of reviewing the aggregated expenditure and undertaking a more focused approach in inviting competitive quotations. Previously for procurement between £5k and £25k departments were asked to obtain three quotations directly, we have since requested that they engage with Procurement Services who will undertake the relevant route to market.

4.3 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.

5 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* Click or tap here to enter text

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item** *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item** If more than one Well-being Goal applies please list below: The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream As indicated in Appendices 1.1 (Summary Information of Compliant Arrangements) and 1.2 **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Click or tap here to enter text.All policies are equality impact assessed prior to approval.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6 RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**Choose an item**
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust - Audit Committee Report – 1st September – 30th November 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division / Department	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	VEL/ Physic	VEL-SQA (2023/24) 44	One-off Purchase	SQA	Supply & Fit of Balance Springs for DXR D3300	Xstrahl Ltd	£10,910.06	One-off Purchase	SQA	N/A	First Submission
Rachel Hennessy	VEL/Nuclear Medicine	VEL-SQA (2023/24) 53	01/11/2023-31/10/2026	SQA	Clinical Scientist Guided Training Programme for 3 Staff	IPEM	£10,350.00	Provide professional registration course training to 3 members of staff	SQA	N/A	First Submission
Carl James	VEL/Estates	VEL-SQA (2023/24) 56	15/11/2023-31/03/2024	SQA	Professional Support - Fulfilling the roles of Building Services Consultant	Consilium Consulting Engineers LTD	£17,945.00	Professional support required post IRS contract for VCC Radiotherpay	SQA	N/A	First Submission
Carl James	VEL/Estates	VEL-STA (2023/24) 57	15/11/2023-31/03/2024	STA	Professional Support - Fulfilling the roles of Principle Designer, Project manager and Architect	HL Design	£36,650.00	Professional support required post IRS contract for VCC Radiotherpay	STA	N/A	First Submission
Rachel Hennessy	VEL/Medical Records	VEL-STA (23-24) 93	01/11/23-30/04/2024	STA - VEAT	Storage and Restoration of Velindre University NHS Trust Health Records	Harwell Restoration	£152,028.40	Continuation of storage of records. New requirement restoration service as a result of flood damage to records	STA - VEAT	N/A	First Submission
Carl James	VEL/Estates	VEL-MIN-MULTIRA334261	01/11/23-31/10/24	Quotation	Training courses for Estates Department	Eastwood Park Ltd	£24,999.00	Provide Training for staff over next 12 months	Quotation issued via MultiQuote	N/A	First Submission
Carl James	VEL	VEL-MIN-MULTIRA335130	01/11/23-31/10/24	Quotation	Call Out Drain Services	Jet Rod SW Ltd	£10,000.00	Renewal of contract – was previously uncompliant	Quotation issued via MultiQuote	N/A	First Submission
Rachel Hennessy	VEL/ Operations	VEL-MIN-MULTIRA335461	01/11/23-29/02/24	Quotation	Provision of Staff safety Wardens	Wales and West High Reach Cleaning	£19,920.00	One-off Requirement	Quotation issued via MultiQuote	N/A	First Submission

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Executive / Director Responsible	Division / Department	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)
Carl James	VEL/Estates	QUOTE (23-24) 25	14/09/23-31/01/24	Quotation	Agency support for Estates Department	Acorn Recruitment Ltd	£9,000.00	One-off Requirement	Direct award VIA CCS framework RM6277	N/A	First Submission
Carl James	VEL/Estates	QUOTE (23-24) 30	01/10/2023-31/03/24	Quotation	Refurbishment of Treatment Room LA3	Lee Wakemans Management	£17,500.00	One-off Requirement	Direct Award via CCS RM6242	N/A	First Submission
Carl James	VEL/Estates	QUOTE (23-24) 33	One-off Purchase	Quotation	Purchase of sport equipment	Net World Sports	£13,908.54	One-off Purchase	3 Quote Exercise Carried out by Estates	N/A	First Submission
Carl James	VEL/Estates	QUOTE (23-24) 35	23/10/23-16/11/23	Quotation	Sports Field Contractor	Thomas Brothers Group	£22,803.84	One-off Requirement	3 Quote Exercise Carried out by Estates	N/A	First Submission
Rachel Hennessy	VEL/Pharmacy	QUOTE (23-24) 42	16/10/23-12/01/24	Quotation	Health professionals, health science & emergency services staff	SET Healthcare Ltd	£13,720.50	One-off Requirement	Direct award via CCS framework RM6161	N/A	First Submission
Sarah Morley	VEL/ Workforce	CAV-DCO (22-23) 61	01/11/23-05/10/24	CCN	Childcare Vouchers and Long-term Complimentary Vouchers	Edenred UK	£7,000.00	Renewal	CCN undertaken via Cardiff's contract	N/A	Repeat Annual Value £5850
Matthew Bunce	VEL/Corporate	VEL-CORP-DCO-50838	01/10/23-31/12/23	CCN	Provision of VAT consultancy	Ernst & Young	£22,500.00	Renewal	CCN to align with CAV renewal	N/A	First Submission
David Powell	VEL - New Velindre Cancer Centre	nVCC-CM90	13/09/23-31/12/23	CCN	nVCC FBC Support	Faithful & Gould	Increase £16,897.50	Increase 50% modification from £33,885 to £50,782.50	Direct Award	N/A	First Submission
David Powell	VEL - New Velindre Cancer Centre	CM76	31/07/23-30/09/23	CCN	Archus – Alex Bowles - Contract Variation	Archus	Increase £45,000.00	Increase 39% and extend contract by 2 months	Direct Award	N/A	First Submission
David Powell	VEL - New Velindre Cancer Centre	VEL-ITT-PROJECT52407	11/09/23-31/03/24	CCN	Provision of Architect Design Consultancy Advice; nVCC	John Cooper Architects	Increase £31,960.00	Increase 47% new value £99,960.00	Tender	N/A	First Submission

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Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible	Division / Department	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)
David Powell	VEL - New Velindre Cancer Centre	VEL-MIN-MULTIRA332741	01/11/23-31/12/23	CCN	Design Consultant	WK Space	Extend only	Extend only	Quotation issued via MultiQuote	N/A	First Submission
David Powell	VEL - New Velindre Cancer Centre	CM45	01/11/23-31/03/24	CCN	nVCC enabling Works	Walters	Increase £759,8983.00	Increase new value £11,316,261.00	Mini Comp via Framework	N/A	First Submission
Rachel Hennessy	VEL/Physics	CQ-0000294927	01/10/2022-30/09/2026	CCN	Maintenance and Support of Radiotherapy Synergy Equipment	Elekta Ltd	£16,100.00	For the current contract it was agreed that 3 of the 4 source changes are carried out by Velindre Clinical Engineering team. Moving froward, the Trust wish for Elekta to perform all source exchanges and services.	Direct Award	N/A	First Submission
David Powell	VEL - New Velindre Cancer Centre	nVCC-CM97	01/11/2023-31/12/2023	CCN	H&K Provision of Tier 2 M&E Advisory Services	Hulley and Kirkwood	Increase £22,500.00	Increase 50% from £45,000 to £67,500 and to extend from 31/10/23 to 31/12/23	Direct Award	N/A	First Submission
Alan Prosser	WBS – Welsh Blood Service	2324/003/WBS	16/10/23-31/01/24	STA	Consultant to support and complete Plasma 4 Medicines Better Business Case submission	PharmaPuls	£55,125.00	This will be led by WBS but HCSNI will be jointly procuring this consultants services, WBS to recharge HCSNI. PR had contacted European Blood Alliance seeking suitable person to complete this work.	STA	N/A	First Submission
Alan Prosser	WBS – Laboratory Services	Q.0014/WBS	09/2023-06/2024	Quotation	MSc in Haematology & Transfusion Science	Manchester Metropolitan University	£10,002.00	One-Off Requirement	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS – Laboratory Services	Q.0015/WBS	09/2023-06/2024	Quotation	MSc in Biomedical Science (Online)	Greenwich University	£9,300.00	One-Off Requirement	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS – Laboratory Services	Q.0016/WBS	One off purchase	Quotation	HLA SSO Kits	IBG Immucor	£8,070.81	One-Off Requirement	Quotation issued via MultiQuote	N/A	First Submission

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Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 1st September – 30th November 2023

Appendix 1.2 - Further Matters / Non-Compliant Arrangements

Executive / Director Responsible	Division / Department	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	VEL/Physics	VEL-FN-036	24/07/2023 - 11/09/2023	File Note	Provision of Agency Staff for Medical Physics	Rig Medical Recruit LTD	£10,124.66	There was no Procurement involvement from the department. The department were not aware that this was required as the agency staff member has been in place for multiple years. This has now been picked up with procurement and a contract going for going forward has been put in place.	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Jaz Abraham	VEL/R&D	VEL-FN-037	One Off Requirement	File Note	Microbiological Safety Cabinet and service	Monmouth Scientific Limited	£9,587.00	The requirement was progressed following approval from capital planning. The requisition was raised, and the order was placed with the company with no procurement involvement.	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Paul Wilkins	VEL/ Fundraising	VEL-FN-039	24/07/2023 - 27/07/2023	File Note	Overseas Bike Ride 2024 - Cardiff to Paris	Passion in Events	£3,792.00	Event organised by a third party fundraiser not by the charity. The fundraiser chose the event organiser. All funds raised from the event have been paid into Velindre which is why we have to pay the invoices.	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	Repeat of VEL-FN-025 £63,200
Carl James	VEL/Estates	VEL-FN-040	One Off Requirement	File Note	Emergency Structural Repairs to Clinical Trials Portacabin zone 2 Hafan Modular Building.	Kelray LTD	£12,686.95	Recommendations made by structural engineer, works completed by contractor (Kelray) as a matter of urgency due lack of alternative space available onsite to continue patient's treatments.	Competition not sought in accordance with SFI'S	Noted that due to urgency the Trust were not able to seek quotes from more than one supplier.	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-041	12 months requirement	File Note	Provision of Escrow Services	Intertrust Escrow and Settlements B.V.	£7,750.00	Procurement was not contacted by the department before the provision was put in place.	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-042	Retrospective	File Note	Professional Mechanical & Electrical Support	Lee Wakemans	£6,907.24	STA not processed in time and work has already been undertaken.	Competition not sought in accordance with SFI'S	Discussed with TCS that a file note is required as the services have already commenced, advised that this breach will be	First submission

Executive / Director Responsible	Division / Department	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
										reported to Audit Committee.	
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-043	Retrospective	File Note	Professional Architectural Consultancy Support	HL Design Ltd	£8,840.00	STA not processed in time and work has already been undertaken.	Competition not sought in accordance with SFI'S	Discussed with TCS that a file note is required as the services have already commenced, advised that this breach will be reported to Audit Committee.	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-044	Retrospective	File Note	Professional Mechanical & Electrical support	Consilium Consulting Engineers	£5,300.00	STA not processed in time and work has already been undertaken.	Competition not sought in accordance with SFI'S	Discussed with TCS that a file note is required as the services have already commenced, advised that this breach will be reported to Audit Committee.	First submission
Sarah Morley	VEL/ People & OD	VEL-FN-045	Retrospective	File Note	Legal Investigation	Ibex Gale Limited	£30,680.16	The investigation that was originally commissioned within budget was extended to investigate a significant number of issues hence breach above the limit.	Extended in excess of SFI allowable limits	Service advised that the original contract was awarded 16th Feb 2023 after approaching 3 suppliers for quotes. The file note is to approve the spend of increased cost of the invoice as due to the complexity of the case, the charges exceeded the original quote.	First submission
Paul Wilkins	VEL/ Fundraising	VEL-FN-048	13th-14th October 2023	File Note	Welsh 3000's Challenge (Third Party Event)	Challenges Un Ltd TA Charity Challenges	£5,625.00	Event organised by a third party fundraiser not by the charity. The fundraiser chose the event organiser. All funds raised from the event have been paid into Velindre which is why the Trust have to pay the invoice.	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Matthew Bunce	VEL/Finance	VEL-FN-049	18/08/2023 – 13/10/2023	File Note	Agency costs for Accountancy Support Officer	Now Careers LTD	£5,934.27	PO is also being put in place for agency member going forward. Agency staff member is finishing 01/12/2023	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission

Executive / Director Responsible	Division / Department	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-050	Retrospective	File Note	Provision of C&S Technical Advice for Design Development nVCC	WSP	£32,500.00	Contract was not signed before work commenced - Direct award was arranged by the TSC project team, however file note completed as the work has already commenced with no signed contract	Retrospective - Contract was not signed before work commenced	Advised TSC that no contract should commence without a signed agreement and what risks are involved.	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-051	Retrospective	File Note	nVCC Strategic Advisor	WSP	£90,831.00	Urgent cover required due to Trust's Techincal Advisor being off on sick leave	Competition not sought in accordance with SFI'S	Procurement were advised of this issue and offered to support TSC to carry out Direct Award.	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-054	1st April - 31st Dec 2023	File Note	Design Development FM and Energy Support nVCC	Mott MacDonald	£70,000.00	Provider delayed signing of SLA. Due to Project deadlines following the start of the Successful Participant period and submission of the PCPs for review, the provider commenced the works prior to signing the contract.	Retrospective - Contract was not signed before work commenced	Procurement notes that no contract has been signed and works have commenced from 1st April 2023. Procurement have advised this does leave the Trust at risk with no compliance or governance under T&C's.	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-055	1st April - 31st October 2023	File Note	Archus FBC Support (CM99)	Archus	£30,000.00	Work commissioned as part of the FBC development – but costings not confirmed so unable to raise contract and procurement paperwork, or gain Trust Board approval, to time.	Competition not sought in accordance with SFI'S	Procurement not involved in the contract and works commenced from 1st April 2023. Retrospective and will be reported to next Audit Committee.	First submission
Jaz Abraham / Carl James	VEL - New Velindre Cancer Centre	VEL-FN-056	May 2023 - Oct 2023	File Note	Cardiff Cancer Research Hub (CCRH)	Moorhouse	£122,096.20	The work had already commenced before procurement (Nia Price) was contacted back in May 23 to carry out a direct award. In addition, Procurement did not complete the relevant paperwork (i.e SLA/Call Off Form or Proc Report).	Retrospective	Flagged to AHOP errors made by both parties - as the work has commenced needs to be reported to AC in order to pay the invoice.	First submission
Lauren Fear	VEL/ Corporate Governance	VEL-FN-057	11/10/2023-10/01/2024	File Note	Legal & Consultancy Advice	Mills & Reeve	£10,000.00	Mills & Reeve provided initial advice on a very confidential matter which is being dealt with at Ministerial level. Given the speed this needed to be progressed, in the public	Extended without appropriate authorisation	Initial work carried out under PO 712169345. Additional work commenced without	Repeat £15,000

Executive / Director Responsible	Division / Department	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
								interest, additional work is required, and we have continued to work with Mills & Reeve on this matter.		prior interaction with Procurement.	
Rachel Hennessy	VEL/ Operational Services	VEL-FN-058	01/05/2023 - 30/09/2023	File Note	Agency staff for Operational Services	Blue Arrow Ltd	£20,000.00	Service had raised multiple POs for individual staff members for different dates. There has been confusion in values left on POs and receipting.	Competition not sought in accordance with SFI'S	This value is associated to one PO for multiple staff, will be reported to audit committee as this exceed £5k with ne procurement involvement.	First submission
Paul Wilkins	VEL/Fundraising	VEL-FN-059	16/06/2023 - 29/09/2023	File Note	Fundraising Agency Staff	Hays Specialist Recruitment Ltd	£8,163.80	There was no Procurement involvement from the department as they did not contact the Procurement team when starting this arrangement.	Competition not sought in accordance with SFI'S	Retrospective spend with no procurement involvement. Report to audit committee.	First submission
Nicola Williams	VEL/IPCS	VEL-FN-060	03/10/2023 - 12/10/2024	File Note	University Courses, Education modules (MSC Level)	USW	£5,275.00	There was no Procurement involvement.	Competition not sought in accordance with SFI'S	No prior procurement involvement – report to audit committee	First submission
Alan Prosser/ Carol Morgan	WBS – Facilities	WBS-2324-FN002	Retrospective	File Note	Payment of Invoice ANNUAL COSTS FOR ACCESS TO DOCUMENT VIEWING SYSTEM 2023	Trans Media Technology Ltd	£9,500.00	There was no Procurement involvement.	Retrospective	Emailed end user to let them know retrospective orders are a breach of SFIs and to raise in advance.	Repeat of WBS-OJEU-45853 (expired)
Alan Prosser	WBS – Molecular Genetics	WBS-2324-FN004	01/11/23-31/03/24	File Note	LinqSeq HPA Kits	VH Bio	£9,370.00	No current compliant route available to purchase the required kits, these were previously on a Single Tender Action but this was not renewed/compliantly contracted for.	Competition not sought in accordance with SFIs	Procurement will work with the service to ensure that a compliant route to market is established over the coming months.	First Submission

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Total Value of Non-Compliant Spend to be reported £509,715.19

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Appendix 1.3 - Exemptions

Executive / Director Responsible & Lead 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
Lauren Fear / Modupe Akinrinade	Corporate Governance	VEL-FN-038	11/04/2023 - 20/07/2023	File Note	Legal Services for COVID-19 Public Inquiry	Hailsham Chambers	£7,760.00	Procurement was not contacted by the department before the services took place. A recommendation from NWSSP Legal Team.	Competition not sought in accordance with SFI'S	Due to legal aspects there is no influence over supplier or call for competition.	Repeat (VEL-FN-033) 11/04/2023 - 20/07/2023 £12,200
Lauren Fear / Modupe Akinrinade	Corporate Governance	VEL-FN-046	03/08/2023 – 30/08/2023	File Note	Legal Services for COVID-19 Public Inquiry	Hailsham Chambers	£5,675.00	Procurement was not contacted by the department before the services took place. A recommendation from NWSSP Legal Team.	Competition not sought in accordance with SFI'S	Due to legal aspects there is no influence over supplier or call for competition.	
Lauren Fear / Modupe Akinrinade	Corporate Governance	VEL-FN-052	15/08/2023 - 11/09/2023	File Note	Legal Services for COVID-19 Public Inquiry	Hailsham Chambers	£3,300.00	Continuation of file Note VEL-FN-046	Competition not sought in accordance with SFI'S	Due to legal aspects there is no influence over supplier or call for competition.	

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Velindre University NHS Trust

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Appendix 1.3 - All Wales Contracts in progress

During the period **September 2023 – November 2023**, activity against 38 contracts have been completed. This includes 15 contracts at the briefing stage and 16 contracts at the ratification stage. In addition to this activity, 7 extensions have been actioned against contracts. A summary of activity for the period is set out in **Appendix 1.3**.

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
1.	**Transitional Drugs 2** This contract is for the tender of Apixaban, Lanreotide, Sugammadex, Dupilumab, Eculizumab, Dabigatran Etexilate and Teriflunomide which are all shortly due to lose their patent exclusivity and therefore will have generic competition available 01/10/2023-30/06/2024 (with option to extend for 12 months to 30/06/2025)	briefing	£30,865,086	03/07/2023	14/07/2023	NA	NA
2.	**Biomass Fuel** Woodchip and Wood Pellet fuel biomass is used as a heating fuel by organisations across Wales which have a requirement 01/08/2023 – 31/07/2025	ratification	£938,982	03/07/2023	14/07/2023	18/07/2023	NA
3.	**E-expenses** Selenity e-Expenses has been in operation within NHS Wales since 2012 and has been developed significantly over the years in NHS Wales. The current arrangement was procured through G-Cloud 12 5th August 2023 – 4th August 2026	briefing	£885,600	29/06/2023	NA direct award framework	NA	NA
4.	**Aggregation: Mobile Voice & Data Services** The current contractual position across NHS Wales varies greatly for mobile call and data packages, and the specification procured is tailored around the needs of the NHS Wales organisation's 2 years plus option to extend for 2 periods of 12 months	briefing	£28,260,462	03/07/2023	NA direct award framework	NA	NA
5.	**PROMs** Measures a patient's health status or health-treated quality of life at a single point in time and are collected through self-completed questionnaire (proforma) or a set of questionnaires. PROMs can be issued to a patient at any point along their treatment pathway 4 year framework	ratification	£14,250,677	04/07/2023	25/08/2023	25/08/2023	25/08/2023
6.	**Erythropoietin Stimulating Agents & IV Iron Erythropoiesis** The process by which red blood cells are produced. It is stimulated by the decreased oxygen in circulation, which is detected by the kidneys, which then secrete the hormone erythropoietin. Erythropoietin Stimulating Agents (ESA) are structurally and biologically similar to naturally occurring protein erythropoietin. Clinicians prescribe ESAs to maintain haemoglobin at the lowest level that both minimises transfusions and best meets individual patient needs. IV iron is necessary to treat iron deficiency in patients who are receiving ESA treatment.	ratification	£20,092,264	06/07/2023	14/07/2023	24/07/2023	26/07/2023

No.	Contract Title	Doc Type	Total Value	Director of Procurement Services (Jonathan Irvine) approval <£750K	WG approval >£500k	General Manager (Neil Frow) approval £750-£1M	Chair (Tracy Myhill) Approval £1M+
	1st October 2023 to 30th September 2025 (with an option to extend for up to a further period of 24 months to 30th September 2027)						
7.	**Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)** WTAIL operates the Welsh Histocompatibility and Immunogenetics Service (WHAIS), which provides scientific advice, results, and expertise for a range of NHS Wales organisations, including hospitals, transfusion centres and General Practitioners Five (5) year contract with options to extend for a further one plus one years.	briefing	£1,104,000	06/07/2023	27/07/2023	NA	NA
8.	**Procedure Packs** Custom Procedure Packs are bundled medical disposables that are available in sterile packages. Typically, these disposable packs include drapes, gowns, swabs, polyware, blades, sutures, syringes and other products associated with clinical procedures 1st August 2019 - 31st July 2023 extension - 1st August 2023 – 31st July 2024	extension	£14,480,843	22/06/2023	original approval applies 1/8/19	07/07/2023	07/07/2023
9.	**E-expenses** Selenity e-Expenses has been in operation within NHS Wales since 2012 and has been developed significantly over the years in NHS Wales. The current arrangement was procured through G-Cloud 12 5th August 2023 – 4th August 2026	ratification	£845,030	12/07/2023	NA direct award framework	18/07/2023	18/07/2023
10.	**PHW -Infection Prevention and Control (IPC) Case Management and Surveillance System** Supplying cross-hospital electronic infection case management, immediate alerting of information relevant to infection control to ward staff and others including health protection specialists, and in depth and real-time reporting for clinical and public health action 15/08/23 for 2+2	briefing	£1,830,000	12/07/2023	NA direct award framework	NA	NA
11.	**TRAC** The Once for Wales e-recruitment system (TRAC) provides visibility of the full end-to-end recruitment process to all users allowing for the tracking of applicants, shortlisting, interview, and appointment stages. The flexibility of functionality provides use across Agenda for Change recruitment, medical recruitment, appointment to the temporary workforce, and more bespoke recruitment such as the Student Streamlining Process and Collaborative Bank with the ability to monitor and manage compliance with NHS Employment Standards 1st August 2023 – 31st July 2026	ratification	£3,057,840	13/07/2023	NA direct award framework	14/07/2023	17/07/2023
12.	**TRAMs** As part of the TRAMS Project (South-East Hub) there is a requirement to engage a specialist clean room contractor for a Design, Build & Validation project Jan 24 for 5 years	briefing	£12,000,000	13/07/2023	WG confirmed approval NA as business case approved	NA	NA
13.	**Pulp Medical Products** Disposable pulp products are a critical category in the prevention of Hospital Acquired Infections 3+1 Years extension 1/8/23-31/7/24	extension	£4,590,610	14/07/2023	original approval applies 14/7/20	14/07/2023	18/07/2023

14.	**Maintenance of Aquilion One Prism CT Scanner to include replacement X ray tube and replacement CT Detector** Provision of regular servicing, corrective maintenance visits to site and the supply and fitting of replacement parts, including specialist elements for the life of the contract. Full technical and clinical applications support is also provided for the life of the contract. 9 years following warranty expiry 16th February 2024 – 31st March 2033	ratification	£699,105	28/07/2023	NA direct award framework	NA	NA
15.	**Postgraduate Dental Education Framework Agreement (HEIW)** A multi supplier framework agreement, lotted on a regional and all Wales basis, covering face to face and online learning methods to support postgraduate education and training for the whole dental workforce in Wales 8th August 2023 - 31st July 2026 with the option to extend for 1 year	ratification	£500,000	28/07/2023	11/08/2023	NA	NA
16.	**Independent mental Health Advocacy** People who may qualify for IMCA support are those who lack capacity: an IMCA must be consulted to support those who lack capacity and "where there is no one who is *willing and able* to represent them or be consulted in the process of working out their best interests" for decisions about serious medical treatment and about whom there is no-one to consult and for decisions about a change of accommodation and about whom there is no-one to consult 1st April 2024 to 31st March 2026 with an option to extend for two further periods, each of one year, up to 31st March 2028	briefing	£3,330,864	28/07/2023	14/08/2023	NA	NA
17.	**Suction Consumables** Medical suction devices such as suction catheters and tubing are required to extract secretions, such as blood, saliva, and mucus from the airway and other cavities within the body 01/04/2024 – 31/03/2028	briefing	£1,608,000	31/07/2023	sent to WG 31/7	NA	NA
18.	**Pathology Consumables** To supply pathology consumables, equipment, and instruments to NHS Wales. 1st September 2023 – 31st August 2027	ratification	£9,873,757	01/08/2023	11/09/2023	11/09/2023	11/09/2023
19.	**Skin & Wound closure** Skin Closure is the immediate treatment of an injury found on a part of the body with the intent to lead to a faster healing process and best cosmetic result. A suture (commonly known as a stitch) is used in procedures to close cuts and wounds in the skin 01/10/2023 – 30/09/2027	briefing	£18,615,197	02/08/2023	sent to WG 2/8	NA	NA
20.	**Home Oxygen Service** Provision of a Home Oxygen Service including management of equipment, servicing and maintenance on behalf of Health Boards in line with the National Home Oxygen Service specification 1st October 2023 – 30th September 2030	ratification	£6,663,483	03/08/2023	11/09/2023	11/09/2023	11/09/2023
21.	**HEIW Provision of Community Nursing Education and Training Services** Seeking to commission Specialist Community Public Health Nursing (SCPHN) and Specialist Practitioner Qualification (SPQ) education and training 5 years with the option to extend in three, 12 month intervals	briefing	£44,200,800	09/08/2023	sent to WG 9/8	NA	NA
22.	**Psychological services education and training** In order to increase the sustainability of psychology services workforce, HEIW sought to procure educational provision for a Level 8 Clinical Psychology Doctorate Programme, a Level 7 Masters Programme for a new profession for Wales, namely	ratification	£1,908,142	04/08/2023	18/09/2023	Sent to NF 21/9	

	Clinical Associate in Applied Psychology (CAAPs) and Level 1 and Level 2 Cognitive Behavioural Therapy (CBT). 1st September 2023 to 31st July 2024 Service Commencement: 1st August 2024 – 31st July 2029						
23.	**Contrast Media** All products currently purchased are contained within the current contract as many of the different contrasts are used in specific specialised areas. The different products will have different licensed indications for use in various therapy areas for example there are specific X-ray media for use within cardiac investigations 1st November 2023 to 31st October 2027	ratification	£15,087,907	09/08/2023	14/08/2023	14/08/2023	24/08/2023
24.	**Commercial storage facilities and distribution services** To establish additional resilince and to enable the holding of the necessary goods, NWSSP SES and SC, L&T engaged with agents and transport providers to establish options around being able to hold up to 15,000 pallets as stock holding at any one time and consideration to expand further. 1st December 2023 to 30th November 2024	briefing	£1,900,000	16/08/2023	sent to WG 16/8	NA	NA
25.	**E-Prescribing system for chemotherapy** implementation of a single E-Prescribing System for Chemotherapy to be implemented across all BCU sites September 14 – September 24	extension	£517,196	10/08/2023	original approval applies 3/2/14	NA	NA
26.	**Infection prevention and control system** ICNET is an Infection Prevention and Control Case Management and Surveillance system supplying cross-hospital electronic infection case management, immediate alerting of information relevant to infection control to ward staff and others including health protection specialists, and in depth and real-time reporting for clinical and public health action. 15/08/2023 – 14/08/2027	ratification	£1,876,878	15/08/2023	NA direct award framework	20/09/2023	21/09/2023
27.	**HCS Vehicle replacement programme** A requirement to seek replacement vehicles for the Supply Chain Operation. 3 years with 2 optional 1 year extension	briefing	£2,000,000	16/08/2023	sent to WG 16/8	NA	NA
28.	**Desktop hardware & peripherals** Seeking to procure a Desktop Hardware & Peripherals contract, which will allow the continuation of the replacement of the current laptop estate in line with lifecycle replacement. Alongside enabling BCU to fulfil new hardware requests and project implementations.	ratification	£600,000	16/08/2023	21/08/2023	NA	NA
29.	**Vaccines** This contract is for Adult Vaccines purchased by hospital Pharmacy Departments. This contract consists of Adult Vaccines only, as Childhood Vaccines are currently purchased from the National Framework, which is managed by NHS England and CMU. (Influenza vaccines for Occupational Health are managed on a separate All Wales agreement). We currently have 11 lines on this contract, including varying strengths of Hepatitis A and B, Varicella, Typhoid and Pneumococcal. 1st February 2021 to 31st January 2025	extension	£945,253	04/09/2023	original approval applies 16/12/20	05/09/2023	NA
30.	**Self-Monitoring Blood Glucose Equipment and Consumables** Formulary The current Formulary seeks to provide a guidance to clinicians. Whilst maintaining a supply route	briefing	£32,000,000	05/09/2023	NA as formularly	NA	NA

	via WP10 prescription for test strips, meters are available free of charge. There are a large variety of meters available to patients on the drug tariff with a range of features and prices. For these reasons, a formulary of recommended meters was agreed with the resulting guidance commencing April 2021 as a means of controlling the broad range of devices available as this can present a clinical risk January 2024 2+2						
31.	**Ontex Continence Products** The contract is for the supply and delivery of disposable and washable (reusable) continence products to Secondary Care and Primary Care patients 1st August 2023 – 31st January 2025 (18 Months)	ratification	£11,250,524	12/09/2023	NA direct award framework	20/09/2023	21/09/2023
32.	**E-scheduling caseload management** E-Scheduling software must be a clinically safe intelligent scheduling system for managing community services and its distributed district Nursing workforce in Wales. 5 Years with options to extend for up to 3 years, in whole or in part.	briefing	£4,000,000	11/09/2023	returned with queries 18/9		
33.	**HEIW Single platform** The delivery of a single platform will follow an agile and phased work-packaged approach with essential functionality delivered initially and follow up work packages to be defined and agreed upon before work starts. 17th January 2024 - 16th January 2026	briefing	£2,400,000	14/09/2023	query returned 21/9		
34.	**Audiology extension** The agreement is currently for the provision of a range of audiology products, including Adult Hearing Aids, Paediatric Specific Hearing Aids, Audiology Parts, Consumables and Accessories, Ear moulds, Batteries, Bone Conduction Hearing Implants (including Middle Ear Devices), Processors & Accessories, Cochlear Implants (including Auditory Brainstem Implants), Processors & Accessories products to all of NHS Wales. 3+1 years (01/01/2021 – 31/12/2024)	extension	£34,200,468	20/09/2023	original approval applies 31/12/20	20/09/2023	21/09/2023
35.	**Transitional Drugs 2** This contract is for the tender of Apixaban, Lanreotide, Sugammadex, Dupilumab, Eculizumab, Dabigatran Etexilate and Teriflunomide which are all shortly due to lose their patent exclusivity and therefore will have generic competition available 01/10/2023-30/06/2024 (with option to extend for 12 months to 30/06/2025)	ratification	£2,334,124	21/09/2023	sent to WG 21/9		
36.	**Whole Blood and Ancillary Collection systems (WBS)** Blood Collection systems (packs used in the collection and manufacturing process) are business critical consumables used to collect blood from donors and produce blood components for use 01/11/23 to 31/10/27	ratification	£2,097,336	22/09/2023	NA direct award framework	Sent to NF 25/9	
37.	**Anti retroviral drugs** There is no cure for infection caused by the human immunodeficiency virus (HIV), but a number of drugs slow or halt the progression. These drugs are known as Anti-Retroviral. 1st February 2022 to 30th June 24	extension	£15,043,351	sent to JI 25/9			
38.	**Disinfectants** These include Alcohol wipes, Chlorhexidine Gluconate solutions, Chlorhexidine Gluconate sprays, Chlorhexidine Gluconate scrubs, Chlorine releasing tablets, Industrial Methylated Spirit, Isopropyl Swabs and Povidone Iodine Solution. 1st February 2021 to 31st January 2025	extension	£3,831,098	sent to JI 25/9			

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Non-Compliant Activity / Contract Breach Summary

The below summary details all Departments who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year		July'23		August '23		September '23		October '23		November '23	
Division / Department	**Executive / Director Responsible**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**
Corporate											
Nursing	Nicola Williams	1								1	
Finance	Matthew Bunce	1						2		1	
Corporate Governance	Lauren Fear	1			1		1		1		
Estates	Carl James					1					
People & OD						1					
RD&I											
Research & Development	Jaz Abraham			1		1					
nVCC											
nVCC Project	David Powell	2		1		4		4			
VCS											
Therapies	Rachel Hennessy	2									
Outpatients											
Operational Services	Rachel Hennessy									1	
Utilities											
VCC Planning											
Private Patients											
Medical Physics	Rachel Hennessy					1					
Service Improvement											
Radiation Protection											
Radiotherapy											
Radiology											
Nuclear Medicine											
Pharmacy											
Charity/Fundraising											
Charity/Fundraising	Paul Wilkins					1		1		1	
WBS											
Corporate Services	Alan Prosser		1								

Year		July'23		August '23		September '23		October '23		November '23	
Division / Department	**Executive / Director Responsible**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**
Facilities	Alan Prosser					1					
Molecular Genetics	Alan Prosser									1	
TOTALS		**6**	**1**	**2**	**1**	**10**	**1**	**7**	**1**	**5**	**0**